2017 Large Group ACCESS Wellness Plans
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.
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Benefits	VIVA Select	VIVA 90	VIVA 80	VIVA 70	VIVA 60
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 will apply to such drugs when provided directly by a physician or hospital.	$300/Single $900/Family	$400/Single $1,200/Family	$600/Single $1,800/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 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 year, the maximum limit may change during the course of the 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.	$7,150/Single $14,300/Family	$7,150/Single $14,300/Family	$7,150/Single $14,300/Family	$7,150/Single $14,300/Family	$7,150/Single $14,300/Family
Preventive Services: • Well Baby Care (Children under age 3) • Routine Physicals (One per Calendar Year for ages 3+) • Covered Immunizations • OB/GYN Preventive Visit (One per Calendar Year) • Preventive Prenatal Care (As defined in the Certificate of Coverage) • Other preventive items and services. See Certificate of Coverage for more information	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Other Primary Care Services: • Medical Physician Services • Hearing Exams • Illness and Injury	$35/visit	$40/visit	$40/visit	$40/visit	60% Coverage[1]
Specialty Care: • Medical Physician Services • OB/GYN Services • Illness and Injury	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Urgent Care Center Services: • Medical Physician Services • Illness and Injury	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Telehealth Services: *(Does not count toward the deductible or out of pocket maximum)*	$40/consultation	$40/consultation	$40/consultation	$40/consultation	$40/consultation
Vision Care: • One routine vision exam per calendar year • Other eye care office visits	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Chiropractic Services: Covered up to 25 visits per Calendar Year	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Allergy Services: • Physician Visits • Testing and treatment	$50/visit 80% Coverage[1]	$55/visit 80% Coverage[1]	$60/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	60% Coverage[1] 60% Coverage[1]

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Benefits	VIVA Select	VIVA 90	VIVA 80	VIVA 70	VIVA 60
Chronic Care Maintenance: *(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)*	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Laboratory Services:					
• Laboratory Procedures	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
• Covered Genetic Testing	80% Coverage[1]	80% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Diagnostic Services:					
• X-Rays	$10/image	$10/image	$10/image	$10/image	$10/image
• Other Diagnostic Services *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$250 per service	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Outpatient Services:					
• Surgery and Other Outpatient Services	$250 per visit	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
• Outpatient Hospital Observation (No procedure performed)	$250 per visit	90% Coverage[1]	80% Coverage[1]	$350/day	60% Coverage[1]
Hospital Inpatient Services:					
• Physician Services	100% Coverage	90% Coverage[1]	80% Coverage[1]	100% Coverage	60% Coverage[1]
• Semi-private Room	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]
Maternity Services: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)*					
• Physician Services (*Prenatal, delivery, and postnatal care)*	$50/delivery	$55/delivery	$60/delivery	$60/delivery	60% Coverage[1]
• Maternity Hospitalization	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]
Emergency Room Services:	$250/visit	$275/visit	$300/visit	70% Coverage[1]	60% Coverage[1]
Emergency Ambulance Services:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Skilled Nursing Facility Services:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Durable Medical Equipment & Prosthetic Devices:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Diabetic Supplies: Insulin covered under prescription drug rider	100% Coverage	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Rehabilitation Services: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 25 total outpatient visits per Calendar Year)*	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Home Health Care Services: *(Limited to 60 visits per Calendar Year)*	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]
Mental Health & Substance Abuse Services: *(Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details)*					
• Inpatient Services	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]
• Outpatient Services	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Temporomandibular Joint Disorder *($2,000 maximum benefit per Lifetime)*	$50/visit	$55/visit	$60/visit	$60/visit	60% Coverage[1]
Sleep Disorders *(Two Sleep Studies per Lifetime)*	$50/visit; $250/sleep study	$55/visit; 90% Coverage per sleep study[1]	$60/visit; 80% Coverage per sleep study[1]	$60/visit; 70% Coverage per sleep study[1]	60% Coverage[1]
Transplant Services	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]

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Prescription Benefits	VIVA Select	VIVA 90	VIVA 80	VIVA 70	VIVA 60
Prescription Drug Rider:					
• Retail (30 Day Supply)					
○ Preferred Generic	$5	$5	$5	$5	$5
○ Generic	$20	$20	$20	$20	$20
○ Preferred Brand	$40	$40	$60	$60	$60
○ Non-Preferred Brand	$65	$65	$80	$80	$80
• Mail Order (90 Day Supply)					
○ Preferred Generic	$12	$12	$12	$12	$12
○ Generic	$43	$43	$43	$43	$43
○ Preferred Brand	$86	$86	$150	$150	$150
○ Non-Preferred Brand	$162	$162	$200	$200	$200
Oral Contraceptives:	$0 for select generic drugs; Applicable copayment for other generic drugs and all brand-name drugs				
Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals:	80% Coverage	80% Coverage	80% Coverage	70% Coverage	60% Coverage

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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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