VIVA HEALTH

2017 ACCESS Small Group 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.
This document is for comparison only and is not an official plan document. ***No referrals required.***

Benefit	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
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 Caremark but will apply to such drugs when provided directly by a physician or hospital.	$200/Individual $600/Family	$800/Individual $2,400/Family	$2,600/Individual $5,200/Family	$3,000/Individual $6,000/Family	$5,500/Individual $11,000/Family	N/A; Reference Row Below
Calendar Year Deductible: (Bronze HSA ONLY) Applies to all benefits except for telehealth, dental, vision, and preventive care services covered at no charge.	N/A; Reference Row Above	N/A; Reference Row Above	N/A; Reference Row Above	N/A; Reference Row Above	N/A; Reference Row Above	$4,750/Individual $9,500/Family
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. If you have a non-calendar plan year, 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 reached the limit earlier in the Calendar Year. See the Certificate of Coverage for details.	$4,000/Individual $8,000/Family	$7,150/Individual $14,300/Family	$7,150/Individual $14,300/Family	$7,150/Individual $14,300/Family	$7,150/Individual $14,300/Family	$6,550/Individual $13,100/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 more information.	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Other Primary Care Services: • Medical Physician Services • Hearing Exams • Illness and Injury	$25/visit	$35/visit	$40/visit	$40/visit	60% Coverage[1]	60% Coverage[1]
Specialty Care: • Medical Physician Services • OB/GYN Services • Illness and Injury	$40/visit	$50/visit	$60/visit	$60/visit	60% Coverage[1]	60% Coverage[1]
Urgent Care Center Services: • Medical Physician Services • Illness and Injury	$40/visit	$50/visit	$60/visit	$60/visit	60% Coverage[1]	60% Coverage[1]

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Benefit	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
Telehealth Services: *(Does not count toward the deductible or out of pocket maximum)*	$40 Copayment per consultation	$40 Copayment per consultation	$40 Copayment per consultation	$40 Copayment per consultation	$40 Copayment per consultation	$40 Copayment per consultation
Pediatric Vision Care: **(Covered for children ages 0 until age 19)** • One routine vision exam per plan year • Contacts or one pair of eyeglasses per plan year	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Pediatric Dental Care (through Delta Dental): **(Covered for children ages 0 until age 19)** • Deductible (Applies to all Services) • Diagnostics & Preventive Services • Basic Services & Major Services. • Orthodontic Benefits	$40 per child 100% Coverage 50% Coverage Medically Necessary	$40 per child 100% Coverage 50% Coverage Medically Necessary	$40 per child 100% Coverage 50% Coverage Medically Necessary	$40 per child 100% Coverage 50% Coverage Medically Necessary	$40 per child 100% Coverage 50% Coverage Medically Necessary	$40 per child 100% Coverage 50% Coverage Medically Necessary
Chiropractic Services:	$40/visit	$50/visit	$60/visit	$60/visit	60% Coverage[1]	60% Coverage[1]
Allergy Services: • Physician Visits • Testing and treatment	$40/visit 90% Coverage[1]	$50/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	$60/visit 65% Coverage[1]	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Chronic Care Maintenance: (Including but not limited to dialysis, radiation therapy, wound care, wound therapy)	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Laboratory Services: • Laboratory Procedures • Covered Genetic Testing	90% Coverage 80% Coverage[1]	80% Coverage[1] 80% Coverage[1]	70% Coverage[1] 70% Coverage[1]	65% Coverage[1] 65% Coverage[1]	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Diagnostic Services: • X-Rays • Other Diagnostic Services (*Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$10/image $200/service	$10/image 80% Coverage[1]	$10/image 70% Coverage[1]	$10/image 65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Outpatient Services: • Surgery and Other Outpatient Services • Outpatient Hospital Observation (no procedure performed)	$200/visit $200/visit	80% Coverage[1] $250/day	70% Coverage[1] $350/day	65% Coverage[1] $350/day	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Hospital Inpatient Services: • Physician Services • Semi-private Room	100% Coverage[1] $200/day; days 1-5	100% Coverage[1] $250/day; days 1-5	100% Coverage[1] $350/day; days1-5	100% Coverage[1] $350/day; days1-5	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Maternity Services: • Physician Services *(Prenatal, delivery, and postnatal care)* • Maternity Hospitalization	$40/delivery $200/day; days 1-5	$50/delivery $250/day; days 1-5	$60/delivery $350/day; days 1-5	$60/delivery $350/day; days 1-5	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Emergency Room Services:	$200/visit	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Emergency Ambulance Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Skilled Nursing Facility Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Durable Medical Equipment & Prosthetic Devices:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Rehabilitation and Habilitation Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]

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

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Temporomandibular Joint Disorder	$40/visit	$50/service	$60/visit	$60/visit	60% Coverage[1]	60% Coverage[1]
Sleep Disorders: (Two sleep studies per lifetime)	$40/visit $200/sleep study	$50/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	$60/visit 65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Transplant Services:	$200/day (Days 1-5)	$250/day (Days 1-5)	$350/day (Days 1-5)	$350/day (Days 1-5)	60% Coverage[1]	60% Coverage[1]
Home Health Care Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Diabetic Supplies: Insulin covered under prescription drug rider	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]	60% Coverage[1]	60% Coverage[1]
Mental Health & Substance Abuse Services: • Inpatient Services • Outpatient Services Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details.	$200/day; days 1-5 $40/visit	$250/day; days 1-5 $50/service	$350/day; days 1-5 $60/service	$350/day; days 1-5 $60/service	60% Coverage[1] 60% Coverage[1]	60% Coverage[1] 60% Coverage[1]
Pharmacy Deductible: Applies to all drugs except for generic oral contraceptives and other preventive drugs required by the Affordable Care Act. Deductible must be satisfied before copays apply.	N/A	N/A	N/A	N/A	$50 per individual	N/A
Covered Prescription Drugs:						
• Retail (30 Day Supply)						
○ Preferred Generic (Tier 1)	$10	$10	$10	$10	$10	60% Coverage
○ Generic (Tier 2)	$25	$25	$30	$30	$30	60% Coverage
○ Preferred Brand (Tier 3)	$45	$45	$60	$60	$60	60% Coverage
○ Non-Preferred Brand (Tier 4)	$70	$70	$80	$80	$80	60% Coverage
• Mail Order (90 Day Supply)						
○ Preferred Generic (Tier 1)	$24	$24	$24	$24	$24	60% Coverage
○ Generic (Tier 2)	$54	$54	$65	$65	$65	60% Coverage
○ Preferred Brand (Tier 3)	$97	$97	$150	$150	$150	60% Coverage
○ Non-Preferred Brand (Tier 4)	$175	$175	$200	$200	$200	60% Coverage
Oral Contraceptives:	$0 for select generic drugs; Applicable copayment for other generic drugs and all brand-name drugs.					
Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals (Tier 5):	90% Coverage	80% Coverage	70% Coverage	70% Coverage	60% Coverage	60% Coverage[1]
Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals (Tier 6):	85% Coverage	75% Coverage	65% Coverage	65% Coverage	55% Coverage	55% Coverage[1]

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).

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