Health Services Foundation

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. The UAB 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 network. The VIVA HEALTH (VIVA) network includes hospitals and health centers contracted with VIVA HEALTH but outside of UAB. "UAB" means UAB Hospital, UAB Women and Infants Center, UAB Highlands, The Kirklin Clinic of UAB Hospital, UAB Spain Rehabilitation Center, UAB Callahan Eye Hospital, UAB St Vincent's, Medical West, and all UAB satellite clinics. For further information, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE – TIER 1 UAB Network	COVERAGE – TIER 2 VIVA Network (outside UAB)
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 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. 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 3+) • **Covered Immunizations** • **Preventive Prenatal Care** • **OB/GYN Preventive Visit** (One per Calendar Year) • **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 details)	$0 Copayment	$0 Copayment
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Hearing Exams** • **Illness and Injury** • **Laboratory Procedures** ○ Covered Genetic Testing	$30 Copayment/visit $30 Copayment/visit $30 Copayment/visit 100% Coverage 80% Coverage after deductible	$50 Copayment/visit $50 Copayment/visit $50 Copayment/visit 100% Coverage 80% Coverage after deductible
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **Laboratory Procedures** ○ Covered Genetic Testing • **OB/GYN Services**	$50 Copayment/visit $50 Copayment/visit 100% Coverage 80% Coverage after deductible $0 Copayment/visit	$60 Copayment/visit $60 Copayment/visit 100% Coverage 80% Coverage after deductible $60 Copayment/visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$30 Copayment/visit	$50 Copayment/visit
EMERGENCY ROOM SERVICES: *(Copayment waived if admitted to hospital)*	$150 Copayment/visit	$150 Copayment/visit
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)	80% Coverage after deductible	80% Coverage after deductible
VISION CARE: *(No PCP Referral Required)* • **Routine vision exam (one/Calendar Year) and other eye care office visits**	$50 Copayment/visit	$60 Copayment/visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing**	$50 Copayment/visit 80% Coverage after deductible	$60 Copayment/visit 80% Coverage after deductible
DIAGNOSTIC SERVICES: • **Outpatient Laboratory Procedures** • **X-rays** • **All other diagnostic procedures** (including, but not limited to, CT scan, MRI, PET/SPECT, & ERCP)	100% Coverage $30 Copayment/visit $30 Copayment/service at UAB & Children's	100% Coverage 60% Coverage after deductible 60% Coverage after deductible outside UAB & Children's
OUTPATIENT SERVICES: Surgery and Other Outpatient Services	$150 Copayment/service	60% Coverage after deductible
HOSPITAL INPATIENT SERVICES: Physician and Facility Services	$300 Copayment/admission	60% Coverage after deductible
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 days per lifetime)*	80% Coverage after deductible	80% Coverage after deductible
CHIROPRACTIC SERVICES: *(No PCP Referral Required)*	$30 Copayment/visit	$30 Copayment/visit

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REHABILITATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$30 Copayment/visit	60% Coverage after deductible
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES:	80% Coverage after deductible	80% Coverage after deductible
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical benefit per lifetime and a separate $5,000 maximum family prescription drug benefit per Calendar Year. Eligibility limited to subscriber and/or subscriber's spouse.)*		
• **Initial consultation and counseling session** • **Semen analysis, HSG test, and endometrial biopsy** • **Medically Necessary office visits and tests** (ultrasound, laboratory tests) • **Prescription drugs** • **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	$0 Copay/visit; One each/Lifetime $0 Copayment; One per Lifetime $0 Copayment Cost varies by tier $0 Copayment/visit	$60 Copay/visit; One each/Lifetime $0 Copayment; One per Lifetime $0 Copayment Cost varies by tier $150 Copayment/visit
MATERNITY SERVICES: *($1,500 out-of-pocket maximum/member/Calendar Year)* • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Hospitalization**	$0 Copayment/delivery $300 Copayment/admission	$150 Copayment/delivery 60% Coverage after deductible
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.		
DIABETES SELF-MANAGEMENT EDUCATION:	$50 Copayment/visit	$60 Copayment/visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage	100% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50 Copayment/visit	$60 Copayment/visit
HOME HEALTH CARE AND HOSPICE SERVICES: • **Home Health** *(Limited to 60 visits per Calendar Year)* • **Home Infusion** • **Hospice**	80% Coverage (no deductible) 80% Coverage after deductible 80% Coverage (no deductible)	80% Coverage after deductible 80% Coverage after deductible 80% Coverage after deductible
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment/visit	$60 Copayment/visit
SLEEP DISORDERS: • **Sleep Study**	$50 Copayment/visit; $150 Copayment/sleep study	$60 Copayment/visit; $150 Copayment/sleep study
TRANSPLANT SERVICES:	$300 Copayment/visit	60% Coverage after deductible
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES: • **Inpatient Services** • **Outpatient Services**	$200 Copayment/admission $30 Copayment/Visit	80% Coverage after deductible $30 Copayment/visit
PHARMACEUTICAL BENEFITS	**COVERAGE**	
COVERED PRESCRIPTION DRUGS[1]:		
• **Generic Drugs** ○ From a Participating Pharmacy ○ Mail-order	$20 Copayment per 30-day supply ($60 per 90-day supply[2]) $40 Copayment per 90-day supply[2]	
• **Preferred Brand Drugs** ○ From a Participating Pharmacy ○ Mail-order	$50 Copayment per 30-day supply ($150 per 90-day supply[2]) $100 Copayment per 90-day supply[2]	
• **Non-Preferred Brand Drugs** ○ From a Participating Pharmacy ○ Mail-order	$75 Copayment per 30-day supply ($225 per 90-day supply[2]) $150 Copayment per 90-day supply[2]	
• **Select Preferred Generic & Specialty Drugs**[3, 4] • **Select Non-Preferred Generic & Specialty Drugs**[3, 4] • **Oral Contraceptives**	$200 Copayment $350 Copayment $0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs	
• **Diabetic Testing Supplies**	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 www.vivahealth.com/Group/Login. [4]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 deductible or out-of-pocket maximum.

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.

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. Preventive care is not covered out of the Service Area.

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

Eligible Dependent: Eligible Employee's spouse (including common-law) and children of Eligible Employees under age 26 or disabled dependents who meet eligibility criteria.

Pre-Existing Condition Policy: No waiting period for pre-existing conditions.

Note: UAB Network coverage cost-sharing applies to employees in Huntsville and Montgomery under benefit package HSF2 even when accessing care in the more expansive VIVA HEALTH network.