2021 ACCESS Small Group Wellness Plans

Plan Comparison of Commonly Used Services

VIVA HEALTH

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.	$100/Individual $300/Family	$1,100/Individual $3,300/Family	$4,500/Individual $9,000/Family	$4,700/Individual $9,400/Family	$8,550/Individual $17,100/Family	$5,700/Individual $11,400/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.	$4,100/Individual $8,200/Family	$8,550/Individual $17,100/Family	$8,550/Individual $17,100/Family	$8,550/Individual $17,100/Family	$8,550/Individual $17,100/Family	$7,000/Individual $14,000/Family
Preventive Services: • Well Baby Care (Children up to age 3) • Routine Annual Physical (One per Calendar Year for ages 3+) • Covered Immunizations • OB/GYN Annual Preventive visit (One per Calendar Year) • Other preventive items and services	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	100% Coverage after deductible[1]	60% Coverage after deductible[1]
Specialty Care: • Medical Physician Services • OB/GYN Services • Illness and Injury	$40/visit	$50/visit	$60/visit	$60/visit		
Urgent Care Center Services: • Medical Physician Services • Illness and Injury	$40/visit	$50/visit	$60/visit	$60/visit		
Teladoc Telehealth Services: • Primary/Urgent Care Consultations • Behavioral Health Consultations	$45/consultation $40/consultation	$45/consultation $50/consultation	$45/consultation $60/consultation	$45/consultation $60/consultation	$45/consultation See Teladoc for cost	$45/consultation See Teladoc for cost
Pediatric Vision Care: (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)[2]: **(Covered for children ages 0 until age 19)** • Deductible (Applies to all Services) • Diagnostics & Preventive Services • Basic Services & Major Services. • Orthodontic Benefits	$50 per child 100% Coverage 50% Coverage Medically Necessary	$50 per child 100% Coverage 50% Coverage Medically Necessary	$50 per child 100% Coverage 50% Coverage Medically Necessary	$50 per child 100% Coverage 50% Coverage Medically Necessary	$50 per child 100% Coverage 50% Coverage Medically Necessary	$50 per child 100% Coverage 50% Coverage Medically Necessary

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]Does not count toward the Calendar Year Deductible or Out-of-Pocket Maximum.
[3]Pharmacy deductible applies.

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Benefit	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
Chiropractic Services:	$40/visit	$50/visit	$60/visit	$60/visit	100% Coverage after deductible[1]	60% Coverage after deductible[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]		
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]		
Laboratory Services: • Laboratory Procedures • Covered Genetic Testing	90% Coverage[1] 80% Coverage[1]	80% Coverage[1] 80% Coverage[1]	70% Coverage[1] 70% Coverage[1]	65% Coverage[1] 65% 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]		
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		
Hospital Inpatient Services: • Physician Services • Semi-private Room	100% Coverage $200/day; days 1-5	100% Coverage $250/day; days 1-5	100% Coverage $350/day; days 1-5	100% Coverage $350/day; days 1-5		
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		
Emergency Room Services:	$200/visit	80% Coverage1	70% Coverage[1]	65% Coverage[1]		
Emergency Ambulance Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]		
Skilled Nursing Facility Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]		
Durable Medical Equipment & Prosthetic Devices:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]		
Temporomandibular Joint Disorders:	$40/visit	$50/visit	$60/visit	$60/visit		
Rehabilitation and Habilitation Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]		
Sleep Disorders:	$40/visit $200/sleep study	$50/visit 80% Coverage[1]	$60/visit 70% Coverage[1]	$60/visit 65% Coverage[1]		
Transplant Services:	$200/day (Days 1-5)	$250/day (Days 1-5)	$350/day (Days 1-5)	$350/day (Days 1-5)		
Home Health Care Services:	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% Coverage[1]		
Diabetes Self-Management Education:	$40/visit	$50/visit	$60/visit	$60/visit		
Diabetic Supplies: Insulin covered under prescription drug rider	90% Coverage[1]	80% Coverage[1]	70% Coverage[1]	65% 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.	$200/day; days 1-5 $40/visit	$250/day; days 1-5 $50/visit	$350/day; days 1-5 $60/visit	$350/day; days 1-5 $60/visit		

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Pharmaceutical Benefits	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
Pharmacy Deductible: Applies to all drugs except for select generic oral contraceptives and other preventive drugs required by the Affordable Care Act. Deductible must be satisfied before copays apply unless the overall Calendar Year Out-of-Pocket Maximum has been met.	N/A	N/A	$200 per individual	$100 per individual	$900 per individual	N/A
Covered Prescription Drugs:						
• Retail (30 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	$10	$10	$15	$15	$10	60% Coverage[1]
○ Tier 2 (Non-Preferred Generic Drugs)	$25	$25	$30	$30	$30	60% Coverage[1]
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	$45	$45	$65	$65	$60	60% Coverage[1]
○ Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	$70	$70	$100	$100	$80	60% Coverage[1]
○ Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	90% Coverage	80% Coverage	70% Coverage[3]	70% Coverage[3]	60% Coverage[3]	60% Coverage[1]
○ Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	85% Coverage	75% Coverage	65% Coverage[3]	65% Coverage[3]	55% Coverage[3]	55% Coverage[1]
• Mail Order (90 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	$24	$24	$38	$38	$24	60% Coverage[1]
○ Tier 2 (Non-Preferred Generic Drugs)	$54	$54	$65	$65	$65	60% Coverage[1]
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	$97	$97	$163	$163	$150	60% Coverage[1]
○ Tier 4 (Non-Preferred brand and Non-Preferred Generic Drugs)	$175	$175	$250	$250	$200	60% Coverage[1]
Diabetic Testing Supplies:	100% Coverage for select diabetic testing supplies [OneTouch and Freestyle (excluding *Libre*) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]					
Oral Contraceptives:	$0 for select generic drugs; Applicable copayment for other generic drugs and all brand drugs.					

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

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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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