2018 Large Group ACCESS Wellness Plans
Comparison of Commonly Used Services

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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.	$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.	$7,350/Single $14,700/Family	$7,350/Single $14,700/Family	$7,350/Single $14,700/Family	$7,350/Single $14,700/Family	$7,350/Single $14,700/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	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]
Teladoc Telehealth Services: *(Does not count toward the deductible or out-of-pocket maximum)*	$45/consultation	$45/consultation	$45/consultation	$45/consultation	$45/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 90% Coverage[1]	$60/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	60% Coverage[1] 60% Coverage[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]
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]

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 Biological, Biotechnical, and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital.

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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]
Diabetes Self-Management Education:	$50/visit	$55/visit	$60/visit	$60/visit	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]
Habilitation Services: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	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)					
○ Tier 1 (Preferred Generic Drugs)	$5	$5	$5	$5	$5
○ Tier 2 (Non-Preferred Generic Drugs)	$20	$20	$20	$20	$20
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	$40	$40	$60	$60	$60
○ Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	$65	$65	$80	$80	$80
○ Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	80% Coverage[2]	80% Coverage[2]	80% Coverage[2]	70% Coverage[2]	60% Coverage[2]
• Mail Order (90 Day Supply)					
○ Tier 1 (Preferred Generic Drugs)					
○ Tier 2 (Non-Preferred Generic Drugs)	$12	$12	$12	$12	$12
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	$43	$43	$43	$43	$43
○ Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	$86	$86	$150	$150	$150
	$162	$162	$200	$200	$200
Oral Contraceptives:	$0 for select generic drugs; Applicable copayment for other generic drugs and all brand-name drugs				

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