2026 Large Group ACCESS Wellness Plans Comparison of Commonly Used Services

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Medical Benefits	VIVA Select MNS9	VIVA 90 MN99	VIVA 80 MN89	VIVA 70 MN79	VIVA 60 MN69	Viva Value 5000 MNLC	Viva Value 8000 MN8K
Calendar Year Deductible: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost.	$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	$5,000/Single $10,000/Family	$8,000/Single $16,000/Family
Calendar Year Out-Of-Pocket Maximum: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder 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	$8,000/Single $16,000/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 Cal Yr) • Preventive Prenatal Care • Nutritionist Preventive Visits (Up to 3 per Cal Yr with a Registered Dietitian or Nutritionist) • Other preventive items and services	100% Coverage	100% Coverage	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	$40/visit	$35/visit	$35/visit
Specialty Care: • Medical Physician Services • OB/GYN Services • Illness and Injury	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Urgent Care Center Services: • Medical Physician Services • Illness and Injury	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Teladoc Telehealth Services: *(Does not count toward the deductible or out-of-pocket maximum)* • Primary/Urgent Care Consultations • Behavioral Health Consultations	$55/consultation $50/consultation	$55/consultation $55/consultation	$55/consultation $60/consultation	$55/consultation $60/consultation	$55/consultation $60/consultation	$55/consultation $50/consultation	$55/consultation $50/consultation
Hospital Inpatient Services: • Physician and Facility Services	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]	80% Coverage[1]	100% Coverage after ded[1]

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Outpatient Services: • Surgery and Other Outpatient Services • Outpatient Hospital Observation (No procedure performed)	$250 per visit $250 per visit	90% Coverage[1] 90% Coverage[1]	80% Coverage[1] 80% Coverage[1]	70% Coverage[1] $350/day	60% Coverage[1] 60% Coverage[1]	80% Coverage[1] 80% Coverage[1]	100% Coverage after deductible[1]
Vision Care: • One routine vision exam per Calendar Year • Other eye care office visits	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Chiropractic Services: Covered up to 25 visits per Calendar Year	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Allergy Services: • Physician Visits • Testing and treatment	$50/visit 80% Coverage[1]	$55/visit 90% Coverage[1]	$60/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	$60/visit 60% Coverage[1]	$50/visit 80% Coverage[1]	$50/visit 100% Cov after ded[1]
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]	80% Coverage[1]	100% Coverage after deductible[1]
Laboratory Services: • Laboratory Procedures • Covered Genetic Testing	80% Coverage[1] 80% Coverage[1]	90% Coverage[1] 80% Coverage[1]	80% Coverage[1] 80% Coverage[1]	70% Coverage[1] 70% Coverage[1]	60% Coverage[1] 60% Coverage[1]	100% Coverage 80% Coverage[1]	100% Coverage 100% Cov after ded[1]
Diagnostic Services: • X-Rays • Other Diagnostic Services *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$10/image $250 per service	$10/image 90% Coverage[1]	$10/image 80% Coverage[1]	$10/image 70% Coverage[1]	$10/image 60% Coverage[1]	100% Coverage 80% Coverage[1]	100% Coverage 100% Cov after ded[1]
Maternity Services: *(Covered for employee and employee's spouse; not covered for dependent children except as provided under Prev. Care)* • Physician Services (*Prenatal, delivery, and postnatal care)* • Maternity Hospitalization	$50/delivery $250/day; days 1-5	$55/delivery 90% Coverage[1]	$60/delivery 80% Coverage[1]	$60/delivery $350/day; days 1-5	$60/delivery 60% Coverage[1]	$50/delivery 80% Coverage[1]	$50/delivery 100% Cov after ded[1]
Emergency Room Services:	$250/visit	$275/visit	$300/visit	$350/visit	$500/visit	$500/visit	$500/visit
Emergency Ambulance Services:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]	80% Coverage[1]	100% Coverage after deductible[1]
Skilled Nursing Facility Services:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]	80% Coverage[1]	
Durable Medical Equipment & Prosthetic Devices:	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]	80% Coverage[1]	
Medical Nutrition Services: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Diabetes Self-Management Education:	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Diabetic Supplies: Insulin covered under prescription drug rider	100% Coverage	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]	100% Coverage	100% Cov after ded[1]

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Rehabilitation and Habilitation Services: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses)*	80% Coverage[1]	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	60% Coverage[1]	80% Coverage[1]	100% Coverage after deductible[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]	80% Coverage[1]	100% Coverage after deductible[1]
Mental Health & Substance Use Disorder Services: • Inpatient Services • Outpatient Services	$250/day; days 1-5 $50/visit	90% Coverage[1] $55/visit	80% Coverage[1] $60/visit	$350/day; days 1-5 $60/visit	60% Coverage[1] $60/visit	80% Coverage[1] $50/visit	100% Cov after ded[1] $50/visit
Temporomandibular Joint Disorder	$50/visit	$55/visit	$60/visit	$60/visit	$60/visit	$50/visit	$50/visit
Sleep Disorders • Sleep Study	$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/visit; 60% Coverage per sleep study[1]	$50/visit; 80% Coverage per sleep study[1]	$50/visit 100% Cov after ded per sleep study[1]
Transplant Services	$250/day; days 1-5	90% Coverage[1]	80% Coverage[1]	$350/day; days 1-5	60% Coverage[1]	80% Coverage[1]	100% Coverage after deductible[1]

Pharmaceutical Benefits

Pharmaceutical Benefits	VIVA Select MNS9	VIVA 90 MN99	VIVA 80 MN89	VIVA 70 MN79	VIVA 60 MN69	Viva Value 5000 MNLC	Viva Value 8000 MN8K
Prescription Drug Rider[3]:							
• **Retail** (30 Day Supply)							
○ **Tier 1** (Preferred Generic Drugs)	$5	$5	$5	$5	$5	$5	$10
○ **Tier 2** (Non-Preferred Generic Drugs)	$20	$20	$20	$20	$20	$20	$30
○ **Tier 3** (Preferred Brand and Non-Preferred Generic Drugs)	$40	$40	$60	$60	$60	$60	$60
○ **Tier 4** (Non-Preferred Brand and Non-Preferred Generic Drugs)	$65	$65	$80	$80	$80	$80	$80
○ **Tier 5** (Specialty Drugs[4] and Non-Preferred Drugs)	80% Coverage[2]	80% Coverage[2]	80% Coverage[2]	70% Coverage[2]	60% Coverage[2]	60% Coverage[2]	100% Coverage after deductible[1]
• **Mail Order** (90 Day Supply[5])							
○ **Tier 1** (Preferred Generic Drugs)	$12	$12	$12	$12	$12	$12	$24
○ **Tier 2** (Non-Preferred Generic Drugs)	$43	$43	$43	$43	$43	$43	$65
○ **Tier 3** (Preferred Brand and Non-Preferred Generic Drugs)	$86	$86	$150	$150	$150	$150	$150
○ **Tier 4** (Non-Preferred Brand and Non-Preferred Generic Drugs)	$162	$162	$200	$200	$200	$200	$200
• **Oral Contraceptives**	$0 for generic and select brand drugs; Applicable copayment for other brand drugs						
• **Diabetic Testing Supplies**	100% Coverage [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]						

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For new group sales, please contact VIVA HEALTH's Business Development Representative:

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For existing groups, please contact your VIVA HEALTH Account Representative:

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Ronnetta Peoples
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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. [1]Subject to Calendar Year deductible (deductible counts toward the Calendar Year Out-of-Pocket Maximum). [2]Deductible does not apply to Specialty Drugs ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital. [3]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service. 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. [4]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**.** [5]A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.