BAPTIST HEALTH

Effective Dates: January 1, 2024 – December 31, 2024

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, please see the Certificate of Coverage. **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.** The network of Participating facilities for this Plan includes Baptist Medical Center East, Baptist Medical Center South, Prattville Baptist Hospital, The Montgomery Cancer Center, and UAB Hospital (including UAB Callahan Eye Hospital and The Kirklin Clinic) for inpatient and outpatient care, and the Participating Physicians who admit to these facilities for Physician services. It also includes access to the entire VIVA HEALTH network of optometry and ophthalmology, dermatology, mental health, podiatry, pain management, allergy and immunology, and chiropractic providers. Montgomery Surgical Center is a Participating Provider for outpatient surgical services. The Pediatric Clinic, LLC and Children's Hospital are participating providers for pediatric services. Please see the Baptist Health provider directory at myvivaprovider.com for a list of the Plan's Participating Providers.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
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. Certain specialty drugs are considered non-essential health benefits and are not applied to the out-of-pocket maximum. The cost of these drugs (reimbursed by the manufacturer at no cost to the Member) will not be applied toward satisfying the out-of-pocket maximum. See the Certificate of Coverage for details.	$6,000 per individual; $10,000 per family
PREVENTIVE CARE:	
• **Well Baby Care** (Children under age 3)	100% Coverage
• **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 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**	$40 Copayment per visit
• **Hearing Exams**	
• **Illness and Injury**	
• **X-Rays and Laboratory Procedures**	
○ Covered Genetic Testing	80% Coverage
SPECIALTY CARE: *(No PCP Referral Required)*	
• **Medical Physician Services**	$50 Copayment per visit
• **Illness and Injury**	$50 Copayment per visit
• **X-Ray and Laboratory Procedures**	100% Coverage
○ Covered Genetic Testing	80% Coverage
• **OB/GYN Services**	$50 Copayment per visit
URGENT CARE CENTER SERVICES:	
• **Medical Physician Services**	$65 Copayment per visit
• **Illness and Injury**	
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**	80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$50 Copayment per service
OUTPATIENT SERVICES:	
• **Surgery and Other Outpatient Services**	$100 Copayment per visit
HOSPITAL INPATIENT SERVICES:	
• **Physician and Facility Services**	$350 Copayment per admission
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**	$350 Copayment per admission
Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.	
EMERGENCY ROOM SERVICES: *(Copayment waived if admitted to hospital)*	
• **Facility Services**	$200 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(Limited to 100 days per Lifetime)*	100% 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
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)*	$50 Copayment per visit

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TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
DIABETIC SUPPLIES: Call VIVA HEALTH for diabetic supplies. Insulin covered under prescription drug rider. Refer to Baptist Health Diabetes team care to learn how you can receive insulin and diabetic supplies at 100%.	$40 Copayment for 30-day supply
REHABILITIATION AND HABILITATION 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)*	80% Coverage
SLEEP DISORDERS:	$50 Copayment per visit
• **Sleep Study**	$100 Copayment per sleep study
TRANSPLANT SERVICES:	$350 Hospital Copayment
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	$350 Copayment per admission
• **Outpatient Services**	$50 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Generic Drugs**	
○ From Baptist Tower Pharmacy or MCC Apothecary	50% Coinsurance; $3 minimum/$15 maximum copayment per 30-day supply and $9 minimum/ $45 maximum copayment per 90-day supply
○ From other Participating Pharmacy	75% Coinsurance; $15 minimum/$25 maximum copayment per 30-day supply and $45 minimum/ $75 maximum copayment per 90-day supply
• **Preferred Brand Drugs**	
○ From Baptist Tower Pharmacy or MCC Apothecary	$40 Copayment per 30-day supply; $120 Copayment per 90-day supply
○ From other Participating Pharmacy	$50 Copayment per 30-day supply; $150 Copayment per 90-day supply
• **Non-Preferred Brand Drugs** *(90-day supply not allowed; Mail order not allowed)*	
○ From Baptist Tower Pharmacy or MCC Apothecary	$60 Copayment per 30-day supply
○ From other Participating Pharmacy	$70 Copayment per 30-day supply
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[2,3]**	$250 Copayment per occurrence
• **Oral Contraceptives**	$0 Copayment for generics and select brands; Applicable Copayment for other brand drugs
• **Chemotherapy Support Drugs**	100% Coverage at Montgomery Cancer Center
• **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]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 [3]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 ("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.

Smoking Cessation Program: Nicotine replacement drugs will be covered through the prescription drug plan at no copay. Members must complete The Baptist Cardiac Rehab Smoking Cessation Program, which includes seven sessions for covered employees and spouses. Call 286-2859 for more information. Upon completion of the Baptist program, if additional counseling is needed, Quitline, a tobacco cessation program, provides support to participants through telephone-based counseling.

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 are covered as full-time students at an accredited educational institution out of the Service Area, subject to the Cost Sharing described herein. $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

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

Eligible Dependent: Employee's eligible, lawful spouse (common law spouses not eligible), dependent children up to age 26, disabled dependents who meet eligibility criteria

Working Spouse Rule: Enrollment for spouse coverage is not offered if your spouse is eligible for coverage on their employer sponsored medical plan. Spouses not eligible for enrollment on their employer's Medical Plan, or should their employer not offer Medical insurance, may enroll on Baptist Health's Medical Plan providing required documentation** attesting to eligibility is submitted.

***Required documentation: Letter from spouse's employer on company letterhead stating medical insurance is not offered, or spouse is not eligible for enrollment on the employer's medical plan. Scan or email: HR-Benefit@baptistfirst.org | Fax: (334) 286-3420 | Hand-deliver: HR office at South, East, Prattville or MCC.*

Nondiscrimination Notice: VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).
注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 1-800-294-7780 (TTY: 711).