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

Annual Notice of Changes for 2025

You are currently enrolled as a member of VIVA MEDICARE *Classic*. 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.*

- **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.

- 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 *Classic*.
- 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 *Classic*.
- 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 Member Services 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 *Classic*

- 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 *Classic*.

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Summary of Important Costs for 2025

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

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
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.)	$5,400	$9,350
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $20 copay per visit	Primary care visits: $0 per visit Specialist visits: $25 copay per visit; $0 for specialist visits in a skilled nursing facility
Inpatient hospital stays	$245 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization. $0 for additional days.	$385 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization. $0 for additional days.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $0 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 2:** $12 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 3:** $47 per prescription filled at network pharmacy (30-day supply). You pay $35 per month supply of each covered insulin product on this tier (30-day supply). • **Drug Tier 4:** $100 per prescription filled at a network pharmacy (30-day supply). You pay $35 per month supply of each covered insulin product on this tier (30-day supply). • **Drug Tier 5:** 33% of the total cost per prescription filled at a network	Deductible: $0 for Tiers 1 and 2 $300 for Tiers 3, 4, and 5 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $0 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 2:** $12 per prescription filled at a network pharmacy (30-day supply). • **Drug Tier 3:** $47 per prescription filled at network pharmacy (30-day supply). You pay $35 per month supply of each covered insulin product on this tier (30-day supply). • **Drug Tier 4:** 45% of the total cost per prescription filled at a network pharmacy (30-day supply). You pay no more than $35 per month supply of each covered insulin product on this tier (30-day supply). • **Drug Tier 5:** 29% of the total cost per prescription filled at a network

Cost	2024 (this year)	2025 (next year)
	pharmacy (30-day supply). You pay no more than $35 per month supply of each covered insulin product on this tier (30-day supply). Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	pharmacy (30-day supply). You pay no more than $35 per month supply of each covered insulin product on this tier (30-day supply). Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

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 **There is no change in your Premium for 2025.** (You must also continue to pay your Medicare Part B premium.)	$0	$0
Medicare Part B Premium Buy-Down	A Medicare Part B Premium Buy-Down is not offered by the plan.	Our plan provides a Medicare Part B Premium Buy-Down (also called a Medicare Part B Premium Giveback) that lowers the cost of your monthly Medicare Part B premium by $2 a month (if you are not receiving government assistance that pays the Medicare Part B premium for you). Depending on how you pay your monthly Medicare Part B premium, the buy-down will be credited to your Social Security check or credited to the amount you owe for your monthly Medicare Part B premium. It may take a few months for the buy-down to be set up by the Social Security Administration (SSA), but you will receive the buy-down for all months you are enrolled in this plan for 2025. See Chapter 1 of your *Evidence of Coverage* for more details regarding

Cost	2024 (this year)	2025 (next year)
		how the Medicare Part B Premium Buy-Down works.

- 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.

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 Your costs for covered medical services (such as copays) count toward your 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 do not count toward your maximum out-of-pocket amount.	$5,400	$9,350 Once you have paid $9,350 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 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 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

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)
Ambulance services	You pay a $275 copay per one-way trip for Medicare-covered ambulance services.	You pay a $350 copay per one-way trip for Medicare-covered ambulance services.
Chiropractic services	You pay a $20 copay for each Medicare-covered chiropractic visit.	You pay a $15 copay for each Medicare-covered chiropractic visit.
Dental services	You have a $1,600 allowance for preventive, diagnostic and comprehensive dental services per calendar year.	You have a $850 allowance for preventive, diagnostic and comprehensive dental services per calendar year.

Cost	2024 (this year)	2025 (next year)
Emergency care (including worldwide emergency care)	You pay a $120 copay for each Medicare-covered emergency room visit (you do not have to pay this amount if you are admitted to the same hospital as an inpatient or for outpatient observation within 24 hours for the same condition).	You pay a $110 copay for each Medicare-covered emergency room visit (you do not have to pay this amount if you are admitted to the same hospital as an inpatient or for outpatient observation within 24 hours for the same condition).
Flex Card	You get a $30 allowance per calendar quarter on a Flex Card to help pay for certain out-of-pocket health expenses.	A Flex Card is not covered for 2025.
Hearing aids	You pay $750-$3,100 for one pair of over-the-counter (OTC) hearing aids (your cost depends on the OTC hearing devices you choose). OTC hearing aids do not require a prescription from a doctor. All hearing aids must be purchased through NationsHearing. Limitations and more details, including information about prescription hearing aids, can be found in Chapter 4 of your *Evidence of Coverage.*	You pay $750-$2,850 for one pair of over-the-counter (OTC) hearing aids (your cost depends on the OTC hearing devices you choose). OTC hearing aids do not require a prescription from a doctor. All hearing aids must be purchased through NationsHearing. Limitations and more details, including information about prescription hearing aids, can be found in Chapter 4 of your *Evidence of Coverage.*
Hearing services	You pay a $20 copay for each specialist visit for Medicare-covered services and for the routine hearing exam from a physician specialist.	You pay a $25 copay for each specialist visit for Medicare-covered services and for the routine hearing exam from a physician specialist.
Inpatient hospital care	You pay a $245 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization.	You pay a $385 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization.

Cost	2024 (this year)	2025 (next year)
Inpatient services in a psychiatric hospital	You pay a $245 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization.	You pay a $385 copay for each Medicare-covered day for days 1-5 for each inpatient hospitalization.
Outpatient diagnostic radiology tests	You pay a $75 copay for each Medicare-covered outpatient diagnostic radiology service such as PET scans, MRI's and CAT/CT scans.	You pay a $200 copay for each Medicare-covered outpatient diagnostic radiology service such as PET scans, MRI's and CAT/CT scans.
Outpatient hospital services and outpatient hospital observation	You pay a $225 copay for each Medicare-covered surgery, procedure, or service including blood transfusions and invasive procedures such as epidurals and bronchoscopies at an outpatient hospital facility and for each Medicare-covered outpatient hospital observation service when no outpatient procedure is performed.	You pay a $385 copay for each Medicare-covered surgery, procedure, or service including blood transfusions and invasive procedures such as epidurals and bronchoscopies at an outpatient hospital facility and for each Medicare-covered outpatient hospital observation service when no outpatient procedure is performed.
Outpatient rehabilitation services	You pay a $20 copay for each Medicare-covered physical therapy, speech therapy, and occupational therapy visit.	You pay a $25 copay for each Medicare-covered physical therapy, speech therapy, and occupational therapy visit.
Over-the-counter (OTC) drugs and supplies	You are covered for up to $60 each calendar quarter for over-the-counter drugs and other health-related items listed in the VIVA MEDICARE Over-the-Counter (OTC) Product Catalog. See your *Evidence of Coverage* for more details.	You are covered for up to $40 each calendar quarter for over-the-counter drugs and other health-related items listed in the VIVA MEDICARE Over-the-Counter (OTC) Product Catalog. Some items in your 2025 Over-the-Counter (OTC) Product Catalog have increased or decreased in cost. In addition, some items

Cost	2024 (this year)	2025 (next year)
		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 order starting in 2025. To view a copy of the 2025 Over-the-Counter (OTC) Product Catalog, please go to our website at www.VivaHealth.com/Medicare/ Member-Resources or login to your NationsBenefits account at www.VIVA.NationsBenefits.com. You may also request that a 2025 Over-the-Counter (OTC) Product Catalog be mailed to you 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.
Physician specialist services for doctor's office visits for podiatry, mental health, substance use disorder, opioid treatment, and other physician specialists unless listed separately in this chart. Note: This does not include the cost for specialty care received from a chiropractor.	You pay a $20 copay for each physician specialist visit for Medicare-covered services.	You pay a $25 copay for each physician specialist visit for Medicare-covered services; $0 for Medicare-covered specialist visits in a skilled nursing facility.
Telehealth services provided by a physician specialist	You pay a $20 copay for each Medicare-covered telehealth specialist visit for: • Specialty physician services (does not	You pay a $25 copay for each Medicare-covered telehealth specialist visit for: • Specialty physician services (does not

Cost	2024 (this year)	2025 (next year)
	include services from a chiropractor or podiatrist, hearing or vision exams, diabetes self-management training, kidney disease education, smoking cessation counseling, or services from an urgent care facility) • Individual/group sessions for outpatient mental health services • Individual/group sessions for outpatient substance use disorder services (does not include opioid treatment program counseling) • Individual/group sessions for outpatient psychiatric services • Outpatient physical therapy and speech/language pathology (does not include supervised exercise therapy for PAD, occupational therapy or cardiac and pulmonary rehabilitation) • Other health care professional	include services from a chiropractor or podiatrist, hearing or vision exams, diabetes self-management training, kidney disease education, smoking cessation counseling, or services from an urgent care facility) • Individual/group sessions for outpatient mental health services • Individual/group sessions for outpatient substance use disorder services (does not include opioid treatment program counseling) • Individual/group sessions for outpatient psychiatric services • Outpatient physical therapy and speech/language pathology (does not include supervised exercise therapy for PAD, occupational therapy or cardiac and pulmonary rehabilitation) • Other health care professional
Transportation services	You pay $0 for up to 5 round trips or 10 one-way rides to a plan approved location each calendar year.	Transportation services are not covered for 2025.
Urgently needed services	You pay the following for each Medicare-covered visit for urgently needed services:	You pay the following for each Medicare-covered visit for urgently needed services:

Cost	2024 (this year)	2025 (next year)
	• $0 at your PCP • $20 copay at a physician specialist • $40 copay at a urgent care facility/clinic	• $0 at your PCP • $25 copay at a physician specialist • $40 copay at a urgent care facility/clinic
Vision care	You pay a $20 copay for each specialist visit for Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye); $0 for the routine annual eye exam (eye refractions) for eyeglasses/contacts. You have a $200 allowance for prescription, eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.	You pay a $25 copay for each specialist visit for Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye); $0 for the routine annual eye exam (eye refractions) for eyeglasses/contacts. You have a $150 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 Lis*t 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 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. 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, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to Tier 1 and Tier 2 drugs, covered insulin products, and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	Because we have no deductible, this payment stage does not apply to you.	The deductible is $300 for Tier 3, Tier 4, and Tier 5 drugs. During this stage, you pay $0 cost-sharing for drugs on Tier 1 and $12 cost-sharing for drugs on Tier 2 (30-day supply) and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost-Sharing in the Initial Coverage Stage

For drugs on Tier 4, your cost-sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible for Tiers 3, 4, and 5, you move to the 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.** For 2024, you paid a $100 copayment for drugs on Tier 4. For 2025, you will pay 45% coinsurance for drugs on this tier. The costs in this chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. 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*. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic):** You pay $0 per prescription. **Tier 2 (Generic):** You pay $12 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is $100. **Tier 5 (Specialty Tier):** You pay 33% of the total cost.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 (Preferred Generic):** You pay $0 per prescription. **Tier 2 (Generic):** You pay $12 per prescription. **Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drug):** You pay 45% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 45% of the total cost. **Tier 5 (Specialty Tier):** You pay 29% of the total cost.

Stage	2024 (this year)	2025 (next year)
	You pay no more than $35 per month supply of each covered insulin product on this tier. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	You pay no more than $35 per month supply of each covered insulin product on this tier. 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 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 1-866-788-5146 (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 *Classic*

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 *Classic*.

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

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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 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

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). 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 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, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs 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 contact 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 *Classic*

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 *Classic*. 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.

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。