# VIVA HEALTH

***For Employers with 2-50 Employees***

**PLAN COMPARISON OF COMMONLY USED SERVICES**

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

*PCP Referral Required*

| BENEFITS | VH28 | VH38 |
|---|---|---|
| **Annual Deductible** | $0 | $0 |
| **Primary Care Physician Copay** | 100% after $15 physician copay | 100% after $20 physician copay |
| **Specialty Copay** *(PCP Referral Required, except for Ob/Gyn)* | 100% after $15 physician copay | 100% after $20 physician copay |
| **Vision-** includes annual routine exam (*No PCP Referral Required)* | $100% after $15 physician copay | 100% after $20 physician copay |
| **Allergy** | | |
| • **Physician Visits** | $100% after $15 physician copay | 100% after $20 physician copay |
| • **Testing** | 80% coverage | 80% coverage |
| **Diagnostic Services** *(Including but not limited to CT scan, MRI, PET/SPECT, ERCP)* | 100% after $100 copay | 100% after $150 copay |
| **Outpatient Services** | | |
| • **Surgery & Other Outpatient Services** | 100% after $100 copay | 100% after $150 copay |
| **Inpatient Hospital** | 100% after $100 copay | 100% after $250 copay |
| **Maternity** | | |
| • ***Physician Copay*** *(per delivery)* | 100% after $15 copay | 100% after $20 copay |
| • ***Hospital Copay*** | 100% after $100 copay | 100% after $250 copay |
| **Emergency Room Copay** | 100% after $50 copay | 100% after $75 copay |
| **Emergency Ambulance Services** | 80% Coverage | 80% Coverage |
| **Durable Medical Equipment & Prosthetics** | 80% Coverage | 80% Coverage |
| **Skilled Nursing Facility** | 100% Coverage | 100% Coverage |
| **Rehabilitation Services** | 80% Coverage | 80% Coverage |
| **Home Health Care Services** | 100% Coverage | 100% Coverage |
| **Mental Health/Substance Abuse** | | |
| • ***Inpatient Mental Health*** | 50% Coverage | 50% Coverage |
| • ***Outpatient Mental Health*** | 100% after $50 copay per visit | 100% after $50 copay per visit |
| • ***Substance Abuse: (Detox Only)*** | 50% Coverage | 50% Coverage |
| **Prescription Drug Rider** *(Coverage Limited to $2,500 per Member per Calendar Year)* | | |
| • ***Retail*** *(30 Day Supply)* -Generic/Preferred/ Non-Preferred | $12/$30/$50 | $12/$30/$50 |
| • ***Mail Order*** *(90 Day Supply)* -Generic/Preferred/Non-Preferred | $30/$75/$125 | $30/$75/$125 |
| **Diabetic Supplies:** Insulin covered under prescription drug rider | 100% Coverage | 100% Coverage |
| **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals** | 90% Coverage | 90% Coverage |
| **Mental and Nervous Drugs** | 50% Coverage | 50% Coverage |
| **Lifetime maximum benefit per member** | **$1,000,000** | **$1,000,000** |