



## 2021 Large Group ACCESS Wellness Plans Comparison of Commonly Used Services

*This document is for comparison only and is not an official plan document. No Referrals required.*

Medical Benefits	VIVA Select	Viva Value 5000	VIVA 90	VIVA 80	VIVA 70	VIVA 60
<b>Calendar Year Deductible:</b> Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost.	\$300/Single \$900/Family	\$5,000/Single \$10,000/Family	\$400/Single \$1,200/Family	\$600/Single \$1,800/Family	\$2,000/Single \$4,000/Family	\$4,750/Single \$9,500/Family
<b>Calendar Year Out-Of-Pocket Maximum:</b> 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, ancillary charges, or out-of-network charges over the maximum payment allowance.	\$7,900/Single \$15,800/Family	\$7,900/Single \$15,800/Family	\$7,900/Single \$15,800/Family	\$7,900/Single \$15,800/Family	\$7,900/Single \$15,800/Family	\$7,900/Single \$15,800/Family
<b>Preventive Services:</b> <ul style="list-style-type: none"> <li>• Well Baby Care (Children under age 3)</li> <li>• Routine Physicals (One per Calendar Year for ages 3+)</li> <li>• Covered Immunizations</li> <li>• OB/GYN Preventive Visit (One per Calendar Year)</li> <li>• Preventive Prenatal Care (As defined in the Certificate of Coverage)</li> <li>• Other preventive items and services</li> </ul>	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
<b>Other Primary Care Services:</b> <ul style="list-style-type: none"> <li>• Medical Physician Services</li> <li>• Hearing Exams</li> <li>• Illness and Injury</li> </ul>	\$35/visit	\$35/visit	\$40/visit	\$40/visit	\$40/visit	\$40/visit
<b>Specialty Care:</b> <ul style="list-style-type: none"> <li>• Medical Physician Services</li> <li>• OB/GYN Services</li> <li>• Illness and Injury</li> </ul>	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit
<b>Urgent Care Center Services:</b> <ul style="list-style-type: none"> <li>• Medical Physician Services</li> <li>• Illness and Injury</li> </ul>	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit
<b>Teladoc Telehealth Services:</b> <i>(Does not count toward the deductible or out-of-pocket maximum)</i> <ul style="list-style-type: none"> <li>• Primary/Urgent Care Consultations</li> <li>• Behavioral Health Consultations</li> </ul>	\$45/consultation \$50/consultation	\$45/consultation \$50/consultation	\$45/consultation \$55/consultation	\$45/consultation \$60/consultation	\$45/consultation \$60/consultation	\$45/consultation \$60/consultation
<b>Vision Care:</b> <ul style="list-style-type: none"> <li>• One routine vision exam per Calendar Year</li> <li>• Other eye care office visits</li> </ul>	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit
<b>Chiropractic Services:</b> Covered up to 25 visits per Calendar Year	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit



## 2021 Large Group ACCESS Wellness Plans Comparison of Commonly Used Services

*This document is for comparison only and is not an official plan document. No Referrals required.*

Medical Benefits	VIVA Select	Viva Value 5000	VIVA 90	VIVA 80	VIVA 70	VIVA 60
<b>Allergy Services:</b> <ul style="list-style-type: none"> <li>Physician Visits</li> <li>Testing and treatment</li> </ul>	\$50/visit 80% Coverage <sup>1</sup>	\$50/visit 80% Coverage <sup>1</sup>	\$55/visit 90% Coverage <sup>1</sup>	\$60/visit 80% Coverage <sup>1</sup>	\$60/visit 70% Coverage <sup>1</sup>	\$60/visit 60% Coverage <sup>1</sup>
<b>Chronic Care Maintenance:</b> <i>(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)</i>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Laboratory Services:</b> <ul style="list-style-type: none"> <li>Laboratory Procedures</li> <li>Covered Genetic Testing</li> </ul>	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	100% Coverage 80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup> 70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Diagnostic Services:</b> <ul style="list-style-type: none"> <li>X-Rays</li> <li>Other Diagnostic Services <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i></li> </ul>	\$10/image \$250 per service	100% Coverage 80% Coverage <sup>1</sup>	\$10/image 90% Coverage <sup>1</sup>	\$10/image 80% Coverage <sup>1</sup>	\$10/image 70% Coverage <sup>1</sup>	\$10/image 60% Coverage <sup>1</sup>
<b>Outpatient Services:</b> <ul style="list-style-type: none"> <li>Surgery and Other Outpatient Services</li> <li>Outpatient Hospital Observation (No procedure performed)</li> </ul>	\$250 per visit \$250 per visit	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup> 90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup> \$350/day	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Hospital Inpatient Services:</b> <ul style="list-style-type: none"> <li>Physician Services</li> <li>Semi-private Room</li> </ul>	100% Coverage \$250/day; days 1-5	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup> 90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup> 80% Coverage <sup>1</sup>	100% Coverage \$350/day; days 1-5	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Maternity Services:</b> <i>(Covered for employee and employee's spouse; not covered for dependent children except as provided under Preventive Care)</i> <ul style="list-style-type: none"> <li>Physician Services <i>(Prenatal, delivery, and postnatal care)</i></li> <li>Maternity Hospitalization</li> </ul>	\$50/delivery \$250/day; days 1-5	\$50/delivery 80% Coverage <sup>1</sup>	\$55/delivery 90% Coverage <sup>1</sup>	\$60/delivery 80% Coverage <sup>1</sup>	\$60/delivery \$350/day; days 1-5	\$60/delivery 60% Coverage <sup>1</sup>
<b>Emergency Room Services:</b>	\$250/visit	80% Coverage <sup>1</sup>	\$275/visit	\$300/visit	\$350/visit	60% Coverage <sup>1</sup>
<b>Emergency Ambulance Services:</b>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Skilled Nursing Facility Services:</b>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Durable Medical Equipment &amp; Prosthetic Devices:</b>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Diabetes Self-Management Education:</b>	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit
<b>Diabetic Supplies:</b> Insulin covered under prescription drug rider	100% Coverage	100% Coverage	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Rehabilitation Services:</b> Physical, Speech, and Occupational Therapy <i>(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year)</i>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Habilitation Services:</b> Physical, Speech, and Occupational Therapy and Applied Behavior Analysis <i>(limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)</i>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Home Health Care Services:</b> <i>(Limited to 60 visits per Calendar Year)</i>	80% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>



## 2021 Large Group ACCESS Wellness Plans Comparison of Commonly Used Services

*This document is for comparison only and is not an official plan document. No Referrals required.*

Medical Benefits	VIVA Select	Viva Value 5000	VIVA 90	VIVA 80	VIVA 70	VIVA 60
<b>Mental Health &amp; Substance Abuse Services:</b> <i>(Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details)</i> <ul style="list-style-type: none"> <li>Inpatient Services</li> <li>Outpatient Services</li> </ul>	\$250/day; days 1-5 \$50/visit	80% Coverage <sup>1</sup> \$50/visit	90% Coverage <sup>1</sup> \$55/visit	80% Coverage <sup>1</sup> \$60/visit	\$350/day; days 1-5 \$60/visit	60% Coverage <sup>1</sup> \$60/visit
<b>Temporomandibular Joint Disorder</b>	\$50/visit	\$50/visit	\$55/visit	\$60/visit	\$60/visit	\$60/visit
<b>Sleep Disorders</b> <ul style="list-style-type: none"> <li>Sleep Study</li> </ul>	\$50/visit; \$250/sleep study	\$50/visit; 80% Coverage per sleep study <sup>1</sup>	\$55/visit; 90% Coverage per sleep study <sup>1</sup>	\$60/visit; 80% Coverage per sleep study <sup>1</sup>	\$60/visit; 70% Coverage per sleep study <sup>1</sup>	\$60/visit; 60% Coverage per sleep study <sup>1</sup>
<b>Transplant Services</b>	\$250/day; days 1-5	80% Coverage <sup>1</sup>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	\$350/day; days 1-5	60% Coverage <sup>1</sup>

## Pharmaceutical Benefits

Pharmaceutical Benefits	VIVA Select	Viva Value 5000	VIVA 90	VIVA 80	VIVA 70	VIVA 60
<b>Prescription Drug Rider<sup>3</sup>:</b> <ul style="list-style-type: none"> <li><b>Retail</b> (30 Day Supply) <ul style="list-style-type: none"> <li><b>Tier 1</b> (Preferred Generic Drugs) \$5</li> <li><b>Tier 2</b> (Non-Preferred Generic Drugs) \$20</li> <li><b>Tier 3</b> (Preferred Brand and Non-Preferred Generic Drugs) \$40</li> <li><b>Tier 4</b> (Non-Preferred Brand and Non-Preferred Generic Drugs) \$65</li> <li><b>Tier 5</b> (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>4</sup> and Non-Preferred Drugs) 80% Coverage<sup>2</sup></li> </ul> </li> <li><b>Mail Order</b> (90 Day Supply) <ul style="list-style-type: none"> <li><b>Tier 1</b> (Preferred Generic Drugs) \$12</li> <li><b>Tier 2</b> (Non-Preferred Generic Drugs) \$43</li> <li><b>Tier 3</b> (Preferred Brand and Non-Preferred Generic Drugs) \$86</li> <li><b>Tier 4</b> (Non-Preferred Brand and Non-Preferred Generic Drugs) \$162</li> </ul> </li> <li><b>Oral Contraceptives</b></li> <li><b>Diabetic Testing Supplies</b></li> </ul>						
	\$0 for select generic drugs; Applicable copayment for other generic drugs and all brand drugs					
	100% Coverage [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]					



## 2021 Large Group ACCESS Wellness Plans Comparison of Commonly Used Services

*This document is for comparison only and is not an official plan document. No Referrals required.*

**For questions or concerns, please contact your VIVA HEALTH Account Representative:**

**Allisha Calhoun**  
205-558-7416  
Fax: 205-449-7823  
argriffin@uabmc.edu

**Ronnetta Underwood**  
205-558-7599  
Fax: 205-449-2191  
ronnettaunderwood@uabmc.edu

**Shamar Gramby**  
205-558-3364  
Fax: 205-449-2191  
sgramby@uabmc.edu

**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).

**NOTE:** This is only a brief summary of benefits and limitations. Limitations and coverage maximums apply. See the Attachment A for each plan and Certificate of Coverage for more information.

<sup>1</sup>Subject to Calendar Year deductible (deductible counts toward the Calendar Year Out-of-Pocket Maximum). <sup>2</sup>Deductible 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. <sup>3</sup>Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. When generic is available, Member pays difference between generic and Brand price, plus Copayment. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail. <sup>4</sup>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 medications in this category, please refer to [www.vivaemployer.com/Members/Default.aspx](http://www.vivaemployer.com/Members/Default.aspx).