VIVA HEALTH

MEDICAL WEST HSA ELIGIBLE

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. This health plan is eligible to pair with a health savings account (HSA). Funds distributed into an HSA for use with this health plan, up to the annual contribution limit, are tax-deductible and funds in an HSA grow tax-free. You can withdraw funds from your HSA to pay for qualified medical expenses, like deductibles and coinsurance, without penalty. To be eligible for an HSA you must be covered under a high deductible health plan, such as this, among other requirements set forth by the IRS. As a member of VIVA HEALTH through Medical West, you have a customized provider network that includes the physicians and facilities associated with Medical West and UAB. UAB means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, UAB Callahan Eye Hospital, UAB Spain Rehabilitation Center, UAB St. Vincent's, and all UAB and Medical West satellite clinics. You have access to our entire network of OB/GYN, vision, pain management, podiatry, dermatology, allergy/immunology, mental health, and chiropractic providers. Medical West members under the age of 18 have access to VIVA HEALTH's entire pediatric network.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies to all benefits except Teladoc telehealth, insulin, select diabetic testing supplies at retail pharmacy, and preventive care services covered at no charge. If your coverage tier is anything other than single coverage, you must meet the aggregate family deductible. You must pay all of the cost for Covered Services until the deductible is satisfied, except as noted above. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Coinsurance do not count toward the Deductible.	$1,700 per individual; $3,400 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 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. 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.	$6,750 per individual; $13,500 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 visits 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	80% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury	80% Coverage
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	80% Coverage
VISION CARE: *(No PCP Referral Required)* • One routine vision exam per Calendar Year • Other eye care office visits	80% Coverage
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and Treatment	80% Coverage
CHRONIC CARE MAINTENANCE: *(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)*	80% Coverage
LABORATORY SERVICES: • 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)*	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 except as provided under Preventive Care)* • Physician Services *(Prenatal, delivery, and postnatal care)* • Maternity Hospitalization **Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.**	80% Coverage
EMERGENCY ROOM SERVICES:	80% Coverage
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage

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MEDICAL BENEFITS	COVERAGE
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	80% Coverage
DIABETES SELF-MANAGEMENT EDUCATION	80% Coverage
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	80% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	80% Coverage
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(Limited to 60 total inpatient days & 30 total outpatient visits per Calendar Year for medical diagnoses)*	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)*	80% Coverage
TEMPOROMANDIBULAR JOINT DISORDER:	80% Coverage
SLEEP DISORDERS:	80% Coverage
TRANSPLANT SERVICES:	80% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES: • Inpatient • Outpatient	80% Coverage

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ Participating Pharmacy (30 and 90-day supply)	80% Coverage[2]
○ Mail-order (90-day supply)	80% Coverage[2]
• **Tier 2 (Non-Preferred Generic Drugs)**	
○ Participating Pharmacy (30 and 90-day supply)	80% Coverage[2]
○ Mail-order (90-day supply)	80% Coverage[2]
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ Participating Pharmacy (30 and 90-day supply)	80% Coverage[2]
○ Mail-order (90-day supply)	80% Coverage[2]
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ Participating Pharmacy (30 and 90-day supply)	80% Coverage[2]
○ Mail-order (90-day supply)	80% Coverage[2]
• **Tier 5 (Specialty Drugs[3] and Non-Preferred Drugs)**	70% Coverage
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• **Insulin**	100% Coverage for covered insulin drugs
• **Diabetic Testing Supplies [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]**	100% Coverage

[1]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [2]A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [3]May 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 https://www.vivahealth.com/Group/Login/.

When generic is available, Member pays difference between generic and Brand price, plus Copayment.
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.

Working Spouse Rule: Your spouse is NOT eligible for coverage under this plan if:

1. your spouse is eligible for coverage under his/her employer's plan AND
2. your spouse's employer pays at least 50% of total premium for individuals on any plan offered.

Verification of the spouse's ineligibility for an employer plan that meets the provisions above is required for this plan to be primary. Your spouse may be eligible for secondary coverage under this plan if proof of other primary insurance is provided.