UAB St. Vincent's

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. This is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage. "UAB/UAB St. Vincent's Network" means University Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic, UAB St. Vincent's, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, and all UAB and UAB St. Vincent's satellite clinics. The UAB and UAB St. Vincent's network includes all pediatric care for dependents under age 18 regardless of whether those dependents receive their pediatric care in the VIVA HEALTH (VIVA) network or the UAB and UAB St. Vincent's network. The VIVA HEALTH (VIVA) network includes hospitals and health centers contracted with VIVA HEALTH but outside of UAB and UAB St. Vincent's. **Please keep this Attachment A for your records.**

MEDICAL BENEFITS	COVERAGE- TIER 1 UAB/UAB St. Vincent's Network	COVERAGE- TIER 2 VIVA Network (outside the UAB/UAB St. Vincent's Network)
CALENDAR YEAR MEDICAL DEDUCTIBLE: Applies ONLY to medical benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment or to the pharmaceutical benefits offered through the prescription drug rider. Does apply to Specialty 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. Deductible amounts paid on any tier apply toward all tiers, but Tier 2 has a higher deductible requirement.	$250 per individual; $750 per family, not to exceed $250 per any individual	$1,000 per individual; $2,000 per family, not to exceed $1,000 per any individual
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 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. Out-of-pocket cost sharing paid on any tier applies toward all tiers, but Tier 2 has a higher out-of-pocket maximum. Amounts paid on any tier apply toward all tiers.	$4,000 per individual; $8,000 per family, not to exceed $4,000 per any individual	$7,500 per individual; $15,000 per family, not to exceed $7,500 per any individual
PREVENTIVE CARE: • **Well Baby Care** (Children under age 3) • **Routine Physicals** (One per Calendar Year for ages 3+) • **Covered Immunizations** • **Preventive Prenatal Care** • **OB/GYN Preventive Visit** (One per Calendar Year) • **Nutritionist Preventive Visits** (Up to 3/Yr with a Registered Dietitian or Nutritionist) • **Other preventive items and services** (See Certificate of Coverage for details)	100% Coverage	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Illness and Injury** • **Hearing Exams** • **Laboratory Procedures** ○ Covered genetic testing	 $30 Copay/visit $30 Copay/visit $30 Copay/visit 100% Coverage 80% Coverage after deductible	 $50 Copay/visit $50 Copay/visit $50 Copay/visit 100% Coverage 60% Coverage after deductible
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **Laboratory Procedures** ○ Covered genetic testing • **OB/GYN services**	 $50 Copay/visit $50 Copay/visit 100% Coverage 80% Coverage after deductible $0 Copay/visit	 $60 Copay/visit $60 Copay/visit 100% Coverage 60% Coverage after deductible $60 Copay/visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	 $30 Copay/visit	 $50 Copay/visit
EMERGENCY ROOM SERVICES: *(Copay waived if admitted within 24 hours)*	$250 Copay/visit	$250 Copay/visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage after deductible	80% Coverage after deductible
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	 $50 Copay/visit	 $60 Copay/visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	 $50 Copay/visit 85% Coverage after deductible	 $60 Copay/visit 60% Coverage after deductible
DIAGNOSTIC SERVICES: • **Outpatient Laboratory Procedures** • **X-Rays** • **Covered Genetic Testing** • **Other Diagnostic Services** *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)*	 100% Coverage $30 Copay/visit 80% Coverage after deductible $30 Copay/service	 100% Coverage 60% Coverage after deductible 60% Coverage after deductible 60% Coverage after deductible
HOSPITAL INPATIENT SERVICES: Physician and Facility Services	$300 Copay/admission	60% Coverage after deductible
OUTPATIENT SERVICES: Surgery and Other Outpatient Services	$150 Copay/visit	60% Coverage after deductible
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50 Copay/visit	$60 Copay/visit

VIVA HEALTH® UAB ST. VINCENT'S

MEDICAL BENEFITS	COVERAGE - TIER 1 UAB/UAB St. Vincent's Network	COVERAGE - TIER 2 VIVA Network (outside UAB)
CHRONIC CARE MAINTENANCE: *Including, but not limited to:*		
• **Dialysis**	85% Coverage after deductible	85% Coverage after deductible
• **Radiation therapy, wound care, wound therapy**	85% Coverage after deductible	60% Coverage after deductible
MATERNITY SERVICES[1]: *($1,500 out-of-pocket maximum/member/Calendar Year)*		
• **Physician Services** *(Prenatal, delivery, and postnatal care)*	$0 Copay/delivery	$60 Copay/delivery
• **Hospitalization**	$300 Copay/admission	60% Coverage after deductible
[1]Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered. No coverage for children of employee's dependent child.		
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage after deductible	80% Coverage after deductible
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 days per lifetime)*	80% Coverage after deductible	80% Coverage after deductible
HOME HEALTH CARE AND HOSPICE SERVICES:		
• **Home Health** *(Limited to 60 visits per Calendar Year)*	80% Coverage (no deductible)	80% Coverage after deductible
• **Home Infusion Drug Administration**	80% Coverage after deductible	80% Coverage after deductible
• **Home Infusion Drugs** *($350 maximum per drug infusion)*	80% Coverage after deductible	80% Coverage after deductible
• **Hospice**	80% Coverage (no deductible)	80% Coverage after deductible
DIABETES SELF-MANAGEMENT EDUCATION:	$50 Copay/visit	$60 Copay/visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage	100% Coverage
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$30 Copay/visit	60% Coverage after deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	$30 Copay/visit	$30 Copay/visit
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copay/visit	$60 Copay/visit
SLEEP DISORDERS:	$50 Copay/visit;	$60 Copay/visit;
• **Sleep Study**	$150 Copay/visit	60% Coverage after deductible
TRANSPLANT SERVICES:	$300 Copay/admission	60% Coverage after deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:		
• **Inpatient Services**	$200 Copay/admission	80% Coverage after deductible
• **Outpatient Services**	$30 Copay/visit	$30 Copay/visit

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[2]:	
• **Generic Drugs**	
○ St. Vincent's Hospital Pharmacy	$10 Copay (30-day supply) or $20 Copay (90-day supply[3])
○ Express Scripts (ESI) Participating Retail Pharmacy	$20 Copay (30-day supply) or $60 Copay (90-day supply[3])
○ Mail order (ESI)	$40 Copay (90-day supply[3])
• **Preferred Brand Drugs**	
○ St. Vincent's Hospital Pharmacy	$25 Copay (30-day) or $75 Copay (90-day[3])
○ Express Scripts (ESI) Participating Retail Pharmacy	$50 Copay (30-day) or $150 Copay (90-day[3])
○ Mail order (ESI)	$100 Copay (90-day supply[3])
• **Non-Preferred Brand Drugs**	
○ St. Vincent's Hospital Pharmacy	$75 Copay (30-day) or $225 Copay (90-day[3])
○ Express Scripts (ESI) Participating Retail Pharmacy	$75 Copay (30-day) or $225 Copay (90-day[3])
○ Mail order (ESI)	$150 Copay (90-day supply[3])
• **Preferred Generic & Specialty Drugs[4,5]**	$200 Copay
• **Non-Preferred Generic & Specialty Drugs[4,5]**	$350 Copay
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• **Diabetic Testing Supplies**	100% Coverage

[2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]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. [4]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/. [5]Cost Sharing for certain Specialty Drugs may vary and be set to the maximum of any available manufacturer-funded copay assistance programs and is not applied to the out-of-pocket maximum.

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.

SMOKING CESSATION PRODUCTS: Two, 12-week treatment courses total per Calendar Year. Prescription required. Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix).	$0 Copayment

DEPENDENT STUDENT BENEFITS: (Emergencies and in-area care are covered under the appropriate sections set forth in the Certificate of Coverage.) Services to treat an illness or injury for Covered Dependents will be covered while they are full-time students at an accredited educational institution out of the Service Area, subject to the Copayments described herein and a $1,500 maximum benefit per Calendar Year.

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

Eligible Dependent: To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by the Subscriber, reside in the Service Area or with the Subscriber (exceptions apply), and meet additional qualifying criteria. For exceptions and additional qualifying criteria, please refer to the Certificate of Coverage.

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.