VIVA MEDICARE

We'd like to tell you about some great changes to your 2023 benefits!

Anytime a change is made, we send you a notice, also called an Addendum, to let you know what the changes are and when they will start.

This Addendum explains important changes to your Evidence of Coverage, Annual Notice of Change, and Summary of Benefits.

These changes shown in the chart below impact the following plans and may help you pay less for some Part B prescription drugs: VIVA MEDICARE *Select* (HMO), VIVA MEDICARE *Premier* (HMO), VIVA MEDICARE *Me* (HMO), VIVA MEDICARE *Plus* (HMO), VIVA MEDICARE *Prime* (HMO), VIVA MEDICARE *Classic* (HMO), and VIVA MEDICARE *Preferred* (HMO).

ORIGINAL INFORMATION	UPDATED INFORMATION *(What is Changing)*	EFFECTIVE DATE
Your 2023 plan documents show that you pay 20% of the cost for Medicare-covered Part B prescription drugs (including chemotherapy drugs).	Each calendar quarter, starting in April, Medicare will review Part B drugs to see which ones have prices that are rising faster than the rate of inflation. These drugs are called "rebatable" Part B drugs. Your cost for these Part B "rebatable" drugs will be limited to the cost set by Original Medicare. This will make your cost between $0 and 20% of the Medicare-approved payment amount. The list of Part B "rebatable" drugs and the cost for these drugs can change each calendar quarter. Medicare will let VIVA MEDICARE know which drugs are "rebatable" each quarter. **This change may help you pay less for some Part B prescription drugs.**	**4/1/23**
Your 2023 plan documents show that you pay 20% of the cost for Medicare-covered Part B prescription drugs, including insulin furnished through durable medical equipment.	You will pay no more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment. **This change will help you pay less for insulin furnished through insulin pumps.**	**7/1/23**

VIVA MEDICARE

2023 VIVA MEDICARE *Plus* (HMO) Summary of Copays & Coinsurance

SERVICE	AMOUNT YOU PAY
Monthly Premium	$0/$28[1]
Primary Care Physician (PCP) Visit	$0
Specialist Visit (includes podiatry)	$25
Dental Services	Plan covers up to $1,000 for preventive, diagnostic, and comprehensive dental services per year. For Medicare-covered dental services, copay depends on place of service.
Over-the-Counter (OTC) Drugs and Other Health-Related Items	Plan provides a $50 allowance per calendar quarter.
Inpatient Hospital Admission (includes inpatient mental health care)	Days 1-6: $290 per day; $0 for additional days
Outpatient Surgery at an Outpatient Hospital Facility or Ambulatory Surgical Center (includes invasive diagnostic procedures such as epidurals)	$200 at an Ambulatory Surgical Center; $275 at an Outpatient Hospital; $275 per Outpatient Observation; $0 for Colonoscopy
Emergency Room Visit	$95, waived if you are admitted to the same hospital within 24 hours for same condition
Ambulance Services	$325 per one-way trip
Lab Services	$0
X-Rays	$15 per x-ray
Diagnostic Procedures and Tests (EEGs, sleep studies, etc.)	$0-$75
Diagnostic Radiology such as an MRI, PET, or CT Scan	$100 per service ($15 per ultrasound)
Radiation Therapy and Therapeutic Radiology	$60 per service
Urgently Needed Care Visit	$0 for a PCP Visit; $25 for a Specialist Visit; $40 for an Urgent Care Clinic Visit
Outpatient Mental Health or Substance Abuse Visit	$25; $55 for Partial Hospitalization services
Chiropractor Visit	$20
Medicare-Covered Eye Exams	$25 ($0 for diabetic retinopathy and glaucoma screening)
Routine Annual Vision Exam	$0
Eyewear	Plan covers up to $100 for prescription eyewear per year. $0 copay for one pair of eyeglasses or contact lenses after cataract surgery (you pay any amount over the Medicare allowable amount).
Annual Hearing Exam	$0 if you see a PCP; $25 if you see a Specialist
Hearing Aids	$500-$1,975 for each hearing aid; plan covers one hearing aid per ear, per calendar year.
Physical, Speech, or Occupational Therapy	$25 per visit
Cardiac or Pulmonary Rehabilitation Visit	$20 per visit
Skilled Nursing Facility (100 days per benefit period)	Days 1-20: $0 per day; Days 21-52: $196 per day; Days 53-100: $0 per day

Service	Amount You Pay
Home Health Care	$0
Durable Medical Equipment/Prosthetics	20% ($0 for ostomy supplies)
Diabetic Supplies	$0 per standard-size box for each diabetes supply item; 20% for therapeutic shoes or inserts
Kidney Diseases and Conditions	20% for Renal Dialysis
Telehealth Services	Plan covers telehealth services for PCP and Specialist Visits, Individual and Group Mental Health, Outpatient Substance Abuse, and Physical and Speech Therapy; standard office visit copays apply, when applicable.
24-Hour Nurse Line	Plan includes access to a 24-hour nurse line for general health education and tips for at-home, non-emergency treatments for minor illnesses or injuries.
Fitness	The Silver&Fit® Program (No cost; includes membership at participating fitness centers and at-home, digital options)
Maximum Annual Out-of-Pocket Limit (the most you pay for copays and coinsurance)	$5,900 (does not apply to Part D prescription drugs)
Drugs Covered under Medicare Part D	
Deductible	No Deductible
Initial Coverage Phase: You pay the cost sharing below until your total drug costs reach $4,660.	
Tier 1: Preferred Generics (Preferred Cost Sharing)[2]	$0 for up to a 90-day supply
Tier 1: Preferred Generics (Preferred Mail Order)[2]	$0 for up to a 90-day supply
Tier 1: Preferred Generics (Standard Cost Sharing)	$4 for a 30-day supply; $12 for a 90-day supply
Tier 2: Generics	$12 for a 30-day supply; $36 for a 90-day supply; $24 Preferred Mail Order for a 90-day supply
Tier 3: Preferred Brand	$47 for a 30-day supply; $141 for a 90-day supply; $94 Preferred Mail Order for a 90-day supply
Tier 4: Non-Preferred Drugs	$100 for a 30-day supply; $300 for a 90-day supply; $200 Preferred Mail Order for a 90-day supply
Tier 5: Specialty	33% for a 30-day supply
Coverage Gap Phase: Once your total drug costs reach $4,660, you move into the coverage gap or "donut hole." You pay the following amounts until your out-of-pocket costs reach $7,400.	25% of the price for generic and brand name drugs
Catastrophic Phase: What you pay after you have spent $7,400 out-of-pocket.	The greater of $4.15 generic (including brands treated as generic) and $10.35 all other drugs, or 5% coinsurance

[1]The plan premium is $0 in the following service area: Autauga, Baldwin, Blount, Calhoun, Chambers, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, DeKalb, Elmore, Etowah, Geneva, Henry, Houston, Jefferson, Lauderdale, Lee, Lowndes, Mobile, Montgomery, Shelby, St. Clair, Talladega, Tallapoosa, and Tuscaloosa Counties. The plan premium is $28 in the following service area: Bullock, Franklin, Macon, Pike, and Walker Counties. [2]$0 copay applies only to preferred generics filled at pharmacies offering preferred cost sharing. Please see Viva Medicare's Pharmacy Directory for a complete list of pharmacies. Premiums, copays, and coinsurance may be lower if you are on Medicaid or receive Extra Help. This information is not a complete description of benefits. Refer to the Evidence of Coverage or call 1-888-830-8482 (TTY users dial 711) for more information. Hours: Mon - Fri, 8am - 8pm; Oct 1 - Dec 31: 7 days a week, 8am - 8pm. Or, visit VivaHealth.com/Medicare. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Viva Medicare is an HMO plan with a Medicare contract and a contract with the Alabama Medicaid Agency. Enrollment in Viva Medicare depends on contract renewal. 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. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-830-8482 (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 1-888-830-8482 (TTY: 711). H0154_mcdoc3466r1A_M_03/19/2023