2025 ACCESS Small Group Wellness Plans

Plan Comparison of Commonly Used Services

VIVA HEALTH

Benefit	VIVA Platinum 5PLA	VIVA Gold 5GOL	VIVA Silver Plus 5SIL	VIVA Silver 5SLV	VIVA Silver Lite 5SLT	VIVA Bronze HSA 5BON
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.	N/A	$1,650/Individual $4,950/Family	$6,350/Individual $12,700/Family	$6,800/Individual $13,600/Family	$9,200/Individual $18,400/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	$9,200/Individual $18,400/Family	$9,200/Individual $18,400/Family	$9,200/Individual $18,400/Family	$9,200/Individual $18,400/Family	$8,300/Individual $16,600/Family
Preventive Services: • Well Baby Care (Children up to age 3) • Routine Annual Physical (One per Calendar Year for ages 3+) • Covered Immunizations • Preventive Prenatal Care • Nutritionist Preventive Visits (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) • 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	$45/visit	60% Coverage after deductible[1]
Specialty Care: • Medical Physician Services • OB/GYN Services • Illness and Injury	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	
Urgent Care Center Services: • Medical Physician Services • Illness and Injury	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	
Teladoc Telehealth Services: • Primary/Urgent Care Consultations • Behavioral Health Consultations	$55/consultation $40/consultation	$55/consultation $50/consultation	$55/consultation $55/consultation	$55/consultation $60/consultation	$55/consultation $70/consultation	$55/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 Silver Lite	VIVA Bronze HSA
Chiropractic Services:	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	60% Coverage after deductible[1]
Allergy Services: • Physician Visits • Testing and treatment	$40/visit 90% Coverage	$50/visit 80% Coverage[1]	$55/visit 80% Coverage[1]	$60/visit 65% Coverage[1]	$70/visit 100% Cov after ded[1]	
Chronic Care Maintenance: (Including but not limited to dialysis, radiation therapy, wound care, wound therapy)	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]	100% Coverage after deductible[1]	
Laboratory Services: • Laboratory Procedures • Covered Genetic Testing	90% Coverage 80% Coverage	100% Coverage 80% Coverage[1]	100% Coverage 80% Coverage[1]	100% Coverage 65% 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 $200/service	$10/image 80% Coverage[1]	100% Cov after ded[1] 80% Coverage[1]	100% Cov after ded[1] 65% Coverage[1]	100% Coverage after deductible[1]	
Outpatient Services: • Surgery and Other Outpatient Services • Outpatient Hospital Observation (no procedure performed)	$200/visit $200/visit	80% Coverage[1] $250/day	80% Coverage[1] 80% Coverage[1]	65% Coverage[1] $500/day	100% Coverage after deductible[1]	
Hospital Inpatient Services: • Physician and Facility Services	$200/day, days 1-5	$250/day, days 1-5	80% Coverage[1]	$500/day, days 1-5	100% Coverage after deductible[1]	
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	$55/delivery 80% Coverage[1]	$60/delivery $500/day; days 1-5	$70/delivery 100% Cov after ded[1]	
Emergency Room Services:	$200/visit	$525/visit	$860/visit	$570/visit	$650/visit	
Emergency Ambulance Services:	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]	100% Coverage after deductible[1]	
Skilled Nursing Facility Services:	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]		
Durable Medical Equipment & Prosthetic Devices:	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]		
Temporomandibular Joint Disorders:	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	
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)*	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]	100% Cov after ded[1]	
Sleep Disorders: • Sleep Study	$40/visit $200/sleep study	$50/visit 80% Coverage[1]	$55/visit 80% Coverage[1]	$60/visit 65% Coverage[1]	$70/visit 100% Cov after ded[1]	
Transplant Services:	$200/day (Days 1-5)	$250/day (Days 1-5)	80% Coverage[1]	$500/day (Days 1-5)	100% Cov after ded[1]	
Medical Nutrition Services: (Limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian)	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	
Home Health Care Services:	90% Coverage	80% Coverage[1]	80% Coverage[1]	65% Coverage[1]	100% Cov after ded[1]	
Diabetic Supplies: Insulin covered under prescription drug rider	90% Coverage	80% Coverage[1]	100% Coverage	65% Coverage[1]	100% Cov after ded[1]	
Diabetes Self-Management Education:	$40/visit	$50/visit	$55/visit	$60/visit	$70/visit	
Mental Health & Substance Abuse Services: • Inpatient Services • Outpatient Services	$200/day; days 1-5 $40/visit	$250/day; days 1-5 $50/visit	80% Coverage[1] $55/visit	$500/day; days 1-5 $60/visit	100% Cov after ded[1] $70/visit	

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VIVA HEALTH

Pharmaceutical Benefits	VIVA Platinum	VIVA Gold	VIVA Silver Plus	VIVA Silver	VIVA Silver Lite	VIVA Bronze HSA
Pharmacy Deductible: Applies to all drugs with coinsurance coverage when the Member pays a set percentage of the cost (Tiers 5 & 6). Deductible must be satisfied before cost-sharing applies unless the overall Calendar Year Out-of-Pocket Maximum has been met.	N/A	N/A	$4,250/Individual $8,500/ Family	$2,450 per individual	Calendar year deductible applies to benefits with a coinsurance	N/A
Covered Prescription Drugs:						
• Retail (30 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	$10	$10	$10	$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	$65	60% Coverage[1]
○ Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)	$70	$70	$80	$100	$80	60% Coverage[1]
○ Tier 5 (Preferred Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	90% Coverage	80% Coverage	60% Coverage[3]	70% Coverage[3]	100% Coverage[1]	60% Coverage[1]
○ Tier 6 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and Non-Preferred Drugs)	85% Coverage	75% Coverage	55% Coverage[3]	65% Coverage[3]	100% Coverage[1]	55% Coverage[1]
• Mail Order (90 Day Supply)						
○ Tier 1 (Preferred Generic Drugs)	$24	$24	$24	$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	$163	60% Coverage[1]
○ Tier 4 (Non-Preferred brand and Non-Preferred Generic Drugs)	$175	$175	$200	$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 new group sales, please contact VIVA HEALTH's Business Development Representative:

Billy Rosenfeld

Cell: 205-639-3501 | Fax: 205-449-8394

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

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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).

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