BAPTIST HEALTH – *60 Plan*

Effective Dates: January 1, 2025 – December 31, 2025

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, UAB St. Vincent's, 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 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 Biological, Biotechnical, and Specialty Pharmaceuticals 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 Coinsurance do not count toward the Deductible.	$4,750 per individual; $9,500 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. 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. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Coinsurance do not count toward the Out-of-Pocket Maximum.	$9,200 per individual; $18,400 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 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: • **Surgical and Medical Physician Services** • **Hearing Exams** • **Illness and Injury**	$50 Copayment per visit
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **OB/GYN Services** • **Illness and Injury**	$70 Copayment per visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$85 Copayment per visit
LABORATORY SERVICES: • **Laboratory Procedures** • **Covered Genetic Testing**	60% Coverage
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	$70 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing and Treatment**	$70 Copayment per visit 60% Coverage
CHRONIC CARE MAINTENANCE: *(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)*	60% Coverage
DIAGNOSTIC SERVICES: • **X-Rays** • **Other Diagnostic Services *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)***	$10 Copayment per image 60% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	60% Coverage
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	60% Coverage
EMERGENCY ROOM SERVICES: • **Facility Services**	$500 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	60% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	60% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	60% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$70 Copayment per visit
DIABETES SELF-MANAGEMENT EDUCATION:	$70 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	60% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)*	$70 Copayment per visit

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MEDICAL BENEFITS	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)***	$70 Copayment per delivery
• **Maternity Hospitalization**	60% Coverage
Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered.	
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)*	60% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	60% Coverage
TEMPOROMANDIBULAR JOINT DISORDER:	$70 Copayment per visit
SLEEP DISORDERS:	$70 Copayment per visit
• **Sleep Study**	60% Coverage per sleep study
TRANSPLANT SERVICES:	60% Coverage
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	60% Coverage
• **Outpatient Services**	$70 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From Baptist Tower Pharmacy or MCC Apothecary	$3 Copayment per 30-day supply; $9 Copayment per 90-day supply[2]
○ From other Participating Pharmacy	$15 Copayment per 30-day supply; $45 Copayment per 90-day supply[2]
• **Tier 2 (Non-Preferred Generic Drugs)**	
○ From Baptist Tower Pharmacy or MCC Apothecary	$15 Copayment per 30-day supply; $45 Copayment per 90-day supply[2]
○ From other Participating Pharmacy	$25 Copayment per 30-day supply; $75 Copayment per 90-day supply[2]
• **Tier 3 (Preferred Brand)**	
○ From Baptist Tower Pharmacy or MCC Apothecary	$60 Copayment per 30-day supply; $180 Copayment per 90-day supply[2]
○ From other Participating Pharmacy	$70 Copayment per 30-day supply; $210 Copayment per 90-day supply[2]
• **Tier 4 (Non-Preferred Brand) (90-day supply and mail order not allowed)**	
○ From Baptist Tower Pharmacy or MCC Apothecary	$80 Copayment per 30-day supply
○ From other Participating Pharmacy	$90 Copayment per 30-day supply
• **Tier 5 (Biological Drugs, Biotechnical Drugs, Specialty Pharmaceuticals[3,4,5])**	$250 Copayment per occurrence
• **Oral Contraceptives**	$0 Copayment for generics and select brand drugs; Applicable Copay 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]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 out-of-pocket maximum. [5]Specialty drugs Humira, Enbrel, and Simlandi and their biosimilars are required to be filled at the Baptist South Tower Pharmacy for coverage.

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 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: 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: 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.*