



# VIVA HEALTH 2010

For Employers with  
2-50 Employees

## PLAN COMPARISON OF COMMONLY USED SERVICE

Limitations and Coverage Maximums Apply. Please see Attachment A and the Certificate of Coverage for each plan for more detail.

BENEFITS	VIVA ACCESS NO Referrals Required			
	SG Gold	SG Silver	SG 90	SG 80
<b>Calendar Year Deductible</b>	\$0	\$0	\$250 single \$750 family	\$500 single \$1,500 family
<b>Coinsurance Limit</b> <i>Applies only to out-of-pocket costs on benefits that are subject to the deductible and require the member to pay a percentage of the cost. The deductible does not count toward the Coinsurance Limit. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Mental Health benefits or Biological, Biotechnical, and Specialty Pharmaceuticals which have the separate coinsurance limits listed below.</i>	N/A	N/A	\$1,500 single \$4,500 family	\$2,000 single \$6,000 family
<b>Primary Care Services:</b> • Preventative Care & Other Office Visits	\$20	\$30	\$20	\$25
<b>Specialty Care:</b> • Surgical & Medical Physician Services • X-Ray and Laboratory Procedures • Ob/Gyn Services	\$35	\$45	\$35	\$40
<b>Vision Care:</b> • One routine vision exam every 12 months • Other eye care office visits	\$35	\$45	\$35	\$40
<b>Chiropractic Services</b> (Covered up to 20 visits per Calendar Year)	\$35	\$45	\$35	\$40
<b>Allergy Services:</b> • Physician Visits • Testing	\$35 80%	\$45 80%	\$35 90%*	\$40 80%*
<b>Diagnostic Services:</b> (Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)	\$175	\$250	90%*	80%*
<b>Outpatient Services:</b> • Surgery & Other Outpatient Services	\$175	\$250	90%*	80%*
<b>Hospital Services:</b> • Inpatient Services • Semi-private Room	100% \$500	100% \$750	90%* 90%*	80%* 80%*
<b>Maternity Services:</b> • Physician Copay <i>Prenatal, delivery, and postnatal care</i> • Maternity Hospitalization	\$35 \$500	\$45 \$750	\$35 90%*	\$40 80%*

<b>BENEFITS</b>	<b>SG Gold</b>	<b>SG Silver</b>	<b>SG 90</b>	<b>SG 80</b>
<b>Emergency Room Services</b> <i>(Copay waived if admitted through ER)</i>	\$125	\$150	\$125	\$150
<b>Emergency Ambulance Services</b>	80%	80%	90%*	80%*
<b>Durable Medical Equipment &amp; Prosthetic Devices</b>	80%	80%	90%*	80%*
<b>Skilled Nursing Facility Services</b>	80%	80%	90%*	80%*
<b>Rehabilitation Services</b>	80%	80%	90%*	80%*
<b>Home Health Care Services</b>	80%	80%	90%*	80%*
<b>Mental Health</b>				
• <i>Inpatient</i>	\$500	\$750	90% **	80% **
• <i>Outpatient</i>	\$35	\$45	\$35	\$40
<i>Member Coinsurance Limit Per Member Per Calendar Year</i>	N/A	N/A	\$1,500	\$2,000
<b>Prescription Drug Rider</b>				
• <i>Retail (30 Day Supply)</i>				
• Generic	\$15	\$15	\$15	\$15
• Preferred	\$35	\$35	\$35	\$35
• Non-Preferred	\$60	\$60	\$60	\$60
<i>Coverage maximum per member per Calendar Year</i>	\$3,000	\$3,000	\$3,000	\$3,000
• <i>Mail Order (90 Day Supply)</i>				
• Generic	\$38	\$38	\$38	\$38
• Preferred	\$88	\$88	\$88	\$88
• Non-Preferred	\$150	\$150	\$150	\$150
<b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals</b> <i>The prescription drug limit does not apply. Administered in the home, physician's office or on an outpatient basis, there is a member out of pocket maximum of \$10,000 per member per Calendar Year for biological, biotechnical drugs and specialty pharmaceuticals.</i>	90%	90%	90%	90%
<b>Diabetic Supplies:</b> Insulin covered under prescription drug rider	100%	100%	90%*	80%*

**Lifetime Maximum benefit per member: \$1,000,000 for all plans**

\* Subject to Calendar Year deductible.

\*\* Mental Health benefits are not subject to deductibles.