VIVA HEALTH

PEEHIP

Effective Dates: October 1, 2018 – September 30, 2019

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.

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 willapplytosuchdrugswhenprovideddirectlybyaphysicianorhospital.	$500 per individual; $1,500 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 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. 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 reachedthelimitearlierintheCalendarYear.SeetheCertificateofCoveragefordetails.	$7,350 per individual; $14,700 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	100% Coverage
OB/GYN Preventive Visit (One per Calendar Year)	
Preventive Prenatal Care (As defined in the Certificate of Coverage)	
OtherPreventiveItemsandServices(SeeCertificateofCoverageformoreinformation)	
OTHER PRIMARY CARE SERVICES:	
Medical Physician Services	$25 Copayment per visit
Hearing Exams	
IllnessandInjury	
LABORATORY PROCEDURES:	
Laboratory Procedure	$7.50 Copayment per test at independent labs; 90% Coverage per test at hospital-based labs
CoveredGeneticTesting	80% Coverage
TELADOC TELEHEALTH SERVICES:	$45 Copayment per consult
SPECIALTY CARE: (No PCP Referral Required)	
Medical Physician Services	$40 Copayment per visit
OB/GYNServices	
URGENT CARE CENTER SERVICES:	
Medical Physician Services	$40 Copayment per visit
IllnessandInjury	
VISION CARE: (No PCP Referral Required)	
One Routine Vision Exam per Calendar Year	$40 Copayment per visit
OtherEyeCareOfficeVisits	
ALLERGY SERVICES: (No PCP Referral Required)	
Physician Services	$40 Copayment per visit
Testing & Treatment	80% Coverage
DIAGNOSTICSERVICES:(IncludingbutnotlimitedtoX-Rays,CTScan,MRI,PET/SPECT,ERCP)	90%Coverage
OUTPATIENT SERVICES:	
Ambulatory Surgical Center	$150 Copayment per service
Surgery and Other Outpatient Services	90% Coverage per service
Outpatient Hospital Observation (no procedure performed)	$200 Copayment per admission
HOSPITAL INPATIENT SERVICES:	
Physician Services	100% Coverage
Semi-Private Room	$200 Copay/admission & a $50 Copay for days 2-5
MATERNITY SERVICES:	
Physician Services (Prenatal, delivery, and postnatal care)	$40 Copayment per delivery
Maternity Hospitalization	$200 Copay/admission & a $50 Copay for 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.	
EMERGENCYROOMSERVICES:(CopaymentwaivedifadmittedthroughER)	$200Copaymentpervisit
EMERGENCY AMBULANCE SERVICES: (Must be Medically Necessary)	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLEDNURSINGFACILITYSERVICES:(100DaysperLifetime)	80%Coverage
CHRONIC CARE MAINTENANCE: (Including but not limited to dialysis, wound care, wound therapy)	80% Coverage
DIABETICSELF-MANAGEMENTEDUCATION:	$40Copaymentpervisit
DIABETIC SUPPLIES: (Insulin covered under prescription drug rider; For Diabetic Supplies call VIVA HEALTH)	100% Coverage

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REHABILITATION SERVICES: Physical, Speech, and Occupational Therapy (Limited to 60 Total Inpatient Days and 25 Total Outpatient Visits per Calendar Year)	80% Coverage
HABILITIATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis (Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)	80% Coverage
HOMEHEALTHCARESERVICES:(Limitedto60VisitsperCalendarYear)	100%Coverage
CHIROPRACTIC SERVICES: (No PCP Referral Required. Covered up to 25 Visits per Calendar Year)	$40 Copayment per visit
TEMPOROMANDIBULARJOINTDISORDER:($3,000MaximumBenefitperLifetime)	$40Copaymentpervisit
SLEEP DISORDERS:	$40 Copayment per visit
Two Sleep Studies per Member per Lifetime	$150 Copayment per sleep study
TRANSPLANT SERVICES:	$200 Hospital Copayment & a $50 Copay for days 2-5
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
Inpatient	$200 Copay per admission & a $50 Copay for days 2-5
Outpatient	$40 Copayment per visit
[1]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]:	
Tier 1 (Preferred Generic Drugs)	
o Participating Pharmacy	$5 Copayment per 31-day supply
o Mail-order	$12 Copayment per 90-day supply
o Participating Pharmacy	$15 Copayment per 90-day supply
Tier 2 (Non-Preferred Generic Drugs)	
o Participating Pharmacy	$20 Copayment per 31-day supply
o Mail-order	$43 Copayment per 90-day supply
o Participating Pharmacy	$60 Copayment per 90-day supply
Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	
o Participating Pharmacy	$60 Copayment per 31-day supply
o Mail-order	$150 Copayment per 90-day supply
o Participating Pharmacy	$180 Copayment per 90-day supply
Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	
o Participating Pharmacy	$80 Copayment per 31-day supply
o Mail-order	$200 Copayment per 90-day supply
o Participating Pharmacy	$240 Copayment per 90-day supply
Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs[3])	70% Coverage
Oral Contraceptives	$0 Copayment for select generic drugs; Applicable Copayment for other generic drugs and all brand drugs

[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 Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of the medications in this category, please refer to www.vivaemployer.com/Members/Default.aspx.

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

CheckwithyourParticipatingPharmacytolearnifitiseligibletooffera90-daysupplyatretail.

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.
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: $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.