VIVA MEDICARE

2024 VIVA MEDICARE *Classic* (HMO) Summary of Copays & Coinsurance

SERVICE	AMOUNT YOU PAY
Monthly Premium	$0
Primary Care Physician (PCP) Visit	$0
Specialist Visit	$20
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 $60 allowance per calendar quarter.
Flex Card	Plan provides $30 per calendar quarter on a Flex Card that can be used to help pay for plan-covered dental services, prescription eyewear, hearing aids, and over-the-counter items.
Transportation	10 free rides (5 round trips) a year to the doctor, dentist, gym, or other plan-approved locations
Inpatient Hospital Admission (includes inpatient mental health care)	Days 1-6: $245 per day; $0 for additional days
Outpatient Surgery at an Outpatient Hospital Facility or Ambulatory Surgical Center (includes invasive diagnostic procedures such as epidurals)	$0 at an Ambulatory Surgical Center; $225 at an Outpatient Hospital; $225 per Outpatient Observation; $0 for Colonoscopy
Emergency Room Visit	$120, waived if you are admitted to the same hospital within 24 hours for same condition
Ambulance Services	$275 per one-way trip
Lab Services	$0
X-Rays	$10 per x-ray
Diagnostic Procedures and Tests (EEGs, sleep studies, etc.)	$0-$50
Diagnostic Radiology such as an MRI, PET, or CT Scan	$75 per service ($10 per ultrasound)
Radiation Therapy and Therapeutic Radiology	$60 per service
Urgently Needed Care Visit	$0 for a PCP Visit; $20 for a Specialist Visit; $40 for an Urgent Care Clinic Visit
Outpatient Mental Health or Substance Abuse Visit	$20; $55 for Partial Hospitalization services
Chiropractor Visit	$20
Medicare-Covered Eye Exams	$20 ($0 for diabetic retinopathy and glaucoma screening)
Routine Annual Vision Exam	$0
Eyewear (Eyeglasses or Contact Lenses)	Plan covers up to $200 for prescription eyewear and/or contact lens fittings 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; $20 if you see a Specialist
Hearing Aids	Plan covers one prescription hearing aid per ear, per calendar year ($500-$1,975 for each hearing aid) or one pair of over-the-counter hearing aids purchased through NationsHearing per calendar year ($750-$3,100 for each pair).
Physical, Speech, or Occupational Therapy	$20 per visit
Cardiac or Pulmonary Rehabilitation Visit	$15 per visit

Service	Amount You Pay
Skilled Nursing Facility (100 days per benefit period)	Days 1-20: $0 per day; Days 21-49: $196 per day; Days 50-100: $0 per day
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, 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)
Drugs Covered under Medicare Part B	20%. You may pay less ($0-20%) for certain drugs deemed "rebatable" by Medicare and no more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment (ex: insulin pump).
Maximum Annual Out-of-Pocket Limit (the most you pay for copays and coinsurance)	$5,400 (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 $5,030.	
Tier 1: Preferred Generics (Retail)	$0 for up to a 90-day supply
Tier 1: Preferred Generics (Preferred Mail Order)	$0 for up to a 90-day supply
Tier 2: Generics	$12 for a 30-day supply; $30 for a 90-day supply; $24 Preferred Mail Order for a 90-day supply
Tier 3: Preferred Brand	$47 for a 30-day supply; $117.50 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; $250 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 $5,030, you move into the coverage gap or "donut hole." You pay the following amounts until your out-of-pocket costs reach $8,000.	25% of the price for generic and brand name drugs
Catastrophic Phase: What you pay after you have spent $8,000 out-of-pocket.	$0 for generic and brand name drugs
Note: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or the phase of coverage you're in.	

The service area includes Jackson, Limestone, Madison, Marshall, and Morgan Counties. 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. (ASH Fitness), 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_mcdoc3887A_M_09/06/2023