

Maternity Hospitalization

DOMAN STAFFING 1

Effective Dates: January 1, 2026 – December 31, 2026

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. This is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

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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 Specialty Drugs 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.	\$600 per individual; \$1,800 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: 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: Medical Physician Services Hearing Exams Illness and Injury 	\$40 Copayment per visit
 SPECIALTY CARE: (No PCP Referral Required) Medical Physician Services OB/GYN Services Illness and Injury 	\$60 Copayment per visit
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	\$60 Copayment per visit
TELADOC TELEHEALTH SERVICES: • Primary/Urgent Care Consultations • Behavioral Health Consultations	\$55 per consultation \$60 per consultation
 VISION CARE: (No PCP Referral Required) One routine vision exam per Calendar Year Other eye care office visits 	\$60 Copayment per visit
 ALLERGY SERVICES: (No PCP Referral Required) Physician Services Testing and treatment 	\$60 Copayment per visit 80% Coverage
CHRONIC CARE MAINTENANCE: (Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)	80% Coverage
Laboratory Procedures Covered Genetic Testing	80% Coverage
 DIAGNOSTIC SERVICES: X-Rays Other Diagnostic Services (Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP) 	\$10 Copayment per image 80% Coverage
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services	80% Coverage
HOSPITAL INPATIENT SERVICES: • Physician and Facility Services	80% Coverage
MATERNITY SERVICES: (Covered for employee and employee's spouse; not covered for dependent children excellare) • Physician Services (Prenatal, delivery, and postnatal care)	\$60 Copayment per delivery

Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.

80% Coverage



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MEDICAL BENEFITS		COVERAGE	
EMERGENCY ROOM SERVICES:		\$300 Copayment per visit	
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)		80% Coverage	
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:		80% Coverage	
SKILLED NURSING FACILITY SERVICES: (100 days per Lifetime)		80% Coverage	
MEDICAL NUTRITION SERVICES: (Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)		\$60 Copayment per visit	
DIABETES SELF-MANAGEMENT EDUCATION:		\$60 Copayment per visit	
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.		80% Coverage	
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and O Behavior Analysis (<i>Limited to 60 total inpatient days and 30 total outpatient wedical diagnoses</i>)	, .,	80% Coverage	
HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)		80% 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	
Sleep Study		80% Coverage	
TRANSPLANT SERVICES:		80% Coverage	
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:			
Inpatient Services		80% Coverage	
Outpatient Services		\$60 Copayment per visit	
PHARMACEUTICAL BENEFITS		COVERAGE	
COVERED PRESCRIPTION DRUGS1:			
 Tier 1 (Preferred Generic Drugs) From a Participating Pharmacy Mail-order Tier 2 (Non-Preferred Generic Drugs) 		\$5 Copayment per 30-day supply (\$15 per 90-day supply²) \$12 Copayment per 90-day supply²	
 From a Participating Pharmacy Mail-order Tier 3 (Preferred Brand and Non-Preferred Generic Drugs) 		\$20 Copayment per 30-day supply (\$60 per 90-day supply²) \$43 Copayment per 90-day supply²	
From a Participating Pharmacy Mail-order	\$60 Copayment per 30-d	ay supply (\$180 per 90-day supply ²	

Mail-order

Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)

From a Participating Pharmacy

Mail-order

Oral Contraceptives

Tier 5 (Specialty Drugs³ and Non-Preferred Drugs)

 Diabetic Testing Supplies [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices] \$150 Copayment per 90-day supply²

\$80 Copayment per 30-day supply (\$240 per 90-day supply²) \$200 Copayment per 90-day supply²

\$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs

100% Coverage

80% 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/DMS1.

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: No pre-existing condition exclusions or waiting period.

Eligible Dependent: 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.

Doman Staffing 1 (2026) 10/2025 | Benefit Code: DMS1