VIVA HEALTH

2014 ACCESS Wellness Plans
Plan Comparison of Commonly Used Services

Limitations and coverage maximums apply. Please see Attachment A for each plan and the Certificate of Coverage for more details.
No referrals required.

Benefits	VIVA Platinum	VIVA Gold	VIVA Silver	Viva Bronze
Calendar Year Deductible:	$200 Single $600 Family	$800 Single $2,400 Family	$2,000 Single $4,000 Family	$4,750 Single $9,500 Family
Calendar Year Out-Of-Pocket Maximum: (The most a Member will pay in cost-sharing for qualified medical expenses. Maximum does not include prescription drug and dental costs.	$2,000 Single $6,000 Family	$6,350 Single $12,700 Family	$6,350 Single $12,700 Family	$6,350 Single $12,700 Family
Preventive Services: • Well Baby Care (Children up to 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	100% Coverage	100% Coverage	100% Coverage
Other Primary Care Services: • Surgical and Medical Physician Services • Hearing Exams • Illness and Injury • X-Rays and Laboratory Procedures	$25	$35	$40	60%[1]
Specialty Care: • Surgical and Medical Physician Services • X-Ray and Laboratory Procedures • OB/GYN Services	$40	$50	$60	60%[1]
Pediatric Vision Care: **(Covered for children 0-18)** • One routine vision exam per plan year • Contacts or one pair of eyeglasses per plan year	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Pediatric Dental Care: **(Covered for children 0-18)** • Deductible (Applies to all Services) • Diagnostics & Preventive Services • Basic Services & Major Services. • Orthodontic Benefits **For more information, go to www.deltadentalins.com/vivaehb or call 800-471-8148**	$30 per child 100% Coverage 50% Coverage Medically Necessary	$30 per child 100% Coverage 50% Coverage Medically Necessary	$30 per child 100% Coverage 50% Coverage Medically Necessary	$30 per child 100% Coverage 50% Coverage Medically Necessary
Chiropractic Services:	$40	$50	$60	60%[1]
Allergy Services: • Physician Visits • Testing	$40 90%[1]	$50 80%[1]	$60 70%[1]	60%[1] 60%[1]
Diagnostic Services: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$200	80%[1]	70%[1]	60%[1]
Outpatient Services: • Surgery and Other Outpatient Services	$200	80%[1]	70%[1]	60%[1]
Hospital Inpatient Services: • Physician Services • Semi-private Room	100% $200/day; days 1-5	100% $250/day; days 1-5	100% $350/day;days1-5	60%[1]

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Maternity Services: • Physician Copayment *Prenatal, delivery, and postnatal care* • Maternity Hospitalization	$40 $200/day; days 1-5	$50 $250/day; days 1-5	$60 $350/day;days1-5	60%[1] 60%[1]
Emergency Room Services:	$200	80%[1]	70%[1]	60%[1]
Emergency Ambulance Services:	90%[1]	80%[1]	70%[1]	60%[1]
Skilled Nursing Facility Services:	90%[1]	80%[1]	70%[1]	60%[1]
Durable Medical Equipment & Prosthetic Devices:	90%[1]	80%[1]	70%[1]	60%[1]
Rehabilitation Services:	90%[1]	80%[1]	70%[1]	60%[1]
Home Health Care Services:	90%[1]	80%[1]	70%[1]	60%[1]
Mental Health & Substance Abuse: • 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.*	$200/day; days 1-5 $40	$250/day; days 1-5 $50	$350/day;days1-5 $60	60%[1] 60%[1]
Prescription Drug Rider: • Retail (30 Day Supply) o Preferred Generic o Generic o Preferred Brand o Non-Preferred Brand • Mail Order (90 Day Supply) o Preferred Generic o Generic o Preferred Brand o Non-Preferred Brand	 $5 $20 $40 $65 $12 $43 $86 $162	 $5 $20 $40 $65 $12 $43 $86 $162	 $5 $20 $60 $80 $12 $43 $150 $200	 $5 $20 $60 $80 $12 $43 $150 $200
Oral Contraceptives:	$0 for generic drugs; Applicable copayment for brand-name drugs			
Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals: *There is a separate Calendar Year out-of-pocket maximum of $6,350 per member or $12,700 per family for biological, biotechnical, and specialty medications.*	90%	80%	70%	60%
Diabetic Supplies: Insulin covered under prescription drug rider	90%[1]	80%[1]	70%[1]	60%[1]

[1]Subject to Calendar Year deductible (deductible counts toward the Calendar Year out-of-pocket maximum)