VIVA MEDICARE

We'd like to tell you about some great changes to your 2023 benefits!

Anytime a change is made, we send you a notice, also called an Addendum, to let you know what the changes are and when they will start.

This Addendum explains important changes to your Evidence of Coverage, Annual Notice of Change, and Summary of Benefits.

These changes shown in the chart below impact the following plans and may help you pay less for some Part B prescription drugs: VIVA MEDICARE *Select* (HMO), VIVA MEDICARE *Premier* (HMO), VIVA MEDICARE *Me* (HMO), VIVA MEDICARE *Plus* (HMO), VIVA MEDICARE *Prime* (HMO), VIVA MEDICARE *Classic* (HMO), and VIVA MEDICARE *Preferred* (HMO).

ORIGINAL INFORMATION	UPDATED INFORMATION *(What is Changing)*	EFFECTIVE DATE
Your 2023 plan documents show that you pay 20% of the cost for Medicare-covered Part B prescription drugs (including chemotherapy drugs).	Each calendar quarter, starting in April, Medicare will review Part B drugs to see which ones have prices that are rising faster than the rate of inflation. These drugs are called "rebatable" Part B drugs. Your cost for these Part B "rebatable" drugs will be limited to the cost set by Original Medicare. This will make your cost between $0 and 20% of the Medicare-approved payment amount. The list of Part B "rebatable" drugs and the cost for these drugs can change each calendar quarter. Medicare will let VIVA MEDICARE know which drugs are "rebatable" each quarter. **This change may help you pay less for some Part B prescription drugs.**	**4/1/23**
Your 2023 plan documents show that you pay 20% of the cost for Medicare-covered Part B prescription drugs, including insulin furnished through durable medical equipment.	You will pay no more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment. **This change will help you pay less for insulin furnished through insulin pumps.**	**7/1/23**

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

Annual Notice of Changes for 2023

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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 *Drug List* to make sure the drugs you currently take are still covered.

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

☐ 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 www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, 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, 2023.** This will end your enrollment with VIVA MEDICARE *Classic*.
- If you recently moved into, currently live in, or just moved out of 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.

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).
- If you need this information in another format, such as audio or large print, please contact Member Services (phone numbers are in Section 6.1 of this document).
- **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*.

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023 4

SECTION 1 Changes to Benefits and Costs for Next Year 7

Section 1.1 – Changes to the Monthly Premium 7
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount 7
Section 1.3 – Changes to the Provider and Pharmacy Networks 8
Section 1.4 – Changes to Benefits and Costs for Medical Services 8
Section 1.5 – Changes to Part D Prescription Drug Coverage 11

SECTION 2 Deciding Which Plan to Choose 13

Section 2.1 – If you want to stay in VIVA MEDICARE *Classic* 13
Section 2.2 – If you want to change plans 14

SECTION 3 Deadline for Changing Plans 14

SECTION 4 Programs That Offer Free Counseling about Medicare 15

SECTION 5 Programs That Help Pay for Prescription Drugs 15

SECTION 6 Questions? 16

Section 6.1 – Getting Help from VIVA MEDICARE *Classic* 16
Section 6.2 – Getting Help from Medicare 16

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for VIVA MEDICARE *Classic* in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (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	$5,400
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $20 per visit	Primary care visits: $0 per visit Specialist visits: $20 per visit
Inpatient hospital stays	$245 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.	$245 copay for each Medicare-covered day for days 1-6 for each inpatient hospitalization. $0 for additional days. You pay the copay listed above for Medicare-covered admissions for the treatment of COVID-19.

Cost	2022 (this year)	2023 (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:** 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: $12 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	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: $12 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

Cost	2022 (this year)	2023 (next year)
	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).	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).

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium **There is no change in your premium for 2023.** (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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	2022 (this year)	2023 (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	$5,400	$5,400 Once you have paid $5,400 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Cost	2022 (this year)	2023 (next year)
territories do not count toward your maximum out-of-pocket amount. **There is no change to your maximum out-of-pocket amount for 2023.**		

Section 1.3 – Changes to the Provider and Pharmacy Networks

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.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care physician, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* 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	2022 (this year)	2023 (next year)
Emergency care (including worldwide emergency coverage)	You pay a $90 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 $95 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	Not covered.	You will receive $30 per calendar quarter on a Flex Card. The Flex Card is a NationsBenefits Mastercard® and is administered by NationsBenefits. You can use the Flex Card to help pay for your plan-covered dental services, prescription eyewear (contacts, lenses, frames and upgrades), hearing aids and over-the-counter (OTC) items. The Flex Card does not replace these plan covered benefits, but can be used to help pay for these items. Unused amounts left on the card at the end of the calendar quarter will roll over to the next calendar quarter within the same calendar year. You will receive your Flex Card in the mail close to January 1, 2023. The Flex

Cost	2022 (this year)	2023 (next year)
		Card will include instructions on how to activate your card. For more details, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2023 *Evidence of Coverage* available on our website at www.VivaHealth.com/Medicare/Member-Resources.
Inpatient hospital admission for COVID-19	You pay $0 for each Medicare-covered admission for the treatment of COVID-19.	You pay a $245 copay for each Medicare-covered day for days 1-6 for the treatment of COVID-19. $0 for additional days.
Outpatient diagnostic procedures and tests	You pay 10% of the cost for non-standard Medicare-covered outpatient diagnostic lab tests such as genetic testing and drug screens.	You pay $0 for non-standard Medicare-covered outpatient diagnostic lab tests such as genetic testing and drug screens.
Skilled nursing facility (SNF)	You pay $0 for each Medicare-covered day for days 1-20 for each benefit period. You pay a $172 copay for each Medicare-covered day for days 21-55 for each benefit period. You pay $0 for each Medicare-covered day for days 56-100 for each benefit period.	You pay $0 for each Medicare-covered day for days 1-20 for each benefit period. You pay a $196 copay for each Medicare-covered day for days 21-49 for each benefit period. You pay $0 for each Medicare-covered day for days 50-100 for each benefit period.

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.

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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online *Drug List* to provide the most up to date list of drugs.

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.

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. If 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."

The information below shows the changes 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.)

Important Message About What You Pay For Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay For Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it's on.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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 2022 to 2023.

Stage	2022 (this year)	2023 (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 $12 per prescription. *Standard cost sharing*: You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Preferred cost sharing:* You pay $47 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 $12 per prescription. *Standard cost sharing*: You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Preferred cost sharing:* You pay $47 per prescription.

Stage	2022 (this year)	2023 (next year)
	Standard 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.	**Tier 4 (Non-Preferred Drug):** *Preferred cost sharing:* You pay $100 per prescription.
	Standard cost sharing: You pay $100 per prescription.	*Standard cost sharing*: You pay $100 per prescription.
	Tier 5 (Specialty Tier): *Preferred cost sharing:* You pay 33% of the total cost.	**Tier 5 (Specialty Tier):** *Preferred cost sharing:* You pay 33% of the total cost.
	Standard 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).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – 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 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2). 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 3 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, 2023.

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, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 4 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 5 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. 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 (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 6 Questions?

Section 6.1 – 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 *2023 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 2023. For details, look in the *2023 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 6.2 – 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 2023*

Read the *Medicare & You 2023* 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 1-800-633-1542 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. 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.

Portugués: 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。