



2019 ACCESS Small Group Wellness Plans  
Plan Comparison of Commonly Used Services

Benefit	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
<b>Calendar Year Deductible:</b> 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.	\$200/Individual \$600/Family	\$900/Individual \$2,700/Family	\$3,700/Individual \$7,400/Family	\$4,500/Individual \$9,000/Family	\$6,100/Individual \$12,200/Family	\$5,050/Individual \$10,100/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 or out-of-network charges over the maximum payment allowance.	\$4,000/Individual \$8,000/Family	\$7,900/Individual \$15,800/Family	\$7,900/Individual \$15,800/Family	\$7,900/Individual \$15,800/Family	\$7,900/Individual \$15,800/Family	\$6,750/Individual \$13,500/Family
<b>Preventive Services:</b> <ul style="list-style-type: none"> <li>Well Baby Care (Children up to age 3)</li> <li>Routine Annual Physical (One per Calendar Year for ages 3+)</li> <li>Covered Immunizations</li> <li>OB/GYN Annual Preventive visit(One per Calendar Year)</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>	\$25/visit	\$35/visit	\$40/visit	\$40/visit	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<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>	\$40/visit	\$50/visit	\$60/visit	\$60/visit	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Urgent Care Center Services:</b> <ul style="list-style-type: none"> <li>Medical Physician Services</li> <li>Illness and Injury</li> </ul>	\$40/visit	\$50/visit	\$60/visit	\$60/visit	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Teladoc Telehealth Services:</b>	\$45 Copayment per consultation	\$45 Copayment per consultation	\$45 Copayment per consultation	\$45 Copayment per consultation	\$45 Copayment per consultation	\$45 Copayment per consultation
<b>Pediatric Vision Care:</b> (Children ages 0 until age 19) <ul style="list-style-type: none"> <li>One routine vision exam per plan year</li> <li>Contacts or one pair of eyeglasses per plan year</li> </ul>	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
<b>Pediatric Dental Care (through Delta Dental)<sup>2</sup>:</b> <b>(Covered for children ages 0 until age 19)</b> <ul style="list-style-type: none"> <li>Deductible (Applies to all Services)</li> <li>Diagnostics &amp; Preventive Services</li> <li>Basic Services &amp; Major Services.</li> <li>Orthodontic Benefits</li> </ul>	\$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.

<sup>1</sup>Subject to Calendar Year Deductible (deductible counts toward the Calendar Year Out-of-Pocket Maximum) <sup>2</sup>Does not count toward the Calendar Year Deductible or Out-of-Pocket Maximum.

<sup>3</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.



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<b>Chiropractic Services:</b>	\$40/visit	\$50/visit	\$60/visit	\$60/visit	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Allergy Services:</b> • Physician Visits • Testing and treatment	\$40/visit 90% Coverage <sup>1</sup>	\$50/visit 80% Coverage <sup>1</sup>	\$60/visit 70% Coverage <sup>1</sup>	\$60/visit 65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Chronic Care Maintenance:</b> (Including but not limited to dialysis, radiation therapy, wound care, wound therapy)	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Laboratory Services:</b> • Laboratory Procedures • Covered Genetic Testing	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>	65% Coverage <sup>1</sup> 65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Diagnostic Services:</b> • X-Rays • Other Diagnostic Services (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	\$10/image \$200/service	\$10/image 80% Coverage <sup>1</sup>	\$10/image 70% Coverage <sup>1</sup>	\$10/image 65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Outpatient Services:</b> • Surgery and Other Outpatient Services • Outpatient Hospital Observation (no procedure performed)	\$200/visit \$200/visit	80% Coverage <sup>1</sup> \$250/day	70% Coverage <sup>1</sup> \$350/day	65% Coverage <sup>1</sup> \$350/day	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Hospital Inpatient Services:</b> • 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	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Maternity Services:</b> • 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	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>
<b>Emergency Room Services:</b>	\$200/visit	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Emergency Ambulance Services:</b>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Skilled Nursing Facility Services:</b>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Durable Medical Equipment &amp; Prosthetic Devices:</b>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Rehabilitation and Habilitation Services:</b>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Sleep Disorders:</b> (Two sleep studies per lifetime)	\$40/visit \$200/sleep study	\$50/visit 80% Coverage <sup>1</sup>	\$60/visit 70% Coverage <sup>1</sup>	\$60/visit 65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Transplant Services:</b>	\$200/day (Days 1-5)	\$250/day (Days 1-5)	\$350/day (Days 1-5)	\$350/day (Days 1-5)	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Home Health Care Services:</b>	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Diabetes Self-Management Education:</b>	\$40/visit	\$50/visit	\$60/visit	\$60/visit	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Diabetic Supplies:</b> Insulin covered under prescription drug rider	90% Coverage <sup>1</sup>	80% Coverage <sup>1</sup>	70% Coverage <sup>1</sup>	65% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup>
<b>Mental Health &amp; Substance Abuse Services:</b> • 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	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>	60% Coverage <sup>1</sup> 60% Coverage <sup>1</sup>

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.

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Prescription Benefits	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Bronze Plus	VIVA Bronze HSA
<b>Pharmacy Deductible:</b> 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.	N/A	N/A	\$200 per individual	\$100 per individual	\$250 per individual	N/A
<b>Covered Prescription Drugs:</b>						
• Retail (30 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	\$10	\$10	\$15	\$15	\$10	60% Coverage <sup>1</sup>
○ Tier 2 (Non-Preferred Generic Drugs)	\$25	\$25	\$30	\$30	\$30	60% Coverage <sup>1</sup>
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	\$45	\$45	\$65	\$65	\$60	60% Coverage <sup>1</sup>
○ Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	\$70	\$70	\$100	\$100	\$80	60% Coverage <sup>1</sup>
○ Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	90% Coverage <sup>3</sup>	80% Coverage <sup>3</sup>	70% Coverage <sup>3</sup>	70% Coverage <sup>3</sup>	60% Coverage <sup>3</sup>	60% Coverage <sup>1</sup>
○ Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	85% Coverage <sup>3</sup>	75% Coverage <sup>3</sup>	65% Coverage <sup>3</sup>	65% Coverage <sup>3</sup>	55% Coverage <sup>3</sup>	55% Coverage <sup>1</sup>
• Mail Order (90 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	\$24	\$24	\$38	\$38	\$24	60% Coverage <sup>1</sup>
○ Tier 2 (Non-Preferred Generic Drugs)	\$54	\$54	\$65	\$65	\$65	60% Coverage <sup>1</sup>
○ Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)	\$97	\$97	\$163	\$163	\$150	60% Coverage <sup>1</sup>
○ Tier 4 (Non-Preferred brand and Non-Preferred Generic Drugs)	\$175	\$175	\$250	\$250	\$200	60% Coverage <sup>1</sup>
<b>Oral Contraceptives:</b>	\$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:

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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).

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