

Effective Dates: October 1, 2013 – September 30, 2014

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. 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: <i>Applies ONLY to those benefits with 80% Coverage. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Mental Health or Biological, Biotechnical, and Specialty Pharmaceuticals. The family deductible is \$900 not to exceed \$300 per any individual.</i>	\$300 per individual; \$900 aggregate amount per family
COINSURANCE LIMIT: <i>Applies ONLY to out-of-pocket costs on those benefits that require the member to pay a percentage of the cost, except Biological, Biotechnical, and Specialty Pharmaceuticals, which have a separate coinsurance limit listed below. The deductible does not count toward the Coinsurance Limit. Does not apply to benefits with a copayment or prescription benefits.</i>	\$2,000 per individual; \$6,000 aggregate amount per family per Calendar Year
PREVENTIVE CARE: <ul style="list-style-type: none"> • 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) • Other preventive items and services. See Certificate of Coverage for recommendations and guidelines. 	100% Coverage
OTHER PRIMARY CARE SERVICES: <ul style="list-style-type: none"> • Surgical & Medical Physician Services • Hearing Exams • Illness and Injury • X-Rays and Laboratory Procedures 	\$30 Copay per visit
SPECIALTY CARE: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> • Surgical & Medical Physician Services • OB/GYN Services 	\$30 Copay per visit \$30 Copay per visit
VISION CARE: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> • One routine vision exam per Calendar Year • Other eye care office visits 	\$30 Copay per visit \$30 Copay per visit
ALLERGY SERVICES: <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> • Physician Services • Testing 	\$30 Copay per visit 100% Coverage
DIAGNOSTIC SERVICES: <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i>	\$125 Copay per service
OUTPATIENT SERVICES: <ul style="list-style-type: none"> • Surgery & Other Outpatient Services 	\$125 Copay per service
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> • Physician Services • Semi-Private Room 	100% Coverage \$200 Copay per admission & a \$25 Copay for days 2-5
MATERNITY SERVICES: <ul style="list-style-type: none"> • Physician Services <i>(Prenatal, delivery, and postnatal care)</i> • Maternity Hospitalization 	\$30 Copay per delivery \$200 Copay per admission & a \$25 Copay for days 2-5
EMERGENCY ROOM SERVICES: <i>(Copay waived if admitted through ER)</i>	\$150 Copay per visit
EMERGENCY AMBULANCE SERVICES: <i>(Must be Medically Necessary)</i>	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: <i>(100 Days per Lifetime)</i>	80% Coverage
DIABETIC SUPPLIES: <i>(Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.)</i>	100% Coverage
REHABILITATION SERVICES: <i>Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)</i>	80% Coverage
HOME HEALTH CARE SERVICES: <i>(Limited to 60 Visits per Calendar Year)</i>	100% Coverage
CHIROPRACTIC SERVICES: <i>(No PCP Referral Required) (Covered up to 25 Visits per Calendar Year)</i> <ul style="list-style-type: none"> • Treatment for manual manipulation of subluxations only 	\$30 Copay per visit
TEMPOROMANDIBULAR JOINT DISORDER: <i>(\$3,000 Maximum Benefit per Lifetime)</i>	\$30 Copay per visit
SLEEP DISORDERS: <ul style="list-style-type: none"> Two Sleep Studies per Member per Lifetime 	\$30 Copay per visit \$125 Copay per sleep study
TRANSPLANT SERVICES:	100% Coverage after \$200 Hospital Copayment and a \$25 Copay for days 2-5

BENEFITS	COVERAGE
MENTAL HEALTH & SUBSTANCE ABUSE SERVICE:	
<ul style="list-style-type: none"> • Inpatient • Outpatient Partial or day hospitalization, intensive outpatient treatment, and treatment at a residential facility are not covered services. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details. 	100% Coverage after \$200 Copayment per admission and a \$25 Copay for days 2-5 100% after \$30 Copayment per visit
COVERED PRESCRIPTION DRUGS:	
<ul style="list-style-type: none"> • Preferred Generic Drugs <ul style="list-style-type: none"> ○ Participating Pharmacy ○ Mail-order ○ Participating Pharmacy • Generic Drugs <ul style="list-style-type: none"> ○ Participating Pharmacy ○ Mail-order ○ Participating Pharmacy • Preferred Brand-Name Drugs <ul style="list-style-type: none"> ○ Participating Pharmacy ○ Mail-order ○ Participating Pharmacy • Non-Preferred Brand-Name Drugs <ul style="list-style-type: none"> ○ Participating Pharmacy ○ Mail-order ○ Participating Pharmacy • Oral Contraceptives • Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals May be administered in the home, physician's office or on an outpatient basis. There is a Member out-of-pocket maximum of \$1,000 per Member per Calendar Year for biological drugs, biotechnical drugs, and specialty pharmaceuticals. 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 	\$5 Copayment per 31-day supply \$12 Copayment per 90-day supply \$15 Copayment per 90-day supply \$20 Copayment per 31-day supply \$43 Copayment per 90-day supply \$60 Copayment per 90-day supply \$40 Copayment per 31-day supply \$86 Copayment per 90-day supply \$120 Copayment per 90-day supply \$65 Copayment per 31-day supply \$162 Copayment per 90-day supply \$195 Copayment per 90-day supply \$0 copayment for generic drugs; Applicable Copayment for brand-name drugs 90% Coverage
<p>Some medications may require prior authorization from VIVA HEALTH. Please contact Customer Service at the number listed below for more information. 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.</p>	

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	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • Fillings, Simple Extractions, Palliative Services, General Anesthesia, Non-Surgical Periodontics 	50% coverage of Maximum Plan Allowance
Type III Major Services	
<ul style="list-style-type: none"> • 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 & 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.	