VIVA HEALTH

PEEHIP

Effective Dates: October 1, 2024 – September 30, 2025

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
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Deductible.	$300 per individual; $900 per family per Calendar Year
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. 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. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	$9,100 per individual; $18,200 per family per Calendar Year
PREVENTIVE CARE: • **Well Baby Care (Children under age 3)** • **Routine Physicals (One per Calendar year for ages 3+)** • **Covered Immunizations** • **OB/GYN Preventive Visit (One per Calendar Year)** • **Preventive Prenatal Care** • **Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist)** • **Other Preventive Items and Services (See Certificate of Coverage for more information)**	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Hearing Exams** • **Illness and Injury**	$25 Copayment per visit
LABORATORY PROCEDURES: • **Laboratory Procedure** • **Covered Genetic Testing**	$7.50 Copayment per test at independent labs; 90% Coverage per test at hospital-based labs 80% Coverage
TELADOC TELEHEALTH SERVICES: • **Primary/Urgent Care Consultations** • **Behavioral Health Consultations**	$25 Copayment per consult $40 Copayment per consult
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **OB/GYN Services**	$50 Copayment per visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	$50 Copayment per visit
VISION CARE: *(No PCP Referral Required)* • **One Routine Vision Exam per Calendar Year** • **Other Eye Care Office Visits**	$50 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing & Treatment**	$50 Copayment per visit 80% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to X-Rays, CT Scan, MRI, PET/SPECT, ERCP)*	90% Coverage
OUTPATIENT SERVICES: • **Ambulatory Surgical Center** • **Surgery and Other Outpatient Services** • **Outpatient Hospital Observation (no procedure performed)**	$150 Copayment per service 90% Coverage per service $300 Copayment per admission
HOSPITAL INPATIENT SERVICES: • **Physician and Facility Services**	$300 Copay/admission & a $50 Copay/day (days 2-5)
MATERNITY SERVICES: • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization**	$50 Copayment per delivery $300 Copay/admission & a $50 Copay/day (days 2-5)
Maternity services are covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care. **Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.**	
EMERGENCY ROOM SERVICES: *(Copayment waived if admitted through ER)*	$300 Copayment per visit
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 Days per Lifetime)*	80% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50 Copayment per visit

MEDICAL BENEFITS	COVERAGE
CHRONIC CARE MAINTENANCE: *(Including but not limited to dialysis, wound care, wound therapy)*	80% Coverage
DIABETIC SELF-MANAGEMENT EDUCATION:	$50 Copayment per visit
DIABETIC SUPPLIES: (*Insulin covered under prescription drug rider; For Diabetic Supplies call VIVA HEALTH*)	100% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 Visits per Calendar Year)*	100% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 Visits per Calendar Year)*	$50 Copayment per visit
REHABILITATION AND HABILITIATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(Limited to 60 Total Inpatient Days and 30 Total Outpatient Visits per Calendar Year for medical diagnoses)*	80% Coverage
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
SLEEP DISORDERS:	$50 Copayment per visit
• **Sleep Study**	$150 Copayment per sleep study
TRANSPLANT SERVICES:	$300 Copay/admission & a $50 Copay/day (days 2-5)
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient**	$300 Copay/admission & a $50 Copay/day (days 2-5)
• **Outpatient**	$40 Copayment per visit

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

[1]Some medications may require prior authorization from VIVA HEALTH. Please contact Customer Service at the number listed below for more information. [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 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

Pre-Existing Waiting Period: No pre-existing condition exclusions or waiting period.

Eligible Dependent: Employee's lawful spouse and children of eligible employees up to age 26 and disabled dependents who meet eligibility criteria.

Nondiscrimination Notice: VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). VIVA HEALTH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-294-7780（TTY：711）.

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. **For questions regarding the dental plan or to receive a new ID card, please contact Delta Dental Customer Service at 1-800-521-2651.**

Type I Diagnostic/Preventive Services: Routine oral exams, Fluoride treatments (children under 19), Cleanings, X-Rays (limitations may apply), Sealants, Space Maintainers	100% coverage of Maximum Plan Allowance
Type II Basic Services: Fillings, Simple Extractions, Palliative Services, General Anesthesia, Non-Surgical Periodontics	50% coverage of Maximum Plan Allowance
Type III Major Services: Major Restorative (crowns, bridges, and dentures), Denture Repair, Endodontics (root canals), Surgical Periodontics, Oral Surgery (includes surgical extractions)	25% coverage of Maximum Plan Allowance
Maximum Dental Benefit: $750 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.	