VIVA HEALTH

TRITON HEALTH

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.

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.	$500 per individual; $1,500 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. 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.	$7,350 per individual; $14,700 per family
PREVENTIVE CARE:	
• Well Baby Care (Children under age 3)	100% Coverage
• Routine Physicals (One per Calendar Year for ages 3+)	
• Covered Immunizations	
• OB/GYN Preventive Visit (One per Calendar Year)	
• Preventive Prenatal Care (As defined in the Certificate of Coverage)	
• 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.	
OTHER PRIMARY CARE SERVICES:	
• Medical Physician Services	$35 Copayment per visit
• Hearing Exams	
• Illness and Injury	
SPECIALTY CARE: *(No PCP Referral Required)*	
• Medical Physician Services	$50 Copayment per visit
• OB/GYN Services	
• Illness and Injury	
URGENT CARE CENTER SERVICES:	
• Medical Physician Services	$50 Copayment per visit
• Illness and Injury	
TELADOC TELEHEALTH SERVICES:	
• Primary/Urgent Care Consultations	$0 per consultation
• Behavioral Health Consultations	$0 per consultation
VISION CARE: *(No PCP Referral Required)*	
• One routine vision exam per Calendar Year	$50 Copayment per visit
• Other eye care office visits	$50 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)*	
• Physician Services	$50 Copayment per visit
• Testing and Treatment	90% Coverage
CHRONIC CARE MAINTENANCE: *(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)*	90% Coverage
LABORATORY SERVICES:	
• Laboratory Procedures	90% Coverage
• Covered Genetic Testing	80% Coverage
DIAGNOSTIC SERVICES:	
• X-Rays	$10 Copayment per image
• Other Diagnostic Services *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage
OUTPATIENT SERVICES:	
• Surgery and Other Outpatient Services Performed at a Hospital	$300 Copayment per service at UAB*; 90% Coverage outside UAB
• Surgery and Other Outpatient Services Performed at an Ambulatory Surgical Center	$250 Copayment per service
• Outpatient Hospital Observation (No procedure performed)	$250 Copayment per day (Days 1-5)
HOSPITAL INPATIENT SERVICES:	
• Physician and Facility Services	$250 Copayment per day (Days 1-5) at UAB*; 90% Coverage outside UAB
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)*	$50 Copayment per delivery
• Maternity Hospitalization	$250 Copayment per day (Days 1-5) at UAB*; 90% Coverage outside UAB
Eligible baby must be enrolled in plan within 31 days of birth or adoption for care to be covered.	
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	90% Coverage

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EMERGENCY ROOM SERVICES:	$275 Copayment per visit at UAB*; $325 Copayment per visit outside UAB
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	90% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	90% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION:	$50 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
REHABILITIATION AND HABILITIATION 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)*	90% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	90% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)*	$50 copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
SLEEP DISORDERS: • Sleep Study	$50 Copayment per visit 90% Coverage per sleep study
TRANSPLANT SERVICES:	$250 Hospital Copayment per day (Days 1-5) at UAB*; 90% Coverage outside UAB
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• Inpatient	$250 Copayment per day (Days 1-5) at UAB*; 90% Coverage outside UAB
• Outpatient	$50 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$10 Copayment per 30-day supply ($30 per 90-day supply[2])
○ Mail-order	$25 Copayment per 90-day supply[2]
• **Tier 2 (Generic Drugs)**	
○ From a Participating Pharmacy	$30 Copayment per 30-day supply ($90 per 90-day supply[2])
○ Mail-order	$75 Copayment per 90-day supply[2]
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$75 Copayment per 30-day supply ($225 per 90-day supply[2])
○ Mail-order	$187 Copayment per 90-day supply[2]
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$100 Copayment per 30-day supply ($300 per 90-day supply[2])
○ Mail-order	$250 Copayment per 90-day supply[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
• **Diabetic Testing Supplies** [OneTouch and Freestyle (excluding *Libre*) glucose meters, OneTouch 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 ("ancillary charge"). 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 Employee: Eligible employees must elect coverage within 31 days of becoming eligible or within 31 days of a qualifying life event.
Eligible Dependent: Eligible employee's lawful spouse and children of Eligible Employees up to 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. Eligible dependents must enroll in coverage within 31 days of the eligible employee's initial enrollment, at annual enrollment, or within 31 days of a qualifying life event.
Working Spouse Rule: your spouse is NOT eligible for primary coverage under this plan if:

1. your spouse is eligible for coverage under their employer's plan AND
2. that 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.

**For care delivered outside of Jefferson County, the UAB cost sharing will apply. Inside Jefferson County, UAB cost sharing will apply at University Hospital, UAB Women and Infants Center, UAB Highlands, UAB St. Vincent's, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, all UAB and UAB St. Vincent's satellite clinics, and Children's Hospital.*