

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	\$4,750 per individual; \$9,500 per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. If you have a non-calendar plan year, the maximum limit may change during the course of a calendar year. If the limit increases with a new plan year, you may owe cost-sharing again up to the amount of the increase even if you reached the limit earlier in the Calendar Year. See the Certificate of Coverage for details. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	\$7,900 per individual; \$15,800 per family
PREVENTIVE CARE: <ul style="list-style-type: none"> Well Baby Care (Children under age 3) Routine Physicals (One per Calendar Year for ages 3+) Covered Immunizations OB/GYN Preventive Visit (One per Calendar Year) Preventive Prenatal Care Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) Other preventive items and services. See Certificate of Coverage for more information. 	100% Coverage
OTHER PRIMARY CARE SERVICES: <ul style="list-style-type: none"> Surgical and Medical Physician Services Hearing Exams Illness and Injury 	\$40 Copayment per visit
SPECIALTY CARE: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> Medical Physician Services OB/GYN Services Illness and Injury 	\$60 Copayment per visit
URGENT CARE CENTER SERVICES: <ul style="list-style-type: none"> Medical Physician Services Illness and Injury 	\$60 Copayment per visit
TELADOC TELEHEALTH SERVICES: <ul style="list-style-type: none"> Primary/Urgent Care Consultations Behavioral Health Consultations 	\$55 per consultation \$60 per consultation
LABORATORY SERVICES: <ul style="list-style-type: none"> Laboratory Procedures Covered Genetic Testing 	60% Coverage
VISION CARE: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> One routine vision exam per Calendar Year Other eye care office visits 	\$60 Copayment per visit
ALLERGY SERVICES: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> Physician Services Testing and Treatment 	\$60 Copayment per visit 60% Coverage
CHRONIC CARE MAINTENANCE: <i>(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)</i>	60% Coverage
DIAGNOSTIC SERVICES: <ul style="list-style-type: none"> X-Rays Other Diagnostic Services <i>(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)</i> 	\$10 Copayment per image 60% Coverage
OUTPATIENT SERVICES: <ul style="list-style-type: none"> Surgery and Other Outpatient Services 	60% Coverage
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> Physician and Facility Services 	60% Coverage
EMERGENCY ROOM SERVICES:	\$500 Copayment per visit
EMERGENCY AMBULANCE SERVICES: <i>(Must be Medically Necessary)</i>	60% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	60% Coverage
SKILLED NURSING FACILITY SERVICES: <i>(100 days per Lifetime)</i>	60% Coverage
MEDICAL NUTRITION SERVICES: <i>(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)</i>	\$60 Copayment per visit



INTEGRITY CABINETS

Effective Dates: Coverage Beginning On or After September 1, 2025

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MEDICAL BENEFITS		COVERAGE
DIABETES SELF-MANAGEMENT EDUCATION:		\$60 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.		60% Coverage
MATERNITY SERVICES: Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care		\$60 Copayment per delivery
<ul style="list-style-type: none">Physician Services (Prenatal, delivery, and postnatal care)Maternity Hospitalization		60% Coverage
Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.		
REHABILITATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses)		60% Coverage
HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)		60% Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required. Covered up to 25 visits per Calendar Year)		\$60 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:		\$60 Copayment per visit
SLEEP DISORDERS:		\$60 Copayment per visit
<ul style="list-style-type: none">Sleep Study		60% Coverage per sleep study
TRANSPLANT SERVICES:		60% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:		60% Coverage
<ul style="list-style-type: none">Inpatient ServicesOutpatient Services		\$60 Copayment per visit
PHARMACEUTICAL BENEFITS		COVERAGE
COVERED PRESCRIPTION DRUGS¹:		
<ul style="list-style-type: none">Tier 1 (Preferred Generic Drugs)<ul style="list-style-type: none">From a Participating PharmacyMail-orderParticipating PharmacyTier 2 (Non-Preferred Generic Drugs)<ul style="list-style-type: none">From a Participating PharmacyMail-orderParticipating PharmacyTier 3 (Preferred Brand and Non-Preferred Generic Drugs)<ul style="list-style-type: none">From a Participating PharmacyMail-orderParticipating PharmacyTier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)<ul style="list-style-type: none">From a Participating PharmacyMail-orderParticipating PharmacyTier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals³ and Non-Preferred Drugs)Oral ContraceptivesDiabetic Testing Supplies (OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices)		<ul style="list-style-type: none">\$5 Copayment per 30-day supply\$12 Copayment per 90-day supply²\$15 Copayment per 90-day supply²\$20 Copayment per 30-day supply\$43 Copayment per 90-day supply²\$60 Copayment per 90-day supply²\$60 Copayment per 30-day supply\$150 Copayment per 90-day supply²\$180 Copayment per 90-day supply²\$80 Copayment per 30-day supply\$200 Copayment per 90-day supply²\$240 Copayment per 90-day supply²60% Coverage\$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs100% Coverage

¹Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. ²A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. ³May be administered in the home, physician's office or on an outpatient basis. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to www.vivahealth.com/Group/plans/INCA.

When generic is available, Member pays difference between generic and brand price ("ancillary charge"), plus Copayment. Ancillary charges do not count toward the out-of-pocket maximum. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at www.vivahealth.com

Pre-Existing Condition Policy:
Eligible Dependent:

No pre-existing condition exclusions or waiting period.
Eligible Employee's lawful spouse and children of Eligible Employee under age 26 or disabled dependents who meet eligibility criteria. Dependents with a last name different from employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.