

PEEHIP

Effective Dates: October 1, 2010 – September 30, 2011

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. Please note that criteria for eligible dependents has changed. See eligible dependent section below for new enrollment opportunities. For further information, please see the Certificate of Coverage. Please keep this Attachment A for your records.

ADULT PRIMARY CARE: <ul style="list-style-type: none"> • Preventive Care & Other Office Visits <ul style="list-style-type: none"> • Routine Physicals • Immunization, • Hearing Exam, • Illness and Injury 	\$15 Copay per visit
PEDIATRIC PRIMARY CARE: <ul style="list-style-type: none"> • Preventive Care & Other Office Visits <ul style="list-style-type: none"> • Routine Physicals • Immunizations • Hearing Exams • Illness and Injury 	\$15 Copay per visit
SPECIALTY CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • Surgical & Medical Physician Services • OB/GYN Services (One OB/GYN preventive visit per Calendar Year) 	\$30 Copay per visit \$30 Copay per visit
VISION CARE: (No PCP Referral Required) <ul style="list-style-type: none"> • One routine vision exam every 12 months • Other eye care office visits 	\$30 Copay per visit \$30 Copay per visit
ALLERGY SERVICES: (No PCP Referral Required) <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>	\$75 Copay per service
OUTPATIENT SERVICES: <ul style="list-style-type: none"> • Surgery & Other Outpatient Services 	\$75 Copay per service
HOSPITAL INPATIENT SERVICES: <ul style="list-style-type: none"> • Physician Services • Semi-private room 	100% Coverage \$200 Copay per admission
MATERNITY SERVICES: <ul style="list-style-type: none"> • Physician Services <ul style="list-style-type: none"> • Prenatal, delivery and postnatal care • Maternity Hospitalization 	\$30 Copay per delivery \$200 Copay per admission
EMERGENCY ROOM SERVICES: <i>(Copay waived if admitted within 24 hours)</i>	\$50 Copay per visit
EMERGENCY AMBULANCE SERVICES: <i>(Must be Medically Necessary)</i>	80% Coverage
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES: <i>(Maximum benefit of \$15,000 per Calendar Year)</i>	80% Coverage
SKILLED NURSING FACILITY SERVICES: (100 days per Lifetime)	100% Coverage
REHABILITATION SERVICES: Physical, Speech, and Occupational therapy <i>(Limited to 60 combined inpatient days and 20 combined outpatient visits per Calendar Year)</i>	100% Coverage
DIABETIC SUPPLIES: <i>(Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA Health.)</i>	100% Coverage

HOME HEALTH CARE SERVICES: (Limited to 60 visits per Calendar Year)	100% Coverage
CHIROPRACTIC SERVICES: <i>(No PCP Referral Required)</i> (Covered up to 20 visits per Calendar Year) • Treatment for manual manipulation of subluxations only	\$30 Copay per visit
TEMPOROMANDIBULAR JOINT DISORDER: (\$3,000 maximum benefit per Calendar Year)	\$30 Copay per visit
SLEEP DISORDERS: Two sleep studies per member covered per lifetime.	\$30 Copay per visit \$75 Copay per sleep study
TRANSPLANT SERVICES:	100% Coverage after \$200 Hospital Copay
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES: • Inpatient* • Outpatient* <i>*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.</i>	100% Coverage after \$200 Copay per admission 100% Coverage after \$30 Copay per visit
COVERED PRESCRIPTION DRUGS: (Prescription drug benefits are limited to \$3,000 per member per Calendar Year) Retail • Generic Drugs • Preferred Brand Drugs • Non-Preferred Brand Drugs Mail Order – 90 Day Supply (When generic is available, Member pays the difference between generic and brand name price, plus Copay.) • Biological Drugs, Biotechnical Drugs and Specialty Pharmaceuticals (The prescription coverage limit does not apply. 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. These medications are received from CAREMARK and can be ordered by calling 1-800-237-2767. For a full list of the medications in this category, please refer to www.vivahealth.com .) • Oral Contraceptives <i>*Some medications may require prior authorization from VIVA Health. For further information, please contact Member Services at the phone number listed below.</i>	\$12 Copay \$25 Copay \$45 Copay \$36, \$60, \$100 90% Coverage Covered (subject to above Copays)

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. 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 dental 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 (12 month waiting period**): ◆ Major Restorative (crowns, bridges and dentures), Denture Repair, Endodontics (root canals), Surgical Periodontics, Surgical Oral Surgery (includes surgical extractions)	25% coverage of Maximum Plan Allowance

Maximum Dental Benefit: \$500 Calendar Year maximum. \$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 served on a prior carrier's dental plan with your current employer may be credited towards the Delta Dental plan's waiting periods, subject to Underwriting approval.

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 handicapped dependents who meet eligibility criteria

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in VIVA Health Inc.'s health plan for PEEHIP employees. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective October 1, 2010. For more information, contact the VIVA Health Customer Service.

**If new regulations under the Patient Protection and Affordable Care Act require changes, VIVA Health will reissue this Attachment A.*

VIVA HEALTH CUSTOMER SERVICE (205) 558-7474 or 1-800-294-7780
VISIT OUR WEBSITE AT WWW.VIVAHEALTH.COM/PEEHIP

Other Health Care Reform Notices:

The lifetime limit on the dollar value of benefits under the VIVA Health Inc. group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact VIVA Health Customer Service at (205) 558-7474 or 1-800-294-7780.

VIVA Health, Inc. believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act such as the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to VIVA Health Customer Service at (205) 558-7474 or 1-800-294-7780. More information also is available at www.healthcare.gov