

SUMMARY OF *BENEFITS* 2022

January 1, 2022 – December 31, 2022



If you are a member of this plan, call 1-800-633-1542 (toll-free). TTY users, dial 711.

If you are not a member of this plan, call 1-888-830-8482 (toll-free). TTY users, dial 711.

Hours: Monday through Friday, 8 a.m. to 8 p.m.
(From October 1 to March 31: 7 days a week, 8 a.m. to 8 p.m.)

Our website: www.VivaHealth.com/Medicare

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the “**Evidence of Coverage**.” You can also see the Evidence of Coverage on our website, www.VivaHealth.com/Medicare/MemberResources.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **VIVA MEDICARE Me**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **VIVA MEDICARE Me** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <https://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **VIVA MEDICARE Me**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as audio and large print.

This document can be made available in a non-English language. For additional information, call us at 1-800-633-1542 (TTY: 711).

Things to Know About **VIVA MEDICARE Me**

Hours of Operation & Contact Information

- From October 1 to March 31, we’re open 8 a.m. – 8 p.m. 7 days a week.
- From April 1 to September 30, we’re open 8 a.m. – 8 p.m. Monday through Friday.
- If you are a member of this plan, call us at 1-800-633-1542, TTY: 711.
- If you are not a member of this plan, call us at 1-888-830-8482, TTY: 711.
- Our website: www.VivaHealth.com/Medicare/MemberResources.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Who can join?

To join **VIVA MEDICARE Me**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Alabama: Blount, Chilton, Dale, Geneva, Henry, Houston, Jefferson, Lee, Shelby, St. Clair, Talladega and Walker.

Which doctors, hospitals, and pharmacies can I use?

VIVA MEDICARE Me has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.VivaHealth.com/Medicare/MemberResources).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.VivaHealth.com/Medicare/MemberResources.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact
VIVA MEDICARE.**

SECTION II - SUMMARY OF BENEFITS

VIVA MEDICARE *Me*

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

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|---|---|
| Monthly Plan Premium | You do not pay a separate monthly plan premium for VIVA MEDICARE <i>Me</i> . You must continue to pay your Medicare Part B premium. |
| Deductible | Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable. |
| Maximum Out-of-Pocket Responsibility | Your yearly limit(s) in this plan: <ul style="list-style-type: none">• \$5,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |

COVERED MEDICAL AND HOSPITAL BENEFITS

| | |
|-----------------------------------|--|
| Inpatient Hospital | <u>In-Network:</u> Days 1-6: \$245 Copay per day for each admission. Days 7-90: \$0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization. |
| Ambulatory Surgical Center | <u>In-Network:</u> Ambulatory Surgical Center: \$195 Copay. May require prior authorization. |
| Outpatient Hospital | <u>In-Network:</u> Outpatient hospital: \$225 Copay. Outpatient observation: \$225 Copay. Medicare-covered colonoscopies: \$0 Copay. May require prior authorization. |
| Doctor's Office Visits | <u>In-Network:</u> Primary care physician visit: \$0 Copay. Specialist visit: \$20 Copay. |

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VIVA MEDICARE *Me*

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| Preventive Care <i>(e.g., flu vaccine, diabetic screenings)</i> | <u>In-Network:</u> <p>You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> |
| Emergency Care | <u>In-Network:</u> <p>\$90 Copay per visit.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide Emergency Coverage: \$90 Copay.</p> <p>Worldwide emergency coverage outside the U.S. and its territories is limited to \$50,000 and does not include transportation.</p> |
| Urgently Needed Services | <u>In-Network:</u> <p>Medicare-covered urgently needed service from a PCP: \$0 Copay per visit.</p> <p>Medicare-covered urgently needed service from a specialist: \$20 Copay per visit.</p> <p>Medicare-covered urgently needed service from an urgent care clinic/facility: \$40 Copay per visit.</p> |
| Diagnostic Services/ Labs/Imaging | <u>In-Network:</u> <p>Diagnostic tests and procedures: \$0 - \$50 Copay.</p> <p>Lab services: 0% - 10% Coinsurance.</p> <p>Diagnostic radiology services (such as ultrasound, MRI, CAT Scan): \$10 - \$75 Copay.</p> <p>X-rays: \$10 Copay.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): \$60 Copay.</p> <p>Costs for these services may vary based on place of service.</p> <p>May require prior authorization.</p> |
| Hearing Services | <u>In-Network:</u> <p>Exam to diagnose and treat hearing and balance issues: \$0 - \$20 Copay.</p> <p>Routine hearing exam (up to 1 visit every year): \$0 - \$20 Copay.</p> <p>Hearing Aid (up to 2 hearing aids every year): \$500 - \$1,975 Copay for each hearing aid.</p> |

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| Dental Services | <p><u>In-Network:</u></p> <p>Limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): applicable office visit, outpatient, or inpatient copays apply. VIVA MEDICARE <i>Me</i> also covers up to \$1,100 for preventive, diagnostic, and comprehensive dental benefits every year. You pay anything over \$1,100.</p> |
| Vision Services | <p><u>In-Network:</u></p> <p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 - \$20 Copay.</p> <p>Routine eye exam (up to 1 visit every year): \$0 Copay.</p> <p>Eyeglasses or contact lenses after cataract surgery: \$0 Copay plus you pay any amount over the Medicare allowed amount.</p> <p>Our plan pays up to \$150 for additional eyewear (eyeglass frames, lenses, contact lenses, and upgrades).</p> |
| Mental Health Care | <p><u>In-Network:</u></p> <p>Outpatient group therapy visit: \$20 Copay.</p> <p>Individual therapy visit: \$20 Copay.</p> <p>Inpatient Mental Health Care:</p> <p>Days 1-6: \$245 Copay per day for each admission.</p> <p>Days 7-90: \$0 Copay per day.</p> <p>May require prior authorization.</p> |
| Skilled Nursing Facility (SNF) | <p><u>In-Network:</u></p> <p>Days 1-20: \$0 Copay per day.</p> <p>Days 21-55: \$172 Copay per day.</p> <p>Days 56-100: \$0 Copay per day.</p> <p>May require prior authorization.</p> |
| Outpatient Rehabilitation | <p><u>In-Network:</u></p> <p>Occupational therapy visit: \$20 Copay.</p> <p>Physical therapy and speech and language therapy visit: \$20 Copay.</p> <p>May require prior authorization.</p> |

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| Ambulance | <u>In-Network:</u> Ground Ambulance: \$275 Copay. Air Ambulance: \$275 Copay. May require prior authorization. | | | | | | | | | | | |
|---|--|------------------|--------------------|--|------|------------------|------------------|--------------------|----------------------------|-----------|-----------|------------|
| Transportation | <u>In-Network:</u> Not Covered. | | | | | | | | | | | |
| Medicare Part B Drugs | <u>In-Network:</u> For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. May require prior authorization. | | | | | | | | | | | |
| 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. | | | | | | | | | | | |
| Over-the-Counter (OTC) Drugs and Other Health-Related Items | Plan provides a \$60 allowance every calendar quarter. | | | | | | | | | | | |
| Fitness | The Silver&Fit® Program (no cost; includes membership at participating fitness centers and at-home, digital options). | | | | | | | | | | | |
| PRESCRIPTION DRUG BENEFITS | | | | | | | | | | | | |
| Deductible | Prescription Drug Deductible: Not Applicable. | | | | | | | | | | | |
| Initial Coverage | You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the drug costs paid by both you and our plan. Standard Retail Cost-Sharing <table><tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>\$4 Copay</td><td>\$8 Copay</td><td>\$12 Copay</td></tr></table> | | | | Tier | One-month supply | Two-month supply | Three-month supply | Tier 1 (Preferred Generic) | \$4 Copay | \$8 Copay | \$12 Copay |
| Tier | One-month supply | Two-month supply | Three-month supply | | | | | | | | | |
| Tier 1 (Preferred Generic) | \$4 Copay | \$8 Copay | \$12 Copay | | | | | | | | | |

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|-----------------------------|-----------------|----------------|----------------|
| Tier 2 (Generic) | \$12 Copay | \$24 Copay | \$36 Copay |
| Tier 3 (Preferred Brand) | \$47 Copay | \$94 Copay | \$141 Copay |
| Tier 4 (Non-Preferred Drug) | \$100 Copay | \$200 Copay | \$300 Copay |
| Tier 5 (Specialty Tier) | 33% Coinsurance | Not Applicable | Not Applicable |

Preferred Retail Cost-Sharing

| Tier | One-month supply | Two-month supply | Three-month supply |
|-----------------------------|------------------|------------------|--------------------|
| Tier 1 (Preferred Generic) | \$0 Copay | \$0 Copay | \$0 Copay |
| Tier 2 (Generic) | \$12 Copay | \$24 Copay | \$36 Copay |
| Tier 3 (Preferred Brand) | \$47 Copay | \$94 Copay | \$141 Copay |
| Tier 4 (Non-Preferred Drug) | \$100 Copay | \$200 Copay | \$300 Copay |
| Tier 5 (Specialty Tier) | 33% Coinsurance | Not Applicable | Not Applicable |

Standard Mail Order

| Tier | One-month supply | Two-month supply | Three-month supply |
|-----------------------------|------------------|------------------|--------------------|
| Tier 1 (Preferred Generic) | \$4 Copay | \$8 Copay | \$12 Copay |
| Tier 2 (Generic) | \$12 Copay | \$24 Copay | \$36 Copay |
| Tier 3 (Preferred Brand) | \$47 Copay | \$94 Copay | \$141 Copay |
| Tier 4 (Non-Preferred Drug) | \$100 Copay | \$200 Copay | \$300 Copay |
| Tier 5 (Specialty Tier) | Not Applicable | Not Applicable | Not Applicable |

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|---|--|-------------------------|-------------------------|---------------------------|
| | Preferred Mail Order | | | |
| | Tier | One-month supply | Two-month supply | Three-month supply |
| | Tier 1 (Preferred Generic) | \$0 Copay | \$0 Copay | \$0 Copay |
| | Tier 2 (Generic) | \$10 Copay | \$20 Copay | \$24 Copay |
| | Tier 3 (Preferred Brand) | \$39.50 Copay | \$78.50 Copay | \$94 Copay |
| | Tier 4 (Non-Preferred Drug) | \$85 Copay | \$170 Copay | \$200 Copay |
| | Tier 5 (Specialty Tier) | Not Applicable | Not Applicable | Not Applicable |
| <p>Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.</p> <p>Please call us or see the plan's "Evidence of Coverage" on our website (http://www.vivahealth.com/medicare) for complete information about your costs for covered drugs.</p> | | | | |
| Coverage Gap | <p>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430.</p> <p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$7,050, which is the end of the coverage gap.</p> | | | |
| Catastrophic Coverage | <p>After your yearly out-of-pocket drug costs reach \$7,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copayment for all other drugs, or • 5% of the cost. | | | |

DISCLAIMERS

Other Physicians/Providers are available in our network. This information is not a complete description of benefits. Call 1-888-830-8482 (TTY users dial 711) for more information. 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).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-830-8482 (TTY: 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.VivaHealth.com/Medicare/MemberResources or call 1-888-830-8482 (TTY: 711) to receive a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

