VIVA MEDICARE *Preferred* (HMO) offered by VIVA HEALTH, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of VIVA MEDICARE *Preferred*. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1, 1.2 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in VIVA MEDICARE *Preferred*.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in VIVA MEDICARE *Preferred*.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1**, **2022.** You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-800-633-1542 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., Monday through Friday (from October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week).
- If you need this information in another format, such as audio or large print, please contact Member Services (phone numbers are in Section 7.1 of this booklet).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About VIVA MEDICARE *Preferred*

- 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.
- When this booklet says "we," "us," or "our," it means VIVA HEALTH, Inc. When it says "plan" or "our plan," it means VIVA MEDICARE *Preferred*.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for VIVA MEDICARE *Preferred* in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.VivaHealth.com/Medicare/MemberResources. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$90	$92
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$5,500	$4,500
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $15 copay per visit	Primary care visits: $0 per visit Specialist visits: $15 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$195 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization. $0 for additional days. You do not pay a copay for Medicare-covered admissions for the treatment of COVID-19.	$195 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization. $0 for additional days. You do not pay a copay for Medicare-covered admissions for the treatment of COVID-19.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** Preferred cost sharing: $0 per prescription filled at a network pharmacy that offers preferred cost sharing (30-day supply). Standard cost sharing: $4 per prescription filled at a network pharmacy that offers standard cost sharing (30-day supply). • **Drug Tier 2:** Preferred cost sharing and standard cost sharing: $8 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 3:** Preferred cost sharing and standard cost sharing: $47 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 4:** Preferred cost sharing and standard cost sharing: $100 per prescription filled at a network pharmacy (30-day supply).	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** Preferred cost sharing: $0 per prescription filled at a network pharmacy that offers preferred cost sharing (30-day supply). Standard cost sharing: $4 per prescription filled at a network pharmacy that offers standard cost sharing (30-day supply). • **Drug Tier 2:** Preferred cost sharing and standard cost sharing: $8 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 3:** Preferred cost sharing and standard cost sharing: $47 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 4:** Preferred cost sharing and standard cost sharing: $100 per prescription filled at a network pharmacy (30-day supply).

Cost	2021 (this year)	2022 (next year)
	• **Drug Tier 5:** Preferred cost sharing and standard cost sharing: 33% of the total cost filled at a network pharmacy (30-day supply).	• **Drug Tier 5:** Preferred cost sharing and standard cost sharing: 33% of the total cost filled at a network pharmacy (30-day supply).

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$90	$92

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your plan premium (if any), Medicare Part A and Part B premiums, non-Medicare covered eyewear (glasses, contacts, lenses and frames), non-Medicare covered dental services, non-Medicare covered hearing aids, costs for prescription drugs, and any amount you pay over the $50,000 annual coverage limit for emergency care received outside the United States and its territories does not count toward your maximum out-of-pocket amount.	$5,500	$4,500 Once you have paid $4,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.VivaHealth.com/Medicare/MemberResources. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care physician, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.VivaHealth.com/Medicare/MemberResources. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2022 Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Dental Services	You have a $1,400 allowance for preventive, diagnostic and comprehensive dental services per calendar year.	You have a $1,600 allowance for preventive, diagnostic and comprehensive dental services per calendar year.
Hearing Aid Fitting/Hearing Aid Testing Evaluations	Not Covered	You pay nothing for 1 hearing test and a fitting and evaluation each calendar year. You may also receive up to 3 follow-up visits at no cost to you.
Hearing Aids	Not Covered	You are covered for 1 hearing aid per ear, per calendar year. Hearing aids must be purchased through VIVA MEDICARE's vendor, NationsHearing, a NationsBenefits company. Your copay for a hearing aid will depend on the type of hearing aid technology you receive. The entry level (lowest) copay is $500. Coverage includes 60 batteries per hearing aid (3-year supply) at no cost to you. A one-time replacement is offered for lost, stolen or damaged hearing aids during the 3-year warranty period (members pay a replacement fee that is based on the type of device being replaced). Please

Cost	2021 (this year)	2022 (next year)
		refer to your Evidence of Coverage for more information.
Over-the-Counter (OTC) Items	You are covered for up to a $75 quarterly allowance for over-the-counter drugs and other health-related items listed in the VIVA MEDICARE Over-the-Counter Item Catalog. A one-time purchase is allowed each calendar quarter and the order/purchase cannot go over the benefit limit for the quarter. OTC items must be ordered through VIVA MEDICARE's vendor, OTC Health Solutions through 12/31/21.	You are covered for up to a $90 quarterly allowance for over-the-counter drugs and other health related items listed in the new VIVA MEDICARE Over-the-Counter (OTC) Item Catalog. Starting 1/1/22, there is no limit to the number of orders you can place in a quarter (up to the amount of your quarterly benefit allowance). OTC items must be ordered through VIVA MEDICARE's new vendor, NationsOTC, a NationsBenefits company starting 1/1/22. Please refer to your Evidence of Coverage for more information.
Transportation Services	Not Covered	You pay nothing for up to 12 round-trip or 24 one-way rides to a plan-approved location each calendar year.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are currently receiving a Part D drug that was approved through the plan's formulary exception process during 2021, a new formulary exception request may be required for 2022. When your formulary exception request was approved, we sent you a letter telling you the date the formulary exception request was approved and the date it will expire (terminate). If you are unsure of the expiration date for your approved formulary exception, you can refer to the letter we sent you, contact the physician that prescribed the drug, or contact Member Services (contact information is listed in Section 7.1 of this booklet).

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.VivaHealth.com/Medicare/MemberResources. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2021 to 2022.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic):** *Preferred cost sharing* You pay $0 per prescription *Standard cost sharing*: You pay $4 per prescription **Tier 2 (Generic):** *Preferred cost sharing* You pay $8 per prescription *Standard cost sharing*: You pay $8 per prescription **Tier 3 (Preferred Brand):** *Preferred cost sharing* You pay $47 per prescription *Standard cost sharing*: You pay $47 per prescription **Tier 4 (Non-Preferred Drug):** *Preferred cost sharing* You pay $100 per prescription *Standard cost sharing*: You pay $100 per prescription	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic):** *Preferred cost sharing* You pay $0 per prescription *Standard cost sharing*: You pay $4 per prescription **Tier 2 (Generic):** *Preferred cost sharing* You pay $8 per prescription *Standard cost sharing*: You pay $8 per prescription **Tier 3 (Preferred Brand):** *Preferred cost sharing* You pay $47 per prescription *Standard cost sharing*: You pay $47 per prescription **Tier 4 (Non-Preferred Drug):** *Preferred cost sharing* You pay $100 per prescription *Standard cost sharing*: You pay $100 per prescription

Stage	2021 (this year)	2022 (next year)
	Tier 5 (Specialty Tier): *Preferred cost sharing* You pay 33% of the total cost *Standard cost sharing*: You pay 33% of the total cost Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 (Specialty Tier):** *Preferred cost sharing* You pay 33% of the total cost *Standard cost sharing*: You pay 33% of the total cost Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Geographic/Service Area	Service area includes: Limestone, Madison, and Morgan counties.	Service area includes: Limestone, Madison, Marshall, and Morgan counties.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in VIVA MEDICARE *Preferred*

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in VIVA MEDICARE *Preferred* for 2022.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, VIVA HEALTH, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from VIVA MEDICARE *Preferred*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from VIVA MEDICARE *Preferred*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).

- *– or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Alabama, the SHIP is called Alabama Department of Senior Services.

Alabama Department of Senior Services is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Alabama Department of Senior Services counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Alabama Department of Senior Services at 1-877-425-2243 or 1-800-AGELINE (1-800-243-5463). You can learn more about Alabama Department of Senior Services by visiting their website (www.alabamaageline.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to

75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Alabama AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Alabama AIDS Drug Assistance Program at 1-866-574-9964.

SECTION 7 Questions?

Section 7.1 – Getting Help from VIVA MEDICARE *Preferred*

Questions? We're here to help. Please call Member Services at 1-800-633-1542. (TTY only, call 711). We are available for phone calls from 8 a.m. to 8 p.m., Monday through Friday (from October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week). Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for VIVA MEDICARE *Preferred*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.VivaHealth.com/Medicare/MemberResources. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.VivaHealth.com/Medicare/MemberResources. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.