VIVA MEDICARE

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

SERVICE	AMOUNT YOU PAY
Monthly Premium	$92
Primary Care Physician (PCP) Visit	$0
Specialist Visit (includes podiatry)	$15
Chiropractor Visit	$15
Emergency Room Visit	$95, waived if you are admitted to the same hospital within 24 hours for the same condition
Urgently Needed Care Visit	$0 for a PCP Visit; $15 for a Specialist Visit; $40 for an Urgent Care Clinic Visit
Inpatient Hospital Admission (includes inpatient mental health care)	Days 1-6: $195 per day; $0 for additional days
Outpatient Mental Health or Substance Abuse Visit	$15; $55 for Partial Hospitalization services
Diagnostic Procedures and Tests (EEGs, sleep studies, etc.)	$0-$25
Lab Services	$0
X-Rays	$0 per x-ray
Radiation Therapy and Therapeutic Radiology	$30 per service
Diagnostic Radiology such as an MRI, PET, or CT Scan	$30 per service ($0 per ultrasound)
Annual Physical	$0
Skilled Nursing Facility (100 days per benefit period)	Days 1-20: $0 per day; Days 21-44: $196 per day; Days 45-100: $0 per day
Home Health Care	$0
Outpatient Services/Surgery at an Outpatient Hospital Facility or Ambulatory Surgical Center (includes invasive diagnostic procedures such as epidurals)	$125 per Ambulatory Surgical Center Visit; $175 per Outpatient Hospital Visit; $175 per Outpatient Observation; $0 for Colonoscopy
Ambulance Services	$250 per one-way trip
Physical, Speech, or Occupational Therapy Visit	$15 per visit
Cardiac or Pulmonary Rehabilitation Visit	$10 per visit
Durable Medical Equipment/Prosthetics	20% (0% for ostomy supplies)
Diabetic Self-Management Training and Supplies	$0 for Self-Management Training; $0 per standard-size box for each diabetes supply item; $0 for therapeutic shoes or inserts
Kidney Diseases and Conditions	20% for Renal Dialysis
Other Medicare-Covered Preventive Services	$0
Fitness	The Silver&Fit® Program (No cost; includes membership at participating fitness centers and at-home, digital options)
Transportation	24 free rides (12 round trips) a year to the doctor, dentist, or other plan-approved locations
Medicare-Covered Eye Exams	$15 ($0 for diabetic retinopathy and glaucoma screening)
Routine Annual Vision Exam	$0

Service	Amount You Pay
Eyewear	Plan covers up to $200 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; $15 if you see a Specialist
Hearing Aids	$500-$1,975 for each hearing aid; plan covers one hearing aid per ear, per calendar year.
Dental Services	Plan covers up to $1,600 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 $90 allowance per calendar quarter.
Flex Card	Plan provides $55 per calendar quarter on a Flex Card that can be used to help pay for plan-covered dental services, eyewear, hearing aids, and over-the-counter items.
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.
Drugs Covered under Medicare Part B	20%
Maximum Annual Out-of-Pocket Limit (the most you pay for copays and coinsurance)	$4,500 (does not apply to Part D prescription drugs)
Drugs Covered under Medicare Part D	
Deductible:	No Deductible
Initial Coverage Phase: You will pay the following cost sharing until your total drug costs reach $4,660.	
Tier 1: Preferred Generics (Preferred Cost Sharing)[1]	$0 for up to a 90-day supply
Tier 1: Preferred Generics (Preferred Mail Order)[1]	$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	$8 for a 30-day supply; $24 for a 90-day supply; $16 Preferred Mail Order for a 90-day supply
Tier 3: Preferred Brands	$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]$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. The service area includes Limestone, Madison, Marshall, and Morgan Counties. 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_mcdoc3473A_M_09/06/2022