



# VIVA HEALTH 2010

*For Employers with  
51 or more  
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.*

	VIVA ACCESS <i>NO Referrals Required</i>			
BENEFITS	MG Gold	MG Silver	MG 90	MG 80
<b>Calendar Year Deductible:</b> <i>Applies ONLY to those benefits that require the member to pay a percentage of the coverage. Does not apply to benefits with a copayment or prescription benefits. Does not apply to Biological, Biotechnical and Specialty Pharmaceuticals, Mental Health and Substance Abuse benefits.</i>	\$0	\$0	\$250 single \$750 family	\$500 single \$1,500 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 Inpatient Services:</b> • Physician 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>Emergency Room Services</b> (Copayment waived if admitted through ER)	\$125	\$150	\$125	\$150

<b>BENEFITS</b>	<b>MG Gold</b>	<b>MG Silver</b>	<b>MG 90</b>	<b>MG 80</b>
<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> <ul style="list-style-type: none"> <li>• <i>Inpatient</i></li> <li>• <i>Outpatient</i></li> <li>• <i>Coinsurance Limit</i></li> </ul> <i>* Partial or day hospitalization, intensive outpatient treatment and treatment at a residential facility are not covered services. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details.</i>	\$500 \$35 N/A	\$750 \$45 N/A	90% ** \$35 \$1,500	80% ** \$40 \$2,000
<b>Prescription Drug Rider</b> <ul style="list-style-type: none"> <li>• <i>Retail (30 Day Supply)</i> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Preferred</li> <li>• Non-Preferred</li> </ul> </li> <li>• <i>Mail Order (90 day supply)</i> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Preferred</li> <li>• Non-Preferred</li> </ul> </li> </ul>	\$15 \$35 \$60  \$38 \$88 \$150	\$15 \$35 \$60  \$38 \$88 \$150	\$15 \$35 \$60  \$38 \$88 \$150	\$15 \$35 \$60  \$38 \$88 \$150
<b>Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals</b> <i>*There is a member out-of-pocket maximum of \$10,000 per member per Calendar Year for this benefit.</i>	90%	90%	90%	90%
<b>Diabetic Supplies:</b> Insulin covered under prescription drug rider	100%	100%	90%*	80%*
<b>Calendar Year Coinsurance Limit</b> <i>Applies only to out-of-pocket costs on benefits that require the member to pay a percentage of the cost and is in addition to the deductible and any applicable copayments. Please see Biological, Biotechnical and Specialty Pharmaceuticals, and Mental Health and Substance Abuse separate coinsurance limits above.</i>	N/A	N/A	\$1,500 single \$4,500 family	\$2,000 single \$6,000 family

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

- \* Subject to Calendar Year deductible.
- \*\* Mental Health benefits are not subject to deductible.