VIVA HEALTH

PEEHIP

Effective Dates: October 1, 2015 – September 30, 2016

Attachment A to Certificate of Coverage – Schedule of Copays

The Plan's services and benefits, with their Copays and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** Please remember that this is only a brief listing. For further information, please see the Certificate of Coverage. **Please keep this Attachment A for your records.**

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 Caremark but will apply to such drugs when provided directly by a physician or hospital. The family deductible is $900 not to exceed $300 per any individual.	$300 per individual; $900 aggregate amount per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance abuse 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.	$6,600 per individual; $13,200 aggregate amount 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 (As defined in the Certificate of Coverage)** • **Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.**	100% Coverage
OTHER PRIMARY CARE SERVICES: • **Medical Physician Services** • **Hearing Exams** • **Illness and Injury**	$20 Copay per visit
LABORATORY PROCEDURES: • **Laboratory Procedure** • **Covered Genetic Testing**	$7.50 copay per test at independent labs; 90% coverage per test at hospital-based labs 80% Coverage
TELEHEALTH CONSULTATION:	$40 copay per consult
SPECIALTY CARE: *(No PCP Referral Required)* • **Medical Physician Services** • **OB/GYN Services**	 $40 Copay per visit $40 Copay per visit
URGENT CARE CENTER SERVICES: • **Medical Physician Services** • **Illness and Injury**	 $40 Copay per visit
VISION CARE: *(No PCP Referral Required)* • **One routine vision exam per Calendar Year** • **Other eye care office visits**	 $40 Copay per visit $40 Copay per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • **Physician Services** • **Testing & Treatment**	 $40 Copay 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** • **Outpatient Hospital**	 $150 Copay per service 90% Coverage per service
HOSPITAL INPATIENT SERVICES: • **Physician Services** • **Semi-Private Room**	 100% Coverage $200 Copay per admission & a $50 Copay for days 2-5
MATERNITY SERVICES: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)* • **Physician Services** *(Prenatal, delivery, and postnatal care)* • **Maternity Hospitalization** **Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.**	 $40 Copay per delivery $200 Copay per admission & a $50 Copay for days 2-5
EMERGENCY ROOM SERVICES: *(Copay waived if admitted through ER)*	$200 Copay 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
CHRONIC CARE MAINTENANCE: *(Including but not limited to dialysis, wound care, wound therapy)*	80% Coverage

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DIABETIC SUPPLIES: (*Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.*)	100% Coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)*	80% 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)*	
• **Treatment for manual manipulation of subluxations only**	$40 Copay per visit
TEMPOROMANDIBULAR JOINT DISORDER: *($3,000 Maximum Benefit per Lifetime)*	$40 Copay per visit
SLEEP DISORDERS:	$40 Copay per visit
Two Sleep Studies per Member per Lifetime	$150 Copay per sleep study
TRANSPLANT SERVICES:	$200 Hospital Copayment & a $50 Copay for days 2-5
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• **Inpatient**	$200 Copayment per admission & a $50 Copay for days 2-5
• **Outpatient**	$40 Copayment per visit
[2]Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details.	
COVERED PRESCRIPTION DRUGS[2]:	
• **Preferred Generic Drugs**	
○ Participating Pharmacy	$5 Copayment per 31-day supply
○ Mail-order	$12 Copayment per 90-day supply
○ Participating Pharmacy	$15 Copayment per 90-day supply
• **Generic Drugs**	
○ Participating Pharmacy	$20 Copayment per 31-day supply
○ Mail-order	$43 Copayment per 90-day supply
○ Participating Pharmacy	$60 Copayment per 90-day supply
• **Preferred Brand-Name Drugs**	
○ Participating Pharmacy	$60 Copayment per 31-day supply
○ Mail-order	$150 Copayment per 90-day supply
○ Participating Pharmacy	$180 Copayment per 90-day supply
• **Non-Preferred Brand-Name Drugs**	
○ Participating Pharmacy	$80 Copayment per 31-day supply
○ Mail-order	$200 Copayment per 90-day supply
○ Participating Pharmacy	$240 Copayment per 90-day supply
• **Oral Contraceptives**	$0 copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand-name drugs
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3]**	70% Coverage

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

[3]May be administered in the home, physician's office or on an outpatient basis. When these medications are received from Caremark, they must be ordered by calling 1-800-237-2767. For a list of the medications in this category, please refer to http://www.vivaemployer.com/Members/Default.aspx

When Generic is available, Member pays difference between Generic and Brand-Name price, plus Copayment.

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 waiting period for pre-existing medical conditions.

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

Delta Dental PPO/Premier® Plan

The Indemnity Plan allows you to seek treatment from any licensed dentist. 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: $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 serviced 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.**