VIVA MEDICARE *Extra Care* (HMO SNP) offered by VIVA HEALTH, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of VIVA MEDICARE *Extra Care*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules, please review the *Evidence of Coverage*, which is located on our website at www.VivaHealth.com/Medicare/Member-Resources. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

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.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost-sharing.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.
- Check the changes in the 2025 "*Drug List*" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctor, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare &*

You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in VIVA MEDICARE *Extra Care*.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with VIVA MEDICARE *Extra Care*.
- Look in Section 3.2, page 13 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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). This call is free.
- If you need this information in another format, such as audio or large print, please contact Member Services (phone numbers are listed above).
- **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 *Extra Care*

- 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 document says "we," "us," or "our," it means VIVA HEALTH, Inc. When it says "plan" or "our plan," it means VIVA MEDICARE *Extra Care*.

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for VIVA MEDICARE *Extra Care* in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium	$0 or $41.40 (you pay $0 because of the level of "Extra Help" you receive)	$0 or $40 (you pay $0 because of the level of "Extra Help" you receive)
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	$0	$0

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 or $530 except for covered insulin products and most adult Part D vaccines (you pay $0 because of the level of "Extra Help" you receive). Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5: $0 (if you receive "Extra Help") or 25% of the total cost (if you do not qualify for "Extra Help"). You pay $0 per month supply of each covered insulin product on these tiers (if you receive "Extra Help") or no more than $35 (if you do not qualify for "Extra Help"). Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: $0 or $577 except for covered insulin products and most adult Part D vaccines (you pay $0 because of the level of "Extra Help" you receive). Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5: $0 (if you receive "Extra Help") or 25% of the total cost (if you do not qualify for "Extra Help"). You pay $0 per month supply of each covered insulin product on these tiers (if you receive "Extra Help") or no more than $35 (if you do not qualify for "Extra Help"). Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$6,600 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$6,750 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or $41.40 (you pay $0 because of the level of "Extra Help" you receive).	$0 or $40 (you pay $0 because of the level of "Extra Help" you receive).

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

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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	$6,600	$6,750 Once you have paid $6,750 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Cost	2024 (this year)	2025 (next year)
and its territories do not count toward your maximum out-of-pocket amount.		

Section 1.3 – Changes to the Provider and Pharmacy Networks

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.

Updated directories are located on our website at www.VivaHealth.com/Medicare/Member-Resources. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* at www.VivaHealth.com/Medicare/Member-Resources to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* at www.VivaHealth.com/Medicare/Member-Resources to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Dental services	You have a $2,350 allowance for preventive, diagnostic and comprehensive dental services per calendar year.	You have a $1,500 allowance for preventive, diagnostic and comprehensive dental services per calendar year.

Cost	2024 (this year)	2025 (next year)
Flex Card and mail-order benefit for: • **Over-the-counter (OTC) drugs and supplies; and** • **Food and produce as part of the Value-Based Insurance Design (VBID) Model**	All members in this plan that receive assistance called "Extra Help" or "Low-Income Subsidy (LIS)" get a $130 monthly allowance loaded on a NationsBenefits Prepaid Mastercard® (referred to as a "Flex Card"). The monthly combined allowance can be used to buy plan-approved food/produce and over-the-counter (OTC) drugs and supplies at in-network retailers or by ordering from www.VIVA.NationsBenefits.com.	All members in this plan that receive assistance called "Extra Help" or "Low-Income Subsidy (LIS)" get a $65 monthly allowance loaded on a NationsBenefits Prepaid Mastercard® (referred to as a "Flex Card"). The monthly combined allowance can be used to buy plan-approved food/produce and over-the-counter (OTC) drugs and supplies at in-network retailers or by ordering from www.VIVA.NationsBenefits.com. Some mail-order items in your 2025 Product Catalog have increased or decreased in cost. In addition, some items have been added or removed, and item sizes and quantities may have changed. Shipping costs are still free, but you will pay taxes on your orders starting in 2025. To view the 2025 catalog, go to our website at www.VivaHealth.com/Medicare/Member -Resources.com or login to your NationsBenefits account at www.VIVA.NationsBenefits.com. You may also request a printed copy of the catalog by calling NationsBenefits at 1-877-209-5189 (TTY: 711). Member Experience Advisors are available 8 a.m. to 8 p.m., 7 days a week, except federal holidays.

Cost	2024 (this year)	2025 (next year)
Vision care	You have a $300 allowance for prescription, eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.	You have a $200 allowance for prescription, eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.

Section 1.5 – 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 on our website at www.VivaHealth/Medicare/Member-Resources.

We made changes to our *Drug List,* which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the *Drug List* to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the *Drug List* are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online *Drug List* at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our *Drug List* if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our *Drug List*, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are

taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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 may 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. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. Medicare approved for VIVA MEDICARE *Extra Care* to lower Part D prescription drug copays to $0 for members receiving "Extra Help" as part of the Value-Based Insurance Design (VBID) Model. Members who do not qualify for "Extra Help" will pay 25% of the total cost for Part D prescription drugs.	The deductible is $0 or $530 (you pay $0 because of the level of "Extra Help" you receive). Copayment/Coinsurance during the Yearly Deductible Stage: **Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier):** You pay $0 (if you receive "Extra Help") or 25% of the total cost (if you do not qualify for "Extra Help").	The deductible is $0 or $577 (you pay $0 because of the level of "Extra Help" you receive). Copayment/Coinsurance during the Yearly Deductible Stage: **Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier):** You pay $0 (if you receive "Extra Help") or 25% of the total cost (if you do not qualify for "Extra Help").

Changes to Your Cost-Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (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 chart 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, look in Chapter 6, Section 5 of your *Evidence of Coverage.*	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier):** You pay $0 (if you receive "Extra Help") or 25% of	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty Tier):** You pay $0 (if you receive "Extra Help") or 25% of

Stage	2024 (this year)	2025 (next year)
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*. Most adult Part D vaccines are covered at no cost to you.	the total cost (if you do not qualify for "Extra Help"). _____ Once you have paid $8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	the total cost (if you do not qualify for "Extra Help"). _____ Once you have paid $2,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not Applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs (if you have any drug costs) by spreading them across **monthly payments that vary throughout the year** (January - December). To learn more about this payment option, please contact CVS Caremark Customer Care at 1-866-788-

Description	2024 (this year)	2025 (next year)
		5146 (TTY only, call 711) or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

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

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 *Extra Care*.

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 plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *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.

To learn more about Original Medicare and the different types of Medicare plans use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 *Extra Care*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from VIVA MEDICARE *Extra Care*.
- 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 so.

- – *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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

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, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

Because you have Alabama Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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

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). TTY users should call 711. You can learn more about Alabama Department of Senior Services by visiting their website (www.alabamaageline.gov).

For questions about your Medicaid benefits, contact the Alabama Medicaid Agency at 1-800-362-1504 (toll-free) from 8 a.m. to 4:30 p.m., Monday through Friday. TTY users should call 1-800-253-0799. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

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.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **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. To be eligible for the ADAP operating in your State, 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, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the Alabama AIDS Drug Assistance Program at 1-866-574-9964. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs (if you have any drug costs), starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs (if any) by spreading them across

monthly payments that vary throughout the year (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

"Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please CVS Caremark Customer Care at 1-866-788-5146 (TTY only, call 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from VIVA MEDICARE *Extra Care*

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 *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for VIVA MEDICARE *Extra Care.* 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/Member-Resources. 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/Member-Resources. 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid, you can call the Alabama Medicaid Agency at 1-800-362-1504 toll-free or 1-334-242-5000. TTY users should call 1-800-253-0799.

VIVA MEDICARE

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-633-1542 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-633-1542 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-633-1542 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-633-1542 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-633-1542 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-633-1542 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-633-1542 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-633-1542 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-633-1542 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-633-1542 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على بمساعدتك. 1-800-633-1542 (TTY: 711)**. سيقوم شخص ما يتحدث العربية هذه خدمة مجانية.**

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-633-1542 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-633-1542 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguése: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-633-1542 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-633-1542 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-633-1542 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-633-1542 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。