2026
Employee Benefits Guide
UAB St. Vincent's

Visit **ADP Workforce Now** to access our online benefit enrollment system.

UAB MEDICINE

Here's Where to Find…

Welcome!

We are happy to have you as part of the team at UAB St. Vincent's and are pleased to offer a benefit package to help meet your and your family's personal needs and objectives.

Our medical and dental programs are self insured. This means that UAB St. Vincent's is the payor for medical, prescription, and dental claims, while VIVA HEALTH and BCBS administer the claims and networks. Each employee has a vested interest in making sure use of health/dental services is necessary and appropriate, as this use directly impacts the overall cost of the plan as well as your share of the cost.

Take time and get to know the many benefits offered by UAB St. Vincent's. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan descriptions available on the **ADP Workforce Now** or contact **MyLifeAdvisor@adp.com**.

If you would like to speak to a Benefit Education Specialist about your benefits, we are happy to offer personalized, one-on-one support to our employees. Use the QR code below or call **205-291-2525** to schedule an appointment with our team.

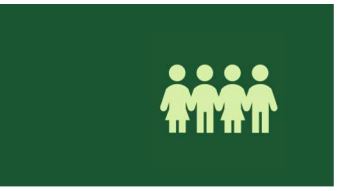
Who Is Eligible?

Benefits are available to full-time and part-time employees working a minimum of 20 hours per week and their dependents. For those enrolling during Open Enrollment, your benefits will become effective on January 1st. For new hires, benefits will become effective on the first of the month after your hire date. Refer to each benefit description for more eligibility details.

Eligible dependents include:

Your spouse (married or common-law)

A marriage certificate must be provided. For a common law marriage, you must complete an affidavit as well as documentation of common residence prior to 1/1/2017. In Alabama, only common-law marriages that commenced prior to 1/1/2017 are eligible. Please contact the Benefits office to obtain the common law marriage affidavit.



Your children from birth to age 26

Including your natural/legally adopted/stepchildren (permanent legal custody), and/or your unmarried dependent children of any age who are mentally or physically disabled and who are dependent on you for support. Appropriate documentation is required (birth certificate, legal adoption decree, court ordered permanent custody document) to enroll in coverage.

How to Enroll

Employees can visit **ADP Workforce Now** to enroll in benefits. For assistance with self-service or ADP logins you can email **MyLifeAdvisor@adp.com** or call **855-547-8508**.

Making Changes

You may only make changes to your elections during Open Enrollment each year or during the year if you experience a qualifying life event. Qualifying life events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marriage or divorce.
- Dependent children reach age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Death of a covered dependent.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or SCHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

Changes to your coverage due to a qualifying life event must be made within 30 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).

Note: *Any change you make to your coverage must be consistent with the change in status.*

Enrollment Deadlines

Type of Employee/ Dependent	Enrollment Opportunity	Coverage Effective Date
Current Employee	Annually during the enrollment period	Start of plan year
New Hire	Must enroll within 30 days of hire	First of the month after hire date
Qualified Life Event	Changes must be made within 30 days of the life event	Date of life event

** Group life and long-term disability are effective upon date of full-time employment for eligible employees.*

Bi-Weekly Employee Payroll Contributions

Medical/Prescription Drug

Plans	Bi-Weekly Cost			
VIVA HEALTH Access Plan	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Salary < $44,000	$38.43	$96.02	$57.52	$113.45
Salary $44,000 - $103,999	$57.42	$163.00	$103.06	$184.23
Salary $104,000 - $214,999	$70.47	$203.00	$132.88	$226.00
Salary $215,000 & above	$86.13	$243.00	$154.88	$278.46
Part-Time Employees	$86.13	$243.00	$154.88	$278.46
Blue Cross Blue Shield of Alabama	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Salary < $44,000	$50.80	$110.42	$73.20	$143.50
Salary $44,000 - $103,999	$75.90	$187.45	$131.16	$232.38
Salary $104,000 - $214,999	$93.15	$233.45	$169.12	$285.07
Salary $215,000 & above	$113.85	$279.45	$197.12	$351.24
Part-Time Employees	$113.85	$279.45	$197.12	$351.24

Dental

Blue Cross Blue Shield Bi-Weekly Cost		
	Basic Plan	**Comprehensive Plan**
Employees Only	$11.08	$14.77
Employees + Spouse	$20.77	$27.23
Employees + Child(ren)	$19.85	$36.46
Employees + Family	$32.31	$54.92

Vision

Vision Service Plan (VSP) Bi-Weekly Cost		
	VSP Standard	**VSP Premium**
Employee Only	$3.39	$5.98
Employee + Spouse	$6.96	$12.26
Employee + Child(ren)	$7.56	$13.60
Employee + Family	$12.08	$21.74

Medical Coverage

VIVA HEALTH Access Group #UASV01

VIVA HEALTH provides medical coverage for in-network providers.

VIVA HEALTH
www.vivahealth.com
205-558-7474

Blue Cross Blue Shield of Alabama – Group #33915

Blue Cross Blue Shield of Alabama and provides coverage for both in-network and out-of-network providers.

BlueCross BlueShield of Alabama
www.bcbsal.org
205-988-2200

As a newly hired employee, your medical and pharmacy coverage is effective the first of the month after your date of hire.

	VIVA HEALTH Access		Blue Cross Blue Shield PPO	
	In-network UAB Provider	**In-network Non-UAB Provider**	**In-network UAB Provider**	**In-network Non-UAB Provider**
Annual Deductible (Individual / Family)	$250 / $750	$1,000 / $2,000	$250 / $750	$1,000 / $2,000
Out-of-Pocket Maximum (Individual / Family)	$4,000 / $8,000	$7,500 / $15,000	$4,000 / $8,000	$7,500 / $15,000
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Primary Physician Office Visit	$30 Copay	$50 Copay	$30 Copay	$50 Copay
Specialist Office Visit	$50 Copay	$60 Copay	$50 Copay	$60 Copay
Virtual Care (virtual visit through your PCP or Specialist)	PCP / Specialist Copay applies	PCP / Specialist Copay applies	PCP / Specialist Copay applies	PCP / Specialist Copay applies
Urgent Care	$30 Copay	$50 Copay	$30 Copay	$50 Copay
Emergency Room	$250 Copay	$250 Copay	$250 Copay	$250 Copay
Inpatient Hospital Services	$300 Copay	40% After Deductible	$300 Copay	40% After Deductible
Outpatient Surgery / Services	$150 Copay	40% After Deductible	$200 Copay	40% After Deductible

	VIVA HEALTH Access		Blue Cross Blue Shield PPO	
	In-network UAB Provider	**In-network Non-UAB Provider**	**In-network UAB Provider**	**In-network Non-UAB Provider**
Outpatient Diagnostics: Lab Work	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Diagnostic X-ray and Imaging: CT/MRI/PET	$30 Copay	40% After Deductible	$30 Copay	40% After Deductible
Chiropractic Care	$30 Copay	$30 Copay	$30 Copay	$30 Copay
Physical Therapy, Occupational Therapy, Speech Therapy	$30 Copay	40% After Deductible	$30 Copay	40% After Deductible
Mental Health / Substance Abuse Inpatient	$200 Copay	20% After Deductible	$200 Copay	20% After Deductible
Mental Health / Substance Abuse Outpatient	$30 Copay	$50 Copay	$30 Copay	$50 Copay
Ambulance Services (Emergency)	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Durable Medical Equipment	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Home Health (up to 60 visits)	20%	20% After Deductible	20%	20% After Deductible
Home Infusion	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Hospice Services	20%	20% After Deductible	20%	20% After Deductible
Skilled Nursing Facility (up to 100 days per lifetime)	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible

Find details from VIVA Health and Blue Cross Blue Shield
See the Appendix of this Guide for additional coverage and cost details from the carriers.

Pharmacy benefits are administered by Express Scripts.

Covered Prescription Drugs[1]	UAB St. Vincent's Retail Pharmacy (30-day supply)	Retail Pharmacy (30-day supply)	Home Delivery/ Mail Order[2]
Generic Drugs	$10 Copay	$20 Copay	$40 Copay
Preferred Brand Drugs	$25 Copay	$50 Copay	$100 Copay
Non-Preferred Brand Drugs	$75 Copay	$75 Copay	$150 Copay
Other Drugs:			
Oral Contraceptives			$0 Copay for generic drugs; Applicable copay for brand drugs
Biological Drugs, Biotechnical Drugs, and Preferred Specialty Pharmaceuticals[3,4]			$200 Copay
Biological Drugs, Biotechnical Drugs and Non-Preferred Specialty Pharmaceuticals[3,4]			$350 Copay
Diabetic Testing Supplies			$0 Copay
Smoking Cessation Products Two 12-week treatment courses total per calendar year. Prescription required. Includes generic nicotine replacement products (the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or varenicline tartrate (Chantix).			$0 Copay
Weight Loss Drugs (GLP-1s)			No coverage

1. Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at (205) 558-7474 (toll free: 1-800-294-7780) or at www.vivahealth.com.
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. There is a member out-of-pocket maximum of $2,000 per member per Calendar Year for biological, biotechnical drugs, and specialty pharmaceuticals. This out-of-pocket maximum does not apply to drugs prescribed for weight loss. 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 Copay. 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.

Reminder! Save with GoodRx
GoodRx is a quick and easy discount service available to everyone. You can compare prices on prescription drugs and save up to 80%. Visit **goodrx.com** to learn more and start saving.

UAB Medicine 4YOU

UAB Medicine

UAB Medicine 4YOU is a service that connects you with UAB Medicine caregivers by providing dedicated appointment and nursing specialists to assist with a variety of access solutions:

- Office Visits
- UAB eMedicine online service
- Urgent Care
- myUABMedicine patient portal
- Live Chat

To take advantage of this convenient benefit or for more information, call **205-975-4YOU (4968)** or visit **http://www.uabmedicine.org/4YOU**.

UAB 975-SICK Acute Care

Same- or next-day appointments

Before you visit the Emergency Room, call **205-975-SICK** to connect with a nurse who will guide you to the appropriate UAB provider for same-day or next-day appointments. This service is dedicated to UAB employees. You'll be pointed to the specific care you need. Nurses will refer you to Family Medicine at The Kirklin Clinic of UAB Hospital, UAB Medicine Urgent Care, the Post-Discharge Clinic, UAB eMedicine, or UAB Medicine Primary Care.

Call **205-975-SICK (7425)** to get started.

UAB eMedicine

On-Demand Urgent Care

Get fast, convenient care online from UAB Medicine providers for common conditions like cold/flu, sinus infection, bladder infection, pink eye, yeast infection, skin issues, and more—anytime, anywhere.

Learn more at **uabemedicine.com**.

Dental

Blue Cross Blue Shield of Alabama

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. If you choose an out-of-network provider, you may be billed the difference between what Blue Cross Blue Shield pays, and what your out-of-network provider charges for the services. To locate an in-network provider, please visit **www.bcbsal.org**.

	Comprehensive Dental Plan A In-network	Basic Dental Plan B In-network
Annual deductible (per person)	$25	$25
Annual maximum (per person)	$1,500	$750
Diagnostic and Preventive Care: Includes cleanings, fluoride treatments, sealants, and x-rays	100% covered, not subject to the deductible	100% covered, not subject to the deductible
Restorative Care Fillings, simple tooth extractions, root canal treatments, emergency treatment for pain, repairs to removable dentures	80% covered, subject to the deductible	50% covered, subject to the deductible
Supplemental Services Oral surgery for jaw issues, mouth cysts and abscesses, impacted teeth, general anesthesia, root tip treatment	80% covered, subject to the deductible	50% covered, subject to the deductible
Periodontic Services Annual exam, removal of diseased gum tissue or bone, reconstruction of gum, plaque, and calculus removal below gum line	80% covered, subject to the deductible	50% covered, subject to the deductible
Prosthetic Services Dentures, bridges, inlays, onlays, crowns	50% covered, subject to the deductible	50% covered, subject to the deductible
Orthodontic Services	50% covered, subject to the deductible for dependent children up to age 26 lifetime maximum of $1,000	N/A

Plan includes out-of-network benefits, see plan summary for additional details.

Employees can elect dental and/or vision regardless of whether they are enrolled in medical.

Vision

VSP Vision Care

www.vsp.com
800-877-7195

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the VSP Vision Care providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, visit **www.vsp.com**.

VSP Coverage with a VSP Provider

Benefit	Description	Copay
Well Vision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$15
Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details. • Available as needed	$0 per screening $20 per exam
Prescription Glasses		**$25**
Frame*	• $210 featured frame brands allowance • $190 frame allowance • 20% savings on the amount over your allowance • $105 Walmart/Sam's Club/Costco frame allowance • Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Scratch-resistant coating • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year	$0 $0 $95 – $105 $150 – $175
Contacts (instead of Glasses)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60

VSP **Plus** Coverage with a VSP Provider

Benefit	Description	Copay
Well Vision Exam	• Focuses on your eyes and overall wellness. • Every calendar year	$15
Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details. • Available as needed	$0 per screening $20 per exam
Prescription Glasses		**$25**
Frame*	• $260 featured frame brands allowance • $240 frame allowance • 20% savings on the amount over your allowance • $130 Walmart*/Sam's Club*/Costco* frame allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Scratch-resistant coating • Anti-glare coating • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year	$0 $0 $35 $95 – $105 $150 – $175
Contacts (instead of Glasses)	• $190 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60

Extra Savings for Both Plans

Glasses and Sunglasses

- Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam.

Routine Retinal Screening

No more than a $39 copay on routine retinal screening as an enhancement to a Well Vision Exam

Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

Coverage with an Out-of-Network Provider

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam	up to $45
Frame	up to $70
Single Vision Lenses	up to $30
Lined Bifocal Lenses	up to $50
Lined Trifocal Lenses	up to $65
Progressive Lenses	up to $50
Contacts	up to $105

Employees can elect dental and/or vision regardless of whether they are enrolled in medical.

Employee Assistance Program

Telus

Telus provides mental health support and work/life services for you and your family. Access resources and information 24/7 at every stage of your journey.

TELUS
telushealth.com
Mobile app: My TELUS

Confidential Emotional Support 	Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including: • Anxiety, depression, stress • Grief, loss, and life adjustments • Relationship/marital conflicts
Work-Life Solutions 	Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as: • Finding child and elder care • Hiring movers or home repair contractors • Planning events or locating pet care
Legal Guidance 	Talk to our attorneys for practical assistance with your most pressing legal issues, including divorce, adoption, family law, wills, trusts, and more
Financial Resources 	Our financial experts can assist with a wide range of issues. Talk to us about: • Retirement planning and taxes • Relocation, mortgages, and insurance • Budgeting, debt, bankruptcy, and more

Employer Provided Life and Disability

Sun Life
www.sunlife.com
800-247-6875

Sun Life

Life Insurance

Sun Life provides Basic Life and AD&D insurance at no cost to you! Full-time regular employees budgeted to work at least 20 hours per week are eligible.

Insurance Coverage	Benefit
Basic Life and AD&D	• 1.25 x Annual Base Salary • Minimum Coverage: $50,000 • Maximum Coverage: $1,250,000

Disability Insurance

These plans give you income protection in the event you are sick or injured and can't work. **Full- and part-time benefit-eligible employees are eligible for Short-term disability after 6 months of employment in an eligible status. Full-time benefit-eligible employees are eligible for long-term disability starting on your hire date**.

	Short-term disability	Long-term disability
Elimination period	7 days	90 days
Benefit Amount	60% of weekly earnings	60% of monthly earnings
Maximum benefit	$2,500 per week	$25,000 monthly maximum
Pre-existing condition clause	N/A	Pre-existing conditions could be excluded from coverage

The following page includes sample scenarios to help you better understand what qualifies as Long-Term Disability. To determine if a specific injury is covered, contact the Benefits Office.

Long-Term Disability Scenarios

Sun Life

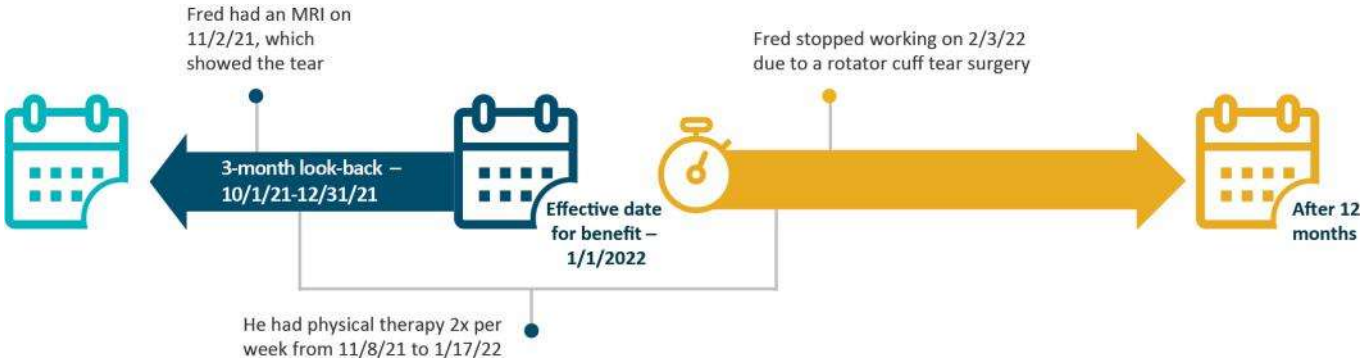
Pre-existing condition scenarios for Long-Term Disability

Below are three scenarios that show how pre-existing conditions may affect what's covered by your Long-Term Disability (LTD) benefit.

Scenario #1: Musculoskeletal

Fred became covered under his employer's LTD plan on 1/1/22. He stopped working 2/3/22 to undergo a rotator cuff tear surgery. Since this occurred within the first 12 months of his LTD benefit becoming effective, a pre-existing review was required. The pre-existing period ("look-back" period) is 10/1/21 – 12/31/21. Medical records were requested for this timeframe. They showed that Fred had an MRI on 11/2/21, which showed the tear. He began physical therapy 2x per week on 11/8/21 and continued until 1/17/22.

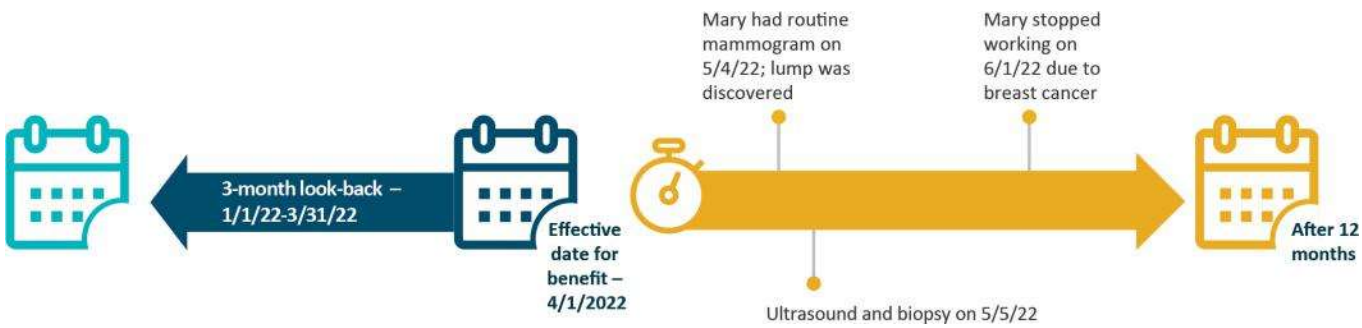
Based on this information, it is likely that the LTD benefit would not be paid because there were treatments related to the diagnosis that occurred during the look-back period.



Scenario #2: Cancer

Mary became covered under her employer's LTD plan on 4/1/22. She stopped working due to treatment for breast cancer on 6/1/22. Since this occurred within the first 12 months of her LTD benefit becoming effective, a pre-existing review was required. The pre-existing period ("look-back" period) is 1/1/22 – 3/31/22. Medical records were requested for this timeframe. They showed that at Mary's routine mammogram on 5/4/22 a lump was discovered. She then had an ultrasound and biopsy on 5/5/22, which confirmed a cancer diagnosis.

Based on the above information, it is likely that the LTD benefit would be paid because the treatments related to the diagnosis occurred after the look-back period.



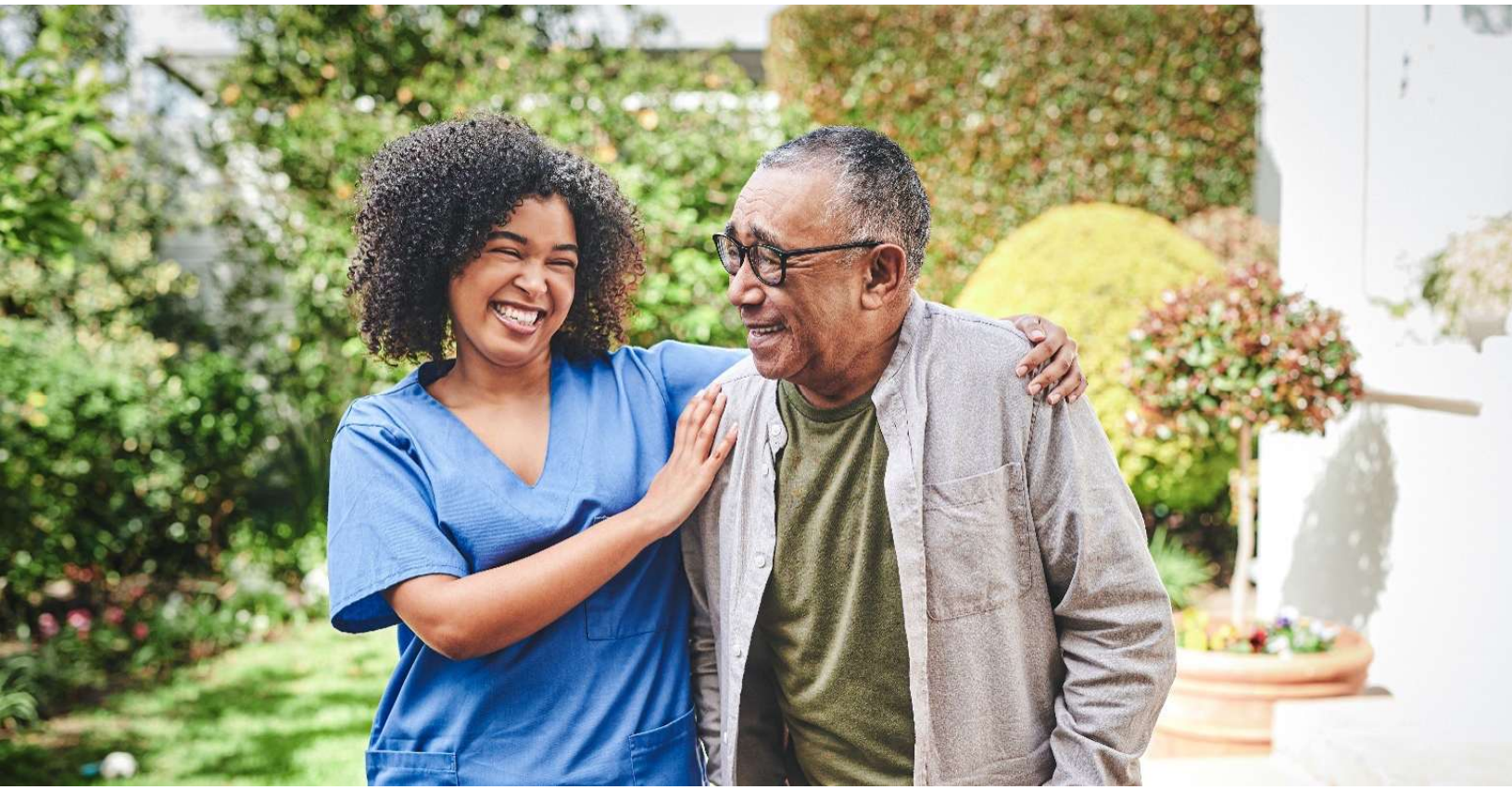
Scenario #3: Cardiac

Sylvester became covered under his employer's LTD plan on 1/1/22. He stopped working due to coronary artery disease on 10/6/22 and needed surgery. Since this occurred within the first 12 months of his LTD benefit becoming effective, a pre-existing review was required.

The pre-existing period ("look-back" period) is 10/1/21 – 12/31/21. Medical records were requested for this timeframe. They showed that Sylvester has been treated with medications for high cholesterol and high blood pressure for the last 3 years. Based on this information, it is likely that the LTD benefit would not be paid because there were treatments related to the diagnosis that occurred during the look-back period.

Full-time regular employees budgeted to work at least 36 hours per week are eligible.

These scenarios were created for example purposes only. Refer to your policy for more information about your pre-existing conditions limitation.



Voluntary Benefits

Sun Life
www.sunlife.com
800-247-6875

Sun Life

Our medical plans provide great coverage for you and your family's healthcare needs. Still, everyone's needs are slightly different. That's where supplemental health options come in! These benefits are designed to protect your family's finances in case of an unforeseen injury or illness.

Voluntary Life Insurance

If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse and your dependent children. You must enroll in coverage for yourself in order to cover your spouse or children. If you don't enroll in Voluntary Life when it's first available to you, or if you elect an amount over the Guaranteed Issue, you may be required to complete an Evidence of Insurability (EOI) form. Full-time regular employees budgeted to work at least 20 hours per week are eligible.

Insurance Coverage	Minimum Benefit	Guarantee Issue (Initial Eligibility)	Maximum Benefit
Voluntary Employee Life	$10,000	$500,000	10x Annual Earnings, $1,400,000 max (in $10,000 increments)
Voluntary Spouse Life*	$10,000	$50,000	$250,000
Voluntary Child Life*	$5,000	N/A	$10,000

** Employee must elect $10,000 coverage for self in order to elect spouse life coverage.*

Additional Voluntary Benefits

Sun Life
www.sunlife.com
800-247-6875

Sun Life

Accident Insurance

Accident Insurance pays a cash benefit directly to you, in addition to any health insurance benefit, to help cover the costs associated with a covered accident. The plan includes a **wellness benefit** that pays **$50 per year** for getting certain health screenings like mammograms, blood tests, or colonoscopies, among others.

Critical Illness Insurance

Critical Illness Insurance helps protect your income and personal assets from expenses as a result of a specified illness. Covered conditions include heart attack, stroke, end stage renal failure, and more. There is also additional coverage to help with expenses for invasive and non-invasive cancer. Includes a **wellness benefit** that pays **$50 per year** for getting certain health screenings like mammograms, blood tests, or colonoscopies, among others.

Hospital Indemnity Insurance

Hospital Indemnity Insurance provides a cash benefit directly to you for both hospital confinement and Emergency Room treatment (for accidents only). This benefit is separate from your health insurance and can be used to help pay unexpected expenses as you see fit for costs associated with the illness or injury, or for additional expenses such lost income, childcare, or other costs. Enhanced benefits are available when using UAB facilities.

Permanent Term Life

This term life insurance plan, administered by Aflac, will stay with you through retirement—all the way to 120! This plan has no benefit reduction once you reach age 65, like many plans do. Upon diagnosis of a terminal illness, you have the flexibility to choose how to receive your payout – either 50% of the plan coverage amount in a lump sum or periodic payments in the amount of 4% of the life benefit. Coverage is available for you, your spouse, and your dependent child(ren). Call **(205) 291-2525** if you have questions or want to enroll.

For detailed information on your Voluntary Benefit options, visit ADP Workforce Now.

Voluntary Benefits Examples

Accident Insurance Example

Junior breaks his leg while playing in a game for his high school basketball team.

Covered services	Benefits
Ambulance ride	$400
Emergency room admission	$250
Diagnosis of leg fracture — closed	$1,500
Medical device (crutches)	$200
Follow-up visit (6 visits)	$600
Physical therapy (10 visits)	$750
Total payments received from Sun Life	**$3,700**

Critical Illness Example

Denise suffered a heart attack due to a blocked artery. After she filed a claim, she received a check for her Critical Illness benefit amount. Denise then needed surgery 8 months later[1] and then suffered another heart attack 2 years later. Fortunately, Denise had Critical Illness insurance with a Recurrence Benefit[2]. Assumed benefit = $10,000

Covered services	Benefits
Wellness Benefit: blood test for cholesterol	$50
Heart attack (100%)	$10,000
Coronary artery bypass graft (25%)	$2,500
Recurrent heart attack (100%)	$10,000
Total payments received from Sun Life	**$22,550**

1. *Your plan may include a waiting period before a different condition may be payable under the same contract.*
2. *Your plan may include a waiting period before the same condition may be payable under recurrence.*

Hospital Indemnity Example

John was in a serious accident. He had to stay in the hospital's intensive care unit for 3 days and then spent 9 days in a regular room. John was in a UAB St. Vincent's facility.

These potential benefits are for illustrative purposes only and actual benefits may vary based on the terms of the policy and the claimant's specific circumstances.

Covered Benefit	Eligible Days	Benefit Amount
First day Hospital confinement	Day 1	$1,000
ICU confinement	Days 1-3	$450
Hospital confinement	Days 1-12	$1,800
Employer Facility / Domestic Steerage benefits	First Day Confinement	$100
	ICU confinement – 3 days	$150
	Hospital Confinement – 12 days	$600
Total payments received from Sun Life		**$4,100**

Emergency Travel Assistance

Sun Life
www.assistamerica.com
800-872-1414

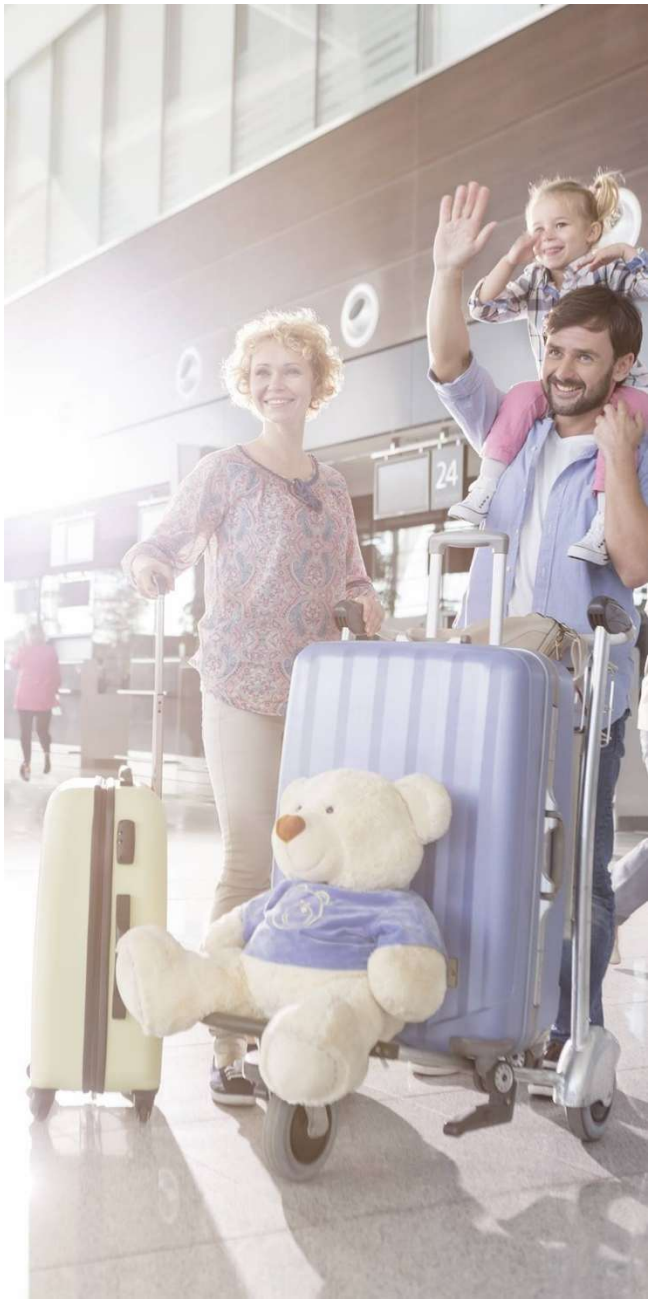
Sun Life – Assist America

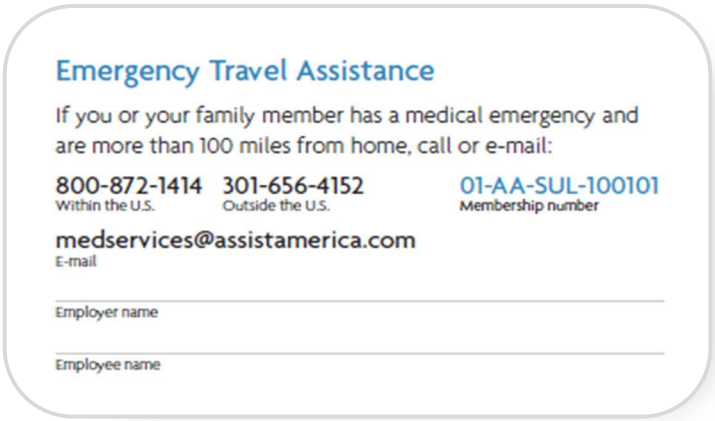
As an eligible participant in Sun Life's Life or Accident insurance, you and your immediate family are members of Assist America and are entitled to its services. If you have a medical emergency while you are more than 100 miles away from home, with one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24/7. No matter where you are in the world, they will help you access or receive:

- Pre-qualified, English-speaking professionals working in hospitals, pharmacies, and dental offices;
- Medical consultation, evaluation, and referral;
- Hospital admission assistance;
- Critical care monitoring;
- Emergency medical evacuation;
- Transportation to return home or to a rehabilitation facility;
- Prescription assistance;
- Legal and interpreter services, and more.

You or your immediate family* (whether traveling together or separately) can activate Assist America's emergency services with one call to the number on an Assist America ID card, whether you are on vacation or on a business trip (spouse business travel excluded). Assist America pays for 100% of the services it arranges and provides.

**The definition of immediate family includes spouse and dependent children.*





ETA Card Example

Flexible Spending Account (FSA)

inspira™ FINANCIAL
www.inspirafinancial.com
800-284-4885

Inspira Financial

What is a Flexible Spending Account?

A flexible spending account (FSA) is an account that can reimburse you for qualified healthcare or dependent care expenses. You can fund qualified expenses with pre-tax dollars deducted from your paychecks. Full and part-time Employees working at least 20 hours per week are eligible.

When electing an FSA, you will set an annual contribution amount. **FSAs do not roll over year to year, so you will have from January 1 to December 31 to use the funds. You must re-enroll in this benefit every year.** The goal is to choose an amount that will cover medical or dependent care expenses but is not so high that the money will be forfeited at the end of the year. You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts.

You can use your Inspira Financial debit card to pay for eligible medical expenses; these purchases are automatically deducted from your FSA. Remember to save all your receipts and Explanation of Benefits from your insurance provider, because you will be required to provide documentation to Inspira Financial for reimbursement of your claims and occasionally for card transactions. Any claims that were incurred during the plan year must be submitted for reimbursement by March 31st of the following year.

Reimbursements may be made via direct deposit. Simply go to **www.inspirafinancial.com** and set up your deposit account under My Account Actions. **The member ID for Employees is your social security number.**

If elected, your benefits begin on the first of the month following date of hire**.**

Healthcare FSA

A healthcare FSA reimburses Employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible healthcare expenses include many out-of-pocket costs you pay to maintain your health and well-being. Visit **irs.gov** for a full list of eligible expenses.

You may contribute up to $3,400 annually (funds will be available as of the election effective date).

Dependent Care FSA

You may use pre-tax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child, spouse, or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as babysitters, nursery schools, or daycare centers.

You may contribute up to $7,500 annually (or $3,750 if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

403(b) Retirement Plan

www.tiaa.org/uabstvincents

800-842-2252

TIAA

The UAB St. Vincent's 403(b) Retirement Plan allows employees to make pre-tax and Roth retirement contributions via payroll deduction. Deferrals automatically begin at 5% pre-tax after the first 30 days of employment. Contributions and investment elections may be changed at any time.

What options are available for me to invest my money in?

UAB St. Vincent's uses TIAA as our investment provider. It offers a wide variety of investment options to meet your needs, including annuity products and mutual funds. Additional funds are also available through the brokerage window with TIAA.

How much can I contribute?

Eligible participants can contribute a percentage of pay, up to the annual IRS limit. Employees aged 50 or older can contribute an additional "catch up" amount, per IRS limits.

Does UAB St. Vincent's contribute any money toward my retirement?

Yes. Eligible employees will receive a one-to-one match on the first 5% of their contribution up to the IRS annual limit.

When can I receive money from my retirement account?

At retirement, if you are disabled, or if you terminate employment.

In the event of an employee's death, retirement funds will be paid out to the beneficiary on file with TIAA. Beneficiaries must be added or updated directly via your profile with TIAA (**www.tiaa.org**)

Are there withdrawal options available while employed?

Loans and hardship withdrawals are available. Refer to your summary plan description for details.

How do I sign up?

1. Visit **www.tiaa.org/uabstvincents**.
   - First time to TIAA – Register then log in
   - Already registered – Log in with your existing ID and password
2. After you determine your contribution amount, complete the online salary reduction agreement. You can select Choose for me (one-step investing) or Choose my own (pick from a list of available
3. investments)
4. Add your beneficiaries.

For assistance with enrollment or general financial questions contact the TIAA contact center at **800-842-2252**. You can also schedule a meeting with a TIAA financial consultant at **www.tiaa.org/schedulenow**.

Want help creating a budget or calculating your needs for retirement? Visit **TIAA.org/tools**.

Additional Benefits

Benefit	Description	Contact information	Who Pays?
Allstate IDENTITY PROTECTION **Identify Theft Protection**	Allstate Identity Protection **Pro+ Cyber** delivers comprehensive identity and financial protection plus powerful personal computer and mobile cybersecurity tools. Full and part-time regular employees budgeted to work at least 20 hours per week are eligible.	Allstate Identity Protection **800-789-2720** **www.myaip.com**	**$9.95** per person/month **$17.95** per family/month
pet benefit solutions **Pet Discount Program**	Comprehensive pet insurance coverage is available with our Total Pet Plan which includes: • Discounts on products & Rx • Discounts on veterinary care • 24/7 pet telehealth • Lost pet recovery service	Pet Benefits Solutions **888-913-7387** **info@petbenefits.com** **www.petbenefits.com**	**$11.75**/month for one pet **$18.50**/month for multiple pets

Tuition Reimbursement

Edcor
uabstvtuition.tap.edcor
1-833-799-5420

Tuition Reimbursement

The UAB St. Vincent's Tuition Reimbursement Program has an online portal for applications and reimbursement requests. Employees can now submit applications, track their status, and request payments through the portal. Key features include:

Application Process

- Employees can access the **Edcor portal** to submit new applications, using their Position ID and home zip code for login.
- Required information includes school details, course information, and fees.

Eligibility

Full-time and part-time employees who are classified as "benefits eligible" under UAB St. Vincent's benefit programs and who have completed 180 days (6 months) of employment in a benefits-eligible position as of the semester/term start date may be eligible for tuition reimbursement under the program.

Reimbursement Limits

Full-time employees can receive up to $5,000 annually, while part-time employees are eligible for $2,500.

Deadlines

- Applications must be submitted within 120 days before and 30 days after the term start date.
- Payment requests must be submitted within 90 days after the term ends.

Customer Service

Edcor provides support via a new customer service line (**1-833-799-5420**) and a chat service on the **portal**.

Premium Assistance Program

The UAB St. Vincent's Premium Assistance program provides eligible active employees with a medical premium discount based on family size and total household income. To apply, employees must submit a Premium Assistance Application along with proof of income from the most recent Federal Income Tax Return.

- The discount amount is $38.43 bi-weekly (up to $999.18 annually) for 2026, and is subject to taxes.
- The regular medical premium remains tax-sheltered.
- The application deadline for Open Enrollment is 60 days from January 1st, and for newly eligible employees, 60 days from the effective date of health insurance enrollment.

Eligibility

Eligibility is based on annual household income and family size, with income thresholds listed for each family size. For example:

- 1 person: $30,120
- 2 people: $40,880
- 3 people: $51,640
- 4 people: $62,400
- 5 people: $73,160
- 6 people: $83,920
- 7 people: $94,680
- 8 people: $105,440

Application Requirements

- Complete the Premium Assistance Application form, found on the ONE site under HR and Benefits > Benefits.
- Submit the most recent Federal Income Tax Return (Forms 1040, 1040A, or 1040EZ), signed, along with all W-2s and 1099s from sources of income.
- If married and filing separately, include both spouses' tax returns.

Important Notes

- The discount applies only for the current plan year and must be reapplied for annually.
- Only one application is reviewed per plan year, unless there is a qualifying life event.

For more information or to apply, employees can contact the UAB St. Vincent's Benefits Office at **205-801-8055** or via email at **uabstvbenefits@uabmc.edu**.

Paid Time Off (PTO)

We offer PTO benefits to all our full-time and part-time regular benefit-eligible employees budgeted to work at least 20 hours per week. **Full-time or Part-time regular employees budgeted for fewer than 40 hours per week will have prorated accruals based on FTE. WOW, 7 on/7, off and PRN employees do not accrue PTO.**

PTO Accrual Rates

Employees accrue additional PTO hours bi-weekly based on seniority date. Years of service will be determined as of the employee's seniority date. The date an employee reaches an incremental service range (e.g., 15 years of service); the employee is eligible for the additional accrual rate of PTO on the pay period following their anniversary date.

Regular part-time employees who are budgeted for and average at least twenty (20) hours per week earn PTO prorated based on assigned full-time equivalent (FTE).

PTO time should be used for vacation time, sick time, personal time, Leave of Absence (LOA), including Family Medical Leave (FML) absence.

Non-Exempt Plan	Hours Per Year	Days Per Year	Per Pay Period Accrual
0-2 years	128	16	4.92
3-5 years	136	17	5.23
6-8 years	152	19	5.85
9-11 years	168	21	6.46
12-14 years	192	24	7.38
15-17 years	208	26	8.00
18-19 years	224	28	8.62
20+ years	232	29	8.92

Max accrual is 320 hours. The full balance will be paid upon voluntary termination if proper notice is provided.

Exempt Plan	Hours Per Year	Days Per Year	Per Pay Period Accrual
0-4 years	168	21	6.46
5-14 years	208	26	8.00
15+ years	216	27	8.31

Max accrual is 320 hours. Up to 176 hours will be paid upon voluntary termination if proper notice is provided.

Holidays

We observe the following holidays:

- New Year's Day
- Dr. Martin Luther King Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
  - The day after Thanksgiving
- Christmas Day

Family Medical Leave Act (FMLA)

The Family Medical Leave Act was enacted in 1993 to protect employees from retribution by their employers because of the need to be away from work due to certain life events as well as to manage a serious health condition of their own or that of a specified family member**. Eligible employees may request up to 12 weeks of leave in a rolling 12-month period for any of the following reasons:**

- The birth of a child and to bond with that child within one year of birth
- The placement of a child for adoption or foster care with the employee, and to bond with this child within one year of placement
- A serious health condition that makes the employee unable to perform the functions of his or her job, including incapacity due to pregnancy and for prenatal medical care
- To care for the employee's spouse, child, or parent who has a serious health condition, including incapacity due to pregnancy and for prenatal care
- Any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is a military member on covered active duty or call to covered active-duty status

To be eligible for FMLA Leave, an employee must:

(1) have been employed for at least a twelve-month period and

(2) have worked at least 1,250 hours of service in the twelve-month period immediately preceding the requested leave. If the employee does not meet these service requirements, they are not eligible for a protected FMLA leave. The department would have to approve any time away from work as a non-FMLA personal medical leave. Employees include any part-time, temporary, seasonal, or full-time workers whose name appears on payroll records, whether or not any compensation is received for the work week.

Paid Parental Leave

- An eligible employee who is the birth or adoptive parent of a newborn or newly adopted child may receive up to six weeks (240 hours maximum) of Paid Parental Leave for recovery from childbirth and/or to bond with the newborn or newly adopted child. This leave must be taken within six months of the birth or adoption and may be taken continuously or intermittently.
- In order for an Employee to be eligible for Paid Parental Leave, the employee must have been employed for at least six months in a benefit-eligible position prior to the birth or adoption.
- For the parent giving birth, Paid Parental Leave coordinates with FMLA (if applicable) and Short-Term Disability coverage.

Contacts

Carrier	Website	Phone
ADP Workforce Now Assistance with self-service navigation and benefits	www.mylifeadvisor@adp.com	1-855-547-8508
Allstate Identity Protection	www.myaip.com	1-800-789-2720
Employee Assistance Program	www.one.telushealth.com	1-800-433-7916
Blue Cross Blue Shield Health & Dental	www.bcbsal.org	1-844-594-6004
VIVA Health Prescription Drugs	www.vivahealth.com	205-558-7474
Sun Life Life, Disability, Hospital Indemnity, Critical Illness, Accident Insurance	www.sunlife.com	800-247-6875
Inspira Financial Flexible Spending Accounts (FSA)	www.inspirafinancial.com	800-284-4885
VSP Vision	www.vsp.com	800-877-7195
TIAA Retirement	www.tiaa.org	800-842-2776
EDCOR Tuition Assistance Plan	www.uabstvtuition.tap.edcor	800-247-6875
UNUM Leave Management	www.portal.unum.com	
Employment Verification - ADP	www.theworknumber.com Company code: 11013534	205-934-1581
Aflac Permanent Term Life	www.aflacgroupinsurance.com	800-433-3036
Pet Benefits Solutions	www.petbenefits.com	888-913-7387

Glossary of Terms

Copay: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

Coinsurance: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

Deductible: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

Formulary: A list of prescription drugs covered by the plan. Also called a drug list.

In-Network: A group of doctors, clinics, hospitals, and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

Out-of-Network: Care received from a doctor, hospital, or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

Out-of-Pocket Maximum: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

Under the Affordable Care Act (ACA) you are generally required to have healthcare coverage that is "minimum essential coverage." Additionally, the ACA establishes minimum value and affordability standards for health coverage offered by employers. UAB St. Vincent's meets these all requirements. If you have questions about your specific circumstances, you should contact your tax advisor or visit **www.healthcare.gov** for more information.

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

Plan Benefits

Dental

UAB St. Vincents

Basic Dental Plan

Effective January 1, 2026

Visit our website:
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL NETWORKS

Covered in-network dental providers are accessible both in and outside Alabama. Blue Cross and Blue Shield of Alabama's **Preferred Dental Network** is a statewide dental network. Currently more than 3,000 dentists in Alabama have joined this network.

The **Access Plus Dental Network** is one of the largest dental networks and it offers access to dental providers outside Alabama. There are nearly 450,000 participating dentists nationwide.
These networks are designed to promote quality and cost effective dental care.

To find a dentist in our network, visit **AlabamaBlue.com/FindADoctor.** Then select “Dentist” under the “Search Term” and enter your zip code or city/state. To view only Alabama Preferred Dental providers or Access Plus Dental providers, choose “Alabama Preferred Dentists” or “Access Plus Dental” under “Network or Plan”.

Dental Network Provisions:

- Network dentists will file all claims and accept the Blue Cross payment as payment in full (after any deductible and coinsurance you owe).
- Payments for covered services will be based on the lesser of the allowed amount or the dentist’s actual charge.
- Covered dental services, level of coverage, deductible and benefit maximum amounts will be the same for in-network and out-of-network dentists (unless otherwise specified). However, if you do not use an in-network dentist, Blue Cross will pay you the “allowed amount” for covered services. You may be responsible for the difference between the Blue Cross payment and the dentist’s charge (plus deductible and coinsurance, if applicable). You may also have to file the claim if the dentist’s office will not.

Filing Dental Claims:

To file your own dental claim, you should complete the top portion of the claim form found by visiting AlabamaBlue.com and selecting Dental Claim Form under Resources. An itemized statement from your dentist will need to be included.

Send dental claims to this address:

Blue Cross and Blue Shield of Alabama
P.O. Box 830389
Birmingham, Alabama 35283-0389

If you have questions about your dental coverage or claim, please call the following number:

Blue Cross and Blue Shield of Alabama Customer Service
1-844-594-6004

UAB St. Vincents
Basic Dental Plan-Plan B
Effective January 1, 2026

BENEFITS	COVERAGE
Calendar Year Deductible	$25 deductible per member per calendar year
Maximum	$750 per member per calendar year
Diagnostic and Preventive	Payable at 100% of the allowed amount, not subject to the deductible • Dental exams up to twice per calendar year • Full mouth x-rays, one set during any 36 consecutive months • Bitewing x-rays, up to twice per calendar year • Other dental x-rays, used to diagnose a specific condition • Routine cleanings, twice per calendar year • Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13 • Fluoride treatment for children through age 18 twice per calendar year • Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18
Restorative	Payable at 50% of the allowed amount, subject to calendar year deductible • Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings) • Simple tooth extractions • Direct pulp capping, removal of pulp and root canal treatment • Repairs to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures • Emergency treatment for pain
Supplemental Services	Payable at 50% of the allowed amount, subject to calendar year deductible • Oral surgery for tooth extractions and impacted teeth and to treat mouth cysts and abscesses of the intra-oral and extra-oral soft tissue • General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide • Treatment of the root tip of the tooth including its removal
Prosthetic Services	Payable at 50% of the allowed amount, subject to calendar year deductible • Full or partial dentures • Fixed or removable bridges • Inlays, onlays, veneers or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth
Note: No benefits for late enrollees until the member has been covered for a continuous 365-days	
Periodontic Services	Payable at 50% of the allowed amount, subject to calendar year deductible • Periodontic exams twice each 12 months • Removal of diseased gum tissue and reconstructing gums • Removal of diseased bone • Reconstruction of gums and mucous membranes by surgery • Removing plaque and calculus below the gum line for periodontal disease
Note: No benefits for late enrollees until the member has been covered for a continuous 365-days	

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

10/15/2025 AR
Group 33915 div. D01, D1S

Notice of Nondiscrimination

Discrimination is Against the Law

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY),1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese:
ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

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Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.

Plan Benefits

Dental

UAB St. Vincents

Comprehensive Dental Plan

Effective January 1, 2026

Visit our website:
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL NETWORKS

Covered in-network dental providers are accessible both in and outside Alabama. Blue Cross and Blue Shield of Alabama's **Preferred Dental Network** is a statewide dental network. Currently more than 3,000 dentists in Alabama have joined this network.

The **Access Plus Dental Network** is one of the largest dental networks and it offers access to dental providers outside Alabama. There are nearly 450,000 participating dentists nationwide.
These networks are designed to promote quality and cost effective dental care.

To find a dentist in our network, visit **AlabamaBlue.com/FindADoctor.** Then select “Dentist” under the “Search Term” and enter your zip code or city/state. To view only Alabama Preferred Dental providers or Access Plus Dental providers, choose “Alabama Preferred Dentists” or “Access Plus Dental” under “Network or Plan”.

Dental Network Provisions:

- Network dentists will file all claims and accept the Blue Cross payment as payment in full (after any deductible and coinsurance you owe).
- Payments for covered services will be based on the lesser of the allowed amount or the dentist’s actual charge.
- Covered dental services, level of coverage, deductible and benefit maximum amounts will be the same for in-network and out-of-network dentists (unless otherwise specified). However, if you do not use an in-network dentist, Blue Cross will pay you the “allowed amount” for covered services. You may be responsible for the difference between the Blue Cross payment and the dentist’s charge (plus deductible and coinsurance, if applicable). You may also have to file the claim if the dentist’s office will not.

Filing Dental Claims:

To file your own dental claim, you should complete the top portion of the claim form found by visiting AlabamaBlue.com and selecting Dental Claim Form under Resources. An itemized statement from your dentist will need to be included.

Send dental claims to this address:

Blue Cross and Blue Shield of Alabama
P.O. Box 830389
Birmingham, Alabama 35283-0389

If you have questions about your dental coverage or claim, please call the following number:

Blue Cross and Blue Shield of Alabama Customer Service
1-844-594-6004

UAB St. Vincents
Comprehensive Dental Plan-Plan A
Effective January 1, 2026

BENEFITS	COVERAGE
Calendar Year Deductible	$25 deductible per member per calendar year
Maximum	$1,500 per member per calendar year
Diagnostic and Preventive	Payable at 100% of the allowed amount, not subject to calendar year deductible • Dental exams up to twice per calendar year • Full mouth x-rays, one set during any 36 consecutive months • Bitewing x-rays, up to twice per calendar year • Other dental x-rays, used to diagnose a specific condition • Routine cleanings, twice per calendar year • Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13 • Fluoride treatment for children through age 18 twice per calendar year • Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18
Restorative	Payable at 80% of the allowed amount, subject to calendar year deductible • Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings) • Simple tooth extractions • Direct pulp capping, removal of pulp and root canal treatment • Repairs to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures • Emergency treatment for pain
Supplemental Services	Payable at 80% of the allowed amount, subject to calendar year deductible • Oral surgery for tooth extractions and impacted teeth and to treat mouth cysts and abscesses of the intra-oral and extra-oral soft tissue • General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide • Treatment of the root tip of the tooth including its removal
Prosthetic Services	Payable at 50% of the allowed amount, subject to calendar year deductible • Full or partial dentures • Fixed or removable bridges • Inlays, onlays, veneers or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth
Note: No benefits for late enrollees until the member has been covered for a continuous 365-days	
Periodontic Services	Payable at 80% of the allowed amount, subject to calendar year deductible • Periodontic exams twice each 12 months • Removal of diseased gum tissue and reconstructing gums • Removal of diseased bone • Reconstruction of gums and mucous membranes by surgery • Removing plaque and calculus below the gum line for periodontal disease
Note: No benefits for late enrollees until the member has been covered for a continuous 365-days	
Orthodontic	Payable at 50% of the allowed amount, subject to calendar year deductible for dependent children up to age 26. Limited to a lifetime maximum of $1,000.
Note: No benefits for late enrollees until the member has been covered for a continuous 365-days	

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

Revised 10/15/25 AR
Group 33915 div. D02, D2S

Notice of Nondiscrimination

Discrimination is Against the Law

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY),1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese:
ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

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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 per Calendar Year 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**	$30 Copay/visit	$50 Copay/visit
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **Illness and Injury** • **OB/GYN Services** • **Laboratory Procedures**	$50 Copay/visit	$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
CHRONIC CARE MAINTENANCE: *Including, but not limited to:* • **Dialysis** • **Radiation therapy, wound care, wound therapy**	85% Coverage after deductible 85% Coverage after deductible	85% Coverage after deductible 60% Coverage after deductible

VIVA HEALTH® UAB ST. VINCENT'S

MEDICAL BENEFITS	COVERAGE - TIER 1 UAB/UAB St. Vincent's Network	COVERAGE - TIER 2 VIVA Network (outside UAB)
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
• **Maternity 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
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50 Copay/visit	$60 Copay/visit
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.

UAB St. Vincent's

BlueCard® PPO

Effective January 1, 2026

UAB St. Vincent's
BlueCard® PPO
Effective January 1, 2026

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS (Includes Mental Health Disorders and Substance Abuse Benefits)		
UAB Providers include: UAB Foundation, UAB Medical West, UAB Provider and Children's Hospital		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible UAB Provider and BlueCard PPO deductible maximums cross apply	**UAB Provider:** $250 per person each calendar year; $750 family maximum. **BlueCard PPO:** $1,000 per person each calendar year; $2,000 family maximum.	
Annual Out-of-Pocket Maximum UAB Provider and BlueCard PPO out-of-pocket maximums cross apply	**UAB Provider:** $4,000 individual; $8,000 family maximum **BlueCard PPO:** $7,500 individual; $15,000 family maximum **In-Network Services:** Deductibles, copays and coinsurance apply to the out-of-pocket maximum, including prescription drugs. **Out-of-Network Services:** Home Health, Hospice, and Other Covered Services apply to the out-of-pocket maximum. UAB provider or PPO provider eligible services provided by a non-network provider in Alabama do not apply to the out-of-pocket After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% of the allowed amount for the remainder of the calendar year.	
INPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse Benefits)		
Inpatient Facility Coverage including Residential Treatment Facilities (including maternity)	**UAB Provider:** Covered at 100% of the allowed amount, subject to a $300 per admission copay **BlueCard PPO:** Covered at 60% of the allowed amount, subject to the calendar year deductible **Mental Health Disorders and Substance Abuse Services inpatient admissions:** **UAB St. Vincents Provider:** Covered at 100% of the allowed amount, subject to a $200 per admission copay **BlueCard PPO:** Covered at 80% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury and medical emergency.	
Preadmission Certification	All hospital admissions require preadmission certification, except maternity and as required by Federal law. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1-800-248-2342 (toll-free). If preadmission certification is not obtained, no benefits are available.	
OUTPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse Benefits)		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Surgery (including Ambulatory Surgical Center)	**UAB Provider:** Covered at 100% of the allowed amount, subject to a $200 copay **BlueCard PPO:** Covered at 60% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible In Alabama, not covered
Medical Emergency	Covered at 100% of the allowed amount subject to the $250 facility copay	Covered at 100% of the allowed amount subject to the $250 facility copay
Accidental Injury	Covered at 100% of the allowed amount subject to the $250 facility copay	Covered at 100% of the allowed amount subject to the $250 facility copay
Diagnostic X-ray and Advanced Imaging	**UAB Provider:** Covered at 100% of the allowed amount subject to the $30 copay **BlueCard PPO:** Covered at 60% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible In Alabama, not covered

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Diagnostic Labs and Pathology	**UAB Provider/PPO Provider: Covered at 100% of the allowed amount, no deductible or copay**	Covered at 80% of the allowed amount, subject to the calendar year deductible In Alabama, not covered
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	**UAB Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible **BlueCard PPO:** Covered at 70% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible In Alabama, not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 80% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
Note: In Alabama, outpatient benefits for non-member hospitals are available **only** in cases of accidental injury.		
PHYSICIAN SERVICES (Includes Mental Health Disorders and Substance Abuse Benefits)		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList; please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/ HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits and Outpatient Consultations (including allergy treatment)	Covered at 100% of the allowed amount subject to the office visit copay **UAB Provider:** Covered at 100% of the allowed amount subject to the $30 PCP office visit copay (Includes **PPO Provider** Pediatricians)/$50 Specialist office visit copay **PPO Provider:** Covered at 100% of the allowed amount subject to the $50 PCP office visit copay/$60 Specialist office visit copay	Covered at 50% of the allowed amount subject to the calendar year deductible
Urgent Care	Covered at 100% of the allowed amount subject to the office visit copay **UAB Provider:** $30 office visit copay **PPO Provider:** $50 office visit copay	Covered at 50% of the allowed amount, subject to the calendar year deductible
Second Surgical Opinions	**UAB Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible **BlueCard PPO:** Covered at 70% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
Emergency Room Physician Fees	Covered at 100% of the allowed amount subject to the office visit copay **UAB Provider:** $30 office visit copay **PPO Provider:** $50 office visit copay **Mental Health Disorders and Substance Abuse Services for in-network emergency room physician:** **Other PPO Provider:** Covered at 100% of the allowed amount subject to the $30 office visit copay	Covered at 100% of the allowed amount subject to the office visit copay **UAB Provider:** $30 office visit copay **PPO Provider:** $50 office visit copay **Mental Health Disorders and Substance Abuse Services for in-network emergency room physician:** **Other PPO Provider:** Covered at 100% of the allowed amount subject to the $30 office visit copay
Surgery and Anesthesia	**UAB Provider and PPO Provider:** Covered at 100% of the allowed amount with no deductible or copay **All OB/GYN outpatient facility surgical charges:** **UAB Provider:** No copay **PPO Provider:** $150 copay	Covered at 50% of the allowed amount, subject to the calendar year deductible
Inpatient Visits and Consultations	**UAB Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible **BlueCard PPO:** Covered at 70% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Maternity (prenatal, postnatal and delivery) **($1,500 out-of-pocket maximum / member / calendar year)**	**UAB Provider:** Physician Services: Covered at 100% of the allowed amount with no deductible or copay. Hospitalization: $300 Copay / admission **PPO Provider:** Physician Services: $60 Copay / delivery. Hospitalization: Covered at 60% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
Diagnostic X-ray and Advanced Imaging	**UAB Provider:** Covered at 100% of the allowed amount subject to the $30 copay **BlueCard PPO:** Covered at 60% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
Diagnostic Labs and Pathology	**UAB Provider/PPO Provider:** Covered at 100% of the allowed amount, no deductible or copay	Covered at 80% of the allowed amount, subject to the calendar year deductible
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	**UAB Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible **BlueCard PPO:** Covered at 70% of the allowed amount, subject to the calendar year deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 100% of the allowed amount with no deductible or copay	Covered at 80% of the allowed amount, subject to the calendar year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for In-network and Out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
ENHANCED PREVENTIVE CARE SERVICES		
Routine Preventive Services and Immunizations	100%, no deductible or copay. See **AlabamaBlue.com/preventiveservices** for a listing of specific covered preventive services and immunizations or call our Customer Service Department for a printed copy **In addition to the standard, the following exceptions apply:** • Routine urinalysis - when necessary • Routine TB skin test - when necessary • Routine CBC - when necessary • Routine cholesterol - once every five calendar years • One routine OB/GYN visit in addition to the one required routine visit per calendar year	Not covered
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse Benefits)		
Precertification is required for some other covered services and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList; please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Chiropractor Services	Covered at 100% of the allowed amount subject to the $30 PCP office visit copay	
Occupational, Speech and Physical Therapy	**UAB Provider:** Covered at 100% of the allowed amount subject to the $30 PCP office visit copay **Other PPO Provider:** Covered at 60% of the allowed amount, subject to the calendar year deductible.	
Durable Medical Equipment	Covered at 80% of the allowed amount, subject to the calendar year deductible	
Ambulance Services	Covered at 80% of the allowed amount, subject to the calendar year deductible	
Bariatric Surgery	Covered at 50% of the allowed amount, subject to the calendar year deductible	Not covered
Preferred Home Health and Hospice	**UAB Provider:** Covered at 80% of the allowed amount, no copay or deductible **PPO Provider**: Covered at 80% of the allowed amount, subject to the calendar deductible Precertification required for services rendered outside of Alabama. Call 1-800-821-7231 Home Health limited to 60 visits per person per calendar year in and out-of-network combined.	Covered at 80% of the allowed amount, subject to the calendar year deductible. Limited to 60 visits per person per calendar year in and out-of-network combined. Precertification required Call 1-800-821-7231 **Non-Preferred in Alabama:** Not covered
Skilled Nursing Facility	**UAB Provider/PPO Provider:** Covered at 80% of the allowed amount, subject to calendar year deductible. Limited to 100 days per lifetime per person in and out-of-network combined. Precertification required for services rendered outside of Alabama. Call 1-800-821-7231	Not covered
Home Infusion	Covered at 80% of the allowed amount, subject to the calendar year deductible. Precertification required for services rendered outside of Alabama. Call 1-800-821-7231	Covered at 50% of the allowed amount, subject to the calendar year deductible. Precertification required Call 1-800-821-7231 **Non-Preferred in Alabama:** Not covered
PRESCRIPTION DRUGS		
Prescription Drugs are administered by Express Scripts, Inc.		
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	A program to assist employees and their families in coordinating care in the event of a lengthy illness.	
Chronic Condition Management	A program for chronic conditions such as asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure and other specialized conditions.	
Baby Yourself®	A maternity program with early intervention for ALL pregnancies-both normal and high risk. Call 1 800 222-4379 to enroll and begin receiving information and gifts to help you "Baby Yourself" and experience the healthiest pregnancy possible. You can also enroll online at **AlabamaBlue.com/BabyYourself**.	
Contraceptive Management	Covers certain contraceptives, which include: insertion and removal of implantable contraceptive capsules, diaphragm or cervical cap fitting with instructions, insertion and removal of intrauterine device (IUD), depo-provera injections, intrauterine copper contraceptive and Levonogestrel (contraceptive) implants system. Pharmacy benefits (which includes birth control pills) are available only when the group has prescription drug benefits with Blue Cross Blue Shield of Alabama.	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (AlabamaBlue.com) or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD, Preferred Care).*
- *Out-of-network providers generally do not contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area or in accordance with applicable Federal Law.*
- *In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*

Notice of Nondiscrimination

Discrimination is Against the Law

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY),1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese:
ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.

VIVA HEALTH Prescription Drug Benefits for UAB ST. VINCENT'S
UAB St. Vincent's Blue Cross and Blue Shield of Alabama Plan

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.

Please keep this Attachment A for your records.

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[1]:	
• **Generic Drugs**	
○ St. Vincent's Hospital Pharmacy	$10 Copay (30-day supply) or $20 Copay (90-day supply[2])
○ Express Scripts (ESI) Participating Retail Pharmacy	$20 Copay (30-day supply) or $60 Copay (90-day supply[2])
○ 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[2])
○ Express Scripts (ESI) Participating Retail Pharmacy	$50 Copay (30-day) or $150 Copay (90-day[2])
○ 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[2])
○ Express Scripts (ESI) Participating Retail Pharmacy	$75 Copay (30-day) or $225 Copay (90-day[2])
○ Mail order (ESI)	$150 Copay (90-day supply[2])
• **Preferred Generic & Specialty Drugs[3,4]**	$200 Copay
• **Non-Preferred Generic & Specialty Drugs[3,4]**	$350 Copay
• **Oral Contraceptives**	$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 https://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.

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

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

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