



# PEEHIP

Effective Dates: October 1, 2014 – September 30, 2015

## 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
<b>CALENDAR YEAR DEDUCTIBLE:</b> <i>Applies ONLY to those benefits with 80% Coverage. 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 provided directly by a physician or hospital. The family deductible is \$900 not to exceed \$300 per any individual.</i>	\$300 per individual; \$900 aggregate amount per family
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM:</b> <i>The most a Member will pay per Calendar Year for qualified medical, mental and substance abuse services and specialty drugs received directly from a health care provider. The maximum includes deductibles, copayments and coinsurance paid by the Member for qualified services but does not include premiums or most prescription drugs. See the Certificate of Coverage for details.</i>	\$6,350 per individual; \$12,700 aggregate amount 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>• Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.</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> <li>• X-Rays</li> </ul>	\$20 Copay per visit
<b>LAB PROCEDURE:</b>	\$5 per test
<b>TELEMEDICINE CONSULTATION:</b>	\$40 per consult
<b>SPECIALTY CARE:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>• Medical Physician Services</li> <li>• OB/GYN Services</li> </ul>	\$40 Copay per visit \$40 Copay per visit
<b>VISION CARE:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>• One routine vision exam per Calendar Year</li> <li>• Other eye care office visits</li> </ul>	\$40 Copay per visit \$40 Copay per visit
<b>ALLERGY SERVICES:</b> <i>(No PCP Referral Required)</i> <ul style="list-style-type: none"> <li>• Physician Services</li> <li>• Testing</li> </ul>	\$40 Copay per visit 100% Coverage
<b>DIAGNOSTIC SERVICES:</b> <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i>	\$150 Copay per service
<b>OUTPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>• Surgery &amp; Other Outpatient Services</li> </ul>	\$150 Copay per service
<b>HOSPITAL INPATIENT SERVICES:</b> <ul style="list-style-type: none"> <li>• Physician Services</li> <li>• Semi-Private Room</li> </ul>	100% Coverage \$200 Copay per admission & a \$25 Copay for days 2-5
<b>MATERNITY SERVICES:</b> <i>(Covered for employee and employee's spouse; not covered for dependent children)</i> <ul style="list-style-type: none"> <li>• Physician Services <i>(Prenatal, delivery, and postnatal care)</i></li> <li>• Maternity Hospitalization</li> <li>• Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.</li> </ul>	\$40 Copay per delivery \$200 Copay per admission & a \$25 Copay for days 2-5
<b>EMERGENCY ROOM SERVICES:</b> <i>(Copay waived if admitted through ER)</i>	\$175 Copay per visit
<b>EMERGENCY AMBULANCE SERVICES:</b> <i>(Must be Medically Necessary)</i>	80% Coverage
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:</b>	80% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> <i>(100 Days per Lifetime)</i>	80% Coverage
<b>DIABETIC SUPPLIES:</b> <i>(Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.)</i>	100% Coverage
<b>REHABILITATION SERVICES:</b> <i>Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)</i>	80% Coverage
<b>HOME HEALTH CARE SERVICES:</b> <i>(Limited to 60 Visits per Calendar Year)</i>	100% Coverage



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<b>CHIROPRACTIC SERVICES:</b> (No PCP Referral Required) (Covered up to 25 Visits per Calendar Year)	
• <b>Treatment for manual manipulation of subluxations only</b>	\$40 Copay per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b> (\$3,000 Maximum Benefit per Lifetime)	\$40 Copay per visit
<b>SLEEP DISORDERS:</b>	\$40 Copay per visit
<b>Two Sleep Studies per Member per Lifetime</b>	\$150 Copay per sleep study
<b>TRANSPLANT SERVICES:</b>	\$200 Hospital Copayment & a \$25 Copay for days 2-5
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE SERVICE:</b>	
• <b>Inpatient</b>	\$200 Copayment per admission & a \$25 Copay for days 2-5 \$40 Copayment per visit
• <b>Outpatient</b>	
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.	

### COVERED PRESCRIPTION DRUGS:

- **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 \$40 Copayment per 31-day supply
  - Mail-order \$86 Copayment per 90-day supply
  - Participating Pharmacy \$120 Copayment per 90-day supply
- **Non-Preferred Brand-Name Drugs**
  - Participating Pharmacy \$65 Copayment per 31-day supply
  - Mail-order \$162 Copayment per 90-day supply
  - Participating Pharmacy \$195 Copayment per 90-day supply
- **Oral Contraceptives** \$0 copayment for generic drugs; Applicable Copayment for brand-name drugs
- **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals** 80% Coverage  
May be administered in the home, physician's office or on an outpatient basis. There is a Calendar Year out-of-pocket maximum of \$6,350 per Member or \$12,700 per family for biological drugs, biotechnical drugs, and specialty pharmaceuticals received from Caremark. 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>

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.**

**VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780**

**Visit our Website at [www.vivahealth.com](http://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 & 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.