

## Attachment A to Certificate of Coverage – Schedule of Copayments

The Plan's services and benefits, with their Copayments, coinsurance, and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a Copayment or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** Please remember that 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.

MEDICAL BENEFITS	COVERAGE
<b>CALENDAR YEAR DEDUCTIBLE:</b> Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital.	\$300 per individual; \$900 per family per Calendar Year
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. The maximum limit may change during the course of a calendar year. If the limit increases with a new plan year, you may owe cost-sharing again up to the amount of the increase even if you reached the limit earlier in the Calendar Year. See the Certificate of Coverage for details.	\$9,100 per individual; \$18,200 per family per Calendar Year
<b>PREVENTIVE CARE:</b> <ul style="list-style-type: none"> <li>Well Baby Care (Children under age 3)</li> <li>Routine Physicals (One per Calendar year for ages 3+)</li> <li>Covered Immunizations</li> <li>OB/GYN Preventive Visit (One per Calendar Year)</li> <li>Preventive Prenatal Care</li> <li>Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)</li> <li>Other Preventive Items and Services (See Certificate of Coverage for more information)</li> </ul>	100% Coverage
<b>OTHER PRIMARY CARE SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Hearing Exams</li> <li>Illness and Injury</li> </ul>	\$25 Copayment per visit
<b>LABORATORY PROCEDURES:</b> <ul style="list-style-type: none"> <li>Laboratory Procedure</li> <li>Covered Genetic Testing</li> </ul>	\$7.50 Copayment per test at independent labs; 90% Coverage per test at hospital-based labs 80% Coverage
<b>TELADOC TELEHEALTH SERVICES:</b> <ul style="list-style-type: none"> <li>Primary/Urgent Care Consultations</li> <li>Behavioral Health Consultations</li> </ul>	\$25 Copayment per consult \$40 Copayment per consult
<b>SPECIALTY CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>OB/GYN Services</li> </ul>	\$50 Copayment per visit
<b>URGENT CARE CENTER SERVICES:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> </ul>	\$50 Copayment per visit
<b>VISION CARE:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>One Routine Vision Exam per Calendar Year</li> <li>Other Eye Care Office Visits</li> </ul>	\$50 Copayment per visit
<b>ALLERGY SERVICES:</b> (No PCP Referral Required) <ul style="list-style-type: none"> <li>Physician Services</li> <li>Testing &amp; Treatment</li> </ul>	\$50 Copayment per visit 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> (Including but not limited to X-Rays, CT Scan, MRI, PET/SPECT, ERCP)	90% Coverage
<b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Ambulatory Surgical Center</li> <li>Surgery and Other Outpatient Services</li> <li>Outpatient Hospital Observation (no procedure performed)</li> </ul>	\$150 Copayment per service 90% Coverage per service \$300 Copayment per admission
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>Physician and Facility Services</li> </ul>	\$300 Copay/admission & a \$50 Copay/day (days 2-5)
<b>MATERNITY SERVICES:</b> <ul style="list-style-type: none"> <li>Physician Services (Prenatal, delivery, and postnatal care)</li> <li>Maternity Hospitalization</li> </ul> Maternity services are covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care. <p style="text-align: center;">Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.</p>	\$50 Copayment per delivery \$300 Copay/admission & a \$50 Copay/day (days 2-5)
<b>EMERGENCY ROOM SERVICES:</b> (Copayment waived if admitted through ER)	\$300 Copayment per visit
<b>EMERGENCY AMBULANCE SERVICES:</b> (Must be Medically Necessary)	80% Coverage
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:</b>	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> (100 Days per Lifetime)	80% Coverage
<b>MEDICAL NUTRITION SERVICES:</b> (Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)	\$50 Copayment per visit
<b>CHRONIC CARE MAINTENANCE:</b> (Including but not limited to dialysis, wound care, wound therapy)	80% Coverage

MEDICAL BENEFITS	COVERAGE
<b>DIABETIC SELF-MANAGEMENT EDUCATION:</b>	\$50 Copayment per visit
<b>DIABETIC SUPPLIES:</b> (Insulin covered under prescription drug rider; For Diabetic Supplies call VIVA HEALTH)	100% Coverage
<b>HOME HEALTH CARE SERVICES:</b> (Limited to 60 Visits per Calendar Year)	100% Coverage
<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required. Covered up to 25 Visits per Calendar Year)	\$50 Copayment per visit
<b>REHABILITATION AND HABILITATION SERVICES:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (Limited to 60 Total Inpatient Days and 30 Total Outpatient Visits per Calendar Year for medical diagnoses)	80% Coverage
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	\$50 Copayment per visit
<b>SLEEP DISORDERS:</b>	\$50 Copayment per visit
• Sleep Study	\$150 Copayment per sleep study
<b>TRANSPLANT SERVICES:</b>	\$300 Copay/admission & a \$50 Copay/day (days 2-5)
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES:</b>	\$300 Copay/admission & a \$50 Copay/day (days 2-5)
• Inpatient	\$40 Copayment per visit
• Outpatient	

PHARMACEUTICAL BENEFITS	COVERAGE
<b>COVERED PRESCRIPTION DRUGS<sup>1</sup>:</b>	
• <b>Tier 1 (Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$5 Copayment per 30-day supply
o Mail-order	\$12 Copayment per 90-day supply
o Participating Pharmacy	\$15 Copayment per 90-day supply
• <b>Tier 2 (Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$20 Copayment per 30-day supply
o Mail-order	\$43 Copayment per 90-day supply
o Participating Pharmacy	\$60 Copayment per 90-day supply
• <b>Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$60 Copayment per 30-day supply
o Mail-order	\$150 Copayment per 90-day supply
o Participating Pharmacy	\$180 Copayment per 90-day supply
• <b>Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)</b>	
o Participating Pharmacy	\$80 Copayment per 30-day supply
o Mail-order	\$200 Copayment per 90-day supply
o Participating Pharmacy	\$240 Copayment per 90-day supply
• <b>Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs<sup>2</sup>)</b>	70% Coverage
• <b>Oral Contraceptives</b>	\$0 Copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand drugs
• <b>Diabetic Testing Supplies</b> [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]	100% Coverage

<sup>1</sup>Some medications may require prior authorization from VIVA HEALTH. Please contact Customer Service at the number listed below for more information. <sup>2</sup>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 the medications in this category, please refer to <https://www.vivahealth.com/Group/Login/>.

**When Generic is available, Member pays difference between Generic and Brand price, plus Copayment ("ancillary charge"). Ancillary charges do not count toward the out-of-pocket maximum. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.**

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

<b>Pre-Existing Waiting Period:</b>	No pre-existing condition exclusions or waiting period.
<b>Eligible Dependent:</b>	Employee's lawful spouse and children of eligible employees up to age 26 and disabled dependents who meet eligibility criteria.
<b>Nondiscrimination Notice:</b>	VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
<b>Language Assistance Services:</b>	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-294-7780 (TTY：711)。

Delta Dental PPO® Plan	
The PPO Plan allows you to seek treatment from any licensed dentist. However, if you receive treatment from a non-PPO provider, you may be required to pay the difference between the billed rate and the allowed rate. Please refer to the Delta Dental Member Handbook for covered benefits, limitations, and exclusions. The Dental Plan is included in the health plan premium for VIVA HEALTH and is offered by Delta Dental. There is no additional cost for this plan. <b>For questions regarding the dental plan or to receive a new ID card, please contact Delta Dental Customer Service at 1-800-521-2651.</b>	
<b>Type I Diagnostic/Preventive Services</b>	
• Routine oral exams, Fluoride treatments (children under 19), Cleanings, X-Rays (limitations may apply), Sealants, Space Maintainers	100% coverage of Maximum Plan Allowance
<b>Type II Basic Services</b>	
• Fillings, Simple Extractions, Palliative Services, General Anesthesia, Non-Surgical Periodontics	50% coverage of Maximum Plan Allowance
<b>Type III Major Services</b>	
• Major Restorative (crowns, bridges, and dentures), Denture Repair, Endodontics (root canals), Surgical Periodontics, Oral Surgery (includes surgical extractions)	25% coverage of Maximum Plan Allowance
<b>Maximum Dental Benefit:</b> \$500 Calendar Year limit. \$50 per person/\$150 per family deductible applies to Basic and Major Services. Please refer to the dental schedule of benefits, limitations, and exclusions for full benefit descriptions. Time served on a prior carrier's dental plan with your current employer may be credited toward the Delta Dental plan's waiting periods, subject to Underwriting approval.	