SUMMARY *OF BENEFITS 2025*

January 1, 2025 – December 31, 2025

VIVA MEDICARE *Plus* (HMO)

VIVA MEDICARE *Prime* (HMO)

VIVA MEDICARE *Premier* (HMO)

If you are a member of this plan, call 1-800-633-1542 (toll-free). TTY users, dial 711.

Hours: Monday through Friday, 8 a.m. to 8 p.m.
(From October 1 to March 31: 7 days a week, 8 a.m. to 8 p.m.)

If you are not a member of this plan, call 1-888-830-8482 (toll-free). TTY users, dial 711.

Hours: Monday through Friday, 8 a.m. to 8 p.m.
(From October 1 to December 31: 7 days a week, 8 a.m. to 8 p.m.)

Our website: www.VivaHealth.com/Medicare

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, www.VivaHealth.com/Medicare/Member-Resources.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **VIVA MEDICARE *Plus***, **VIVA MEDICARE *Prime*,** or **VIVA MEDICARE *Premier***).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **VIVA MEDICARE *Plus*, VIVA MEDICARE *Prime*,** and **VIVA MEDICARE *Premier*** cover and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at https://www.medicare.gov or get a copy 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.

Sections in this booklet

- Things to Know About **VIVA MEDICARE *Plus*, VIVA MEDICARE *Prime*,** and **VIVA MEDICARE *Premier***
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as audio and large print.

This document can be made available in a non-English language. For additional information, call us at 1-800-633-1542 (TTY: 711).

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Things to Know About VIVA MEDICARE *Plus*, VIVA MEDICARE *Prime*, and VIVA MEDICARE *Premier*

Hours of Operation & Contact Information

If you are a member of this plan, call us at 1-800-633-1542, TTY: 711.

- We're open Monday through Friday, 8 a.m. to 8 p.m. (from October 1 to March 31: 7 days a week, 8 a.m. to 8 p.m.).

If you are not a member of this plan, call us at 1-888-830-8482, TTY: 711.

- We're open Monday through Friday, 8 a.m. to 8 p.m. (from October 1 to December 31: 7 days a week, 8 a.m. to 8 p.m.).

Our website: www.VivaHealth.com/Medicare

Who can join?

To join **VIVA MEDICARE *Plus*, VIVA MEDICARE *Prime*, or VIVA MEDICARE *Premier***, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.

Our service area for **VIVA MEDICARE *Plus*** ($20 Part B Premium Buy-Down) includes the following counties in Alabama: Baldwin, Bibb, Blount, Chambers, Dale, Dallas, Geneva, Henry, Houston, Jefferson, Lee, Mobile, Montgomery, Shelby, St. Clair, Talladega, Tuscaloosa, and Walker.

Our service area for **VIVA MEDICARE *Plus*** ($2 Part B Premium Buy-Down) includes the following counties in Alabama: Autauga, Bullock, Calhoun, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Elmore, Etowah, Fayette, Franklin, Lauderdale, Lowndes, Macon, Pike, and Tallapoosa.

The service area for **VIVA MEDICARE *Prime*** includes the following counties in Alabama: Autauga, Baldwin, Bibb, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, Dallas, Elmore, Etowah, Fayette, Franklin, Geneva, Henry, Houston, Jefferson, Lauderdale, Lee, Lowndes, Macon, Mobile, Montgomery, Pike, Shelby, St. Clair, Talladega, Tallapoosa, Tuscaloosa, and Walker.

The service area for **VIVA MEDICARE *Premier*** includes the following counties in Alabama: Autauga, Baldwin, Bibb, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Dale, Dallas, Elmore, Etowah, Fayette, Franklin, Geneva, Henry, Houston, Jackson, Jefferson, Lauderdale, Lee, Limestone, Lowndes, Macon, Madison, Marshall, Mobile, Montgomery, Morgan, Pike, Shelby, St. Clair, Talladega, Tallapoosa, Tuscaloosa, and Walker.

Which doctors, hospitals, and pharmacies can I use?

VIVA MEDICARE *Plus*, VIVA MEDICARE *Prime*, and **VIVA MEDICARE *Premier*** have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directories at our website (www.VivaHealth.com/Medicare/Member-Resources).

Or, call us and we will send you a copy of the provider and pharmacy directories.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.VivaHealth.com/Medicare/Member-Resources.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about these plans' benefits or costs, please contact VIVA MEDICARE.

SECTION II - SUMMARY OF BENEFITS	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	$0 per month. In addition, you must continue to pay your Medicare Part B premium.	$53 per month. In addition, you must continue to pay your Medicare Part B premium.	$103 per month. In addition, you must continue to pay your Medicare Part B premium.
Part B Premium Buy-Down	This plan provides a Part B Premium Buy-Down (also called a Part B Premium Giveback) that lowers the cost of your monthly Part B premium by $20 or $2 a month, depending on the county you live in (if you are not receiving government assistance that pays the Part B premium for you).[1] Please see the Evidence of Coverage for more information.	This plan does not provide a Part B Premium Buy-Down.	This plan does not provide a Part B Premium Buy-Down.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $300 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.	Medical Deductible: Not Applicable. Prescription Drug Deductible: $200 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.	Medical Deductible: Not Applicable. Prescription Drug Deductible: $100 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $9,350 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs, if applicable.	Your yearly limit(s) in this plan: • $7,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs, if applicable.	Your yearly limit(s) in this plan: • $6,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs, if applicable.
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital	**In-Network:** Days 1-6: $375 Copay per day for each admission. Days 7-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.	**In-Network:** Days 1-6: $325 Copay per day for each admission. Days 7-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.	**In-Network:** Days 1-6: $275 Copay per day for each admission. Days 7-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $375 Copay. Outpatient observation: $375 Copay. Medicare-covered colonoscopies: $0 Copay. May require prior authorization.	**In-Network:** Outpatient hospital: $325 Copay. Outpatient observation: $325 Copay. Medicare-covered colonoscopies: $0 Copay. May require prior authorization.	**In-Network:** Outpatient hospital: $275 Copay. Outpatient observation: $275 Copay. Medicare-covered colonoscopies: $0 Copay. May require prior authorization.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 Copay. May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $0 Copay. May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $0 Copay. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care provider (PCP) visit: $0 Copay. Specialist visit: $25 Copay ($0 for a specialist visit in a Skilled Nursing Facility).	**In-Network:** Primary care provider (PCP) visit: $0 Copay. Specialist visit: $25 Copay ($0 for a specialist visit in a Skilled Nursing Facility).	**In-Network:** Primary care provider (PCP) visit: $0 Copay. Specialist visit: $20 Copay ($0 for a specialist visit in a Skilled Nursing Facility).
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** $110 Copay per visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $110 Copay. Worldwide emergency coverage outside the U.S. and its territories is limited to $50,000 and does not include transportation.	**In-Network:** $110 Copay per visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $110 Copay. Worldwide emergency coverage outside the U.S. and its territories is limited to $50,000 and does not include transportation.	**In-Network:** $125 Copay per visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $125 Copay. Worldwide emergency coverage outside the U.S. and its territories is limited to $50,000 and does not include transportation.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Urgently Needed Services	**In-Network:** Medicare-covered urgently needed service from a PCP: $0 Copay per visit. Medicare-covered urgently needed service from a specialist: $25 Copay per visit. Medicare-covered urgently needed service from an urgent care clinic/facility: $40 Copay per visit.	**In-Network:** Medicare-covered urgently needed service from a PCP: $0 Copay per visit. Medicare-covered urgently needed service from a specialist: $25 Copay per visit. Medicare-covered urgently needed service from an urgent care clinic/facility: $40 Copay per visit.	**In-Network:** Medicare-covered urgently needed service from a PCP: $0 Copay per visit. Medicare-covered urgently needed service from a specialist: $20 Copay per visit. Medicare-covered urgently needed service from an urgent care clinic/facility: $40 Copay per visit.
Diagnostic Services/ Labs/Imaging	**In-Network:** Diagnostic tests and procedures (such as EEGs, sleep studies): $0 - $75 Copay. Lab services: $0 Copay. Diagnostic radiology services (such as ultrasound, MRI, CAT Scan): $15 - $200 Copay. X-rays: $15 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $60 Copay. Costs for these services may vary based on place of service. May require prior authorization.	**In-Network:** Diagnostic tests and procedures (such as EEGs, sleep studies): $0 - $50 Copay. Lab services: $0 Copay. Diagnostic radiology services (such as ultrasound, MRI, CAT Scan): $10 - $175 Copay. X-rays: $10 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $60 Copay. Costs for these services may vary based on place of service. May require prior authorization.	**In-Network:** Diagnostic tests and procedures (such as EEGs, sleep studies): $0 - $25 Copay. Lab services: $0 Copay. Diagnostic radiology services (such as ultrasound, MRI, CAT Scan): $0 - $100 Copay. X-rays: $0 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $30 Copay. Costs for these services may vary based on place of service. May require prior authorization.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $0 - $25 Copay. Routine hearing exam (up to 1 visit per year): $0 - $25 Copay. Hearing Aids: Must be purchased through NationsHearing. Over-the-counter (OTC) hearing aids: Sold as a pair (member cost range is $750 - $2,850). Prescription hearing aids: One hearing aid per ear (member cost range is $500 - $1,975). Members may purchase either OTC or prescription hearing aids (not both) per calendar year.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $0 - $25 Copay. Routine hearing exam (up to 1 visit per year): $0 - $25 Copay. Hearing Aids: Must be purchased through NationsHearing. Over-the-counter (OTC) hearing aids: Sold as a pair (member cost range is $750 - $2,850). Prescription hearing aids: One hearing aid per ear (member cost range is $500 - $1,975). Members may purchase either OTC or prescription hearing aids (not both) per calendar year.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $0 - $20 Copay. Routine hearing exam (up to 1 visit per year): $0 - $20 Copay. Hearing Aids: Must be purchased through NationsHearing. Over-the-counter (OTC) hearing aids: Sold as a pair (member cost range is $750 - $2,850). Prescription hearing aids: One hearing aid per ear (member cost range is $500 - $1,975). Members may purchase either OTC or prescription hearing aids (not both) per calendar year.
Dental Services	**In-Network:** Limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): applicable office visit, outpatient, or inpatient copays apply. VIVA MEDICARE *Plus* also covers up to $900 or $835 for preventive, diagnostic, and comprehensive dental benefits per year, depending on the county you live in. You pay anything over $900 or $835.[2]	**In-Network:** Limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): applicable office visit, outpatient, or inpatient copays apply. VIVA MEDICARE *Prime* also covers up to $1,100 for preventive, diagnostic, and comprehensive dental benefits per year. You pay anything over $1,100.	**In-Network:** Limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): applicable office visit, outpatient, or inpatient copays apply. VIVA MEDICARE *Premier* also covers up to $1,250 for preventive, diagnostic, and comprehensive dental benefits per year. You pay anything over $1,250.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $25 Copay. Routine eye exam (up to 1 visit per year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay plus you pay any amount over the Medicare allowed amount. Our plan pays up to $100 for additional prescription eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $25 Copay. Routine eye exam (up to 1 visit per year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay plus you pay any amount over the Medicare allowed amount. Our plan pays up to $150 for additional prescription eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $20 Copay. Routine eye exam (up to 1 visit per year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay plus you pay any amount over the Medicare allowed amount. Our plan pays up to $200 for additional prescription eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Inpatient Mental Health Care: Days 1-5: $375 Copay per day for each admission. Days 6-90: $0 Copay per day. May require prior authorization.	**In-Network:** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Inpatient Mental Health Care: Days 1-6: $325 Copay per day for each admission. Days 7-90: $0 Copay per day. May require prior authorization.	**In-Network:** Outpatient group therapy visit: $20 Copay. Individual therapy visit: $20 Copay. Inpatient Mental Health Care: Days 1-6: $275 Copay per day for each admission. Days 7-90: $0 Copay per day. May require prior authorization.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-52: $196 Copay per day. Days 53-100: $0 Copay per day. May require prior authorization.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-49: $196 Copay per day. Days 50-100: $0 Copay per day. May require prior authorization.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-44: $196 Copay per day. Days 45-100: $0 Copay per day. May require prior authorization.

SECTION II - SUMMARY OF BENEFITS	Viva Medicare *Plus*	Viva Medicare *Prime*	Viva Medicare *Premier*
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.	**In-Network:** Occupational therapy visit: $20 Copay. Physical therapy and speech and language therapy visit: $20 Copay.
Ambulance	**In-Network:** Ground Ambulance: $325 Copay per one-way trip. Air Ambulance: $325 Copay per one-way trip. May require prior authorization.	**In-Network:** Ground Ambulance: $300 Copay per one-way trip. Air Ambulance: $300 Copay per one-way trip. May require prior authorization.	**In-Network:** Ground Ambulance: $275 Copay per one-way trip. Air Ambulance: $275 Copay per one-way trip. May require prior authorization.
Non-Emergency Transportation	**In-Network:** Not Covered.	**In-Network:** Not Covered.	**In-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** 20% of the cost for Medicare-covered Part B drugs, including chemotherapy drugs. You may pay less (0-20%) for certain drugs deemed "rebatable" by Medicare. No more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment (ex: insulin pump). May require prior authorization.	**In-Network:** 20% of the cost for Medicare-covered Part B drugs, including chemotherapy drugs. You may pay less (0-20%) for certain drugs deemed "rebatable" by Medicare. No more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment (ex: insulin pump). May require prior authorization.	**In-Network:** 20% of the cost for Medicare-covered Part B drugs, including chemotherapy drugs. You may pay less (0-20%) for certain drugs deemed "rebatable" by Medicare. No more than $35 for a one-month supply of Medicare-covered insulin furnished through durable medical equipment (ex: insulin pump). May require prior authorization.

SECTION II - SUMMARY OF BENEFITS			
	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
Telehealth Services	Plan covers telehealth services for PCP and specialist visits, mental health, outpatient substance abuse, and physical and speech therapy; standard office visit copays apply, when applicable.	Plan covers telehealth services for PCP and specialist visits, mental health, outpatient substance abuse, and physical and speech therapy; standard office visit copays apply, when applicable.	Plan covers telehealth services for PCP and specialist visits, mental health, outpatient substance abuse, and physical and speech therapy; standard office visit copays apply, when applicable.
24-Hour Nurse Line	Plan includes access to a 24-hour nurse line for general health education and tips for at-home, non-emergency treatments for minor illnesses or injuries.	Plan includes access to a 24-hour nurse line for general health education and tips for at-home, non-emergency treatments for minor illnesses or injuries.	Plan includes access to a 24-hour nurse line for general health education and tips for at-home, non-emergency treatments for minor illnesses or injuries.
Over-the-Counter (OTC) Drugs and Other Health-Related Items	Plan provides a $25 allowance per calendar quarter that can be used for approved over-the-counter items by mail order through NationsBenefits.	Plan provides a $45 allowance per calendar quarter that can be used for approved over-the-counter items by mail order through NationsBenefits.	Plan provides a $70 allowance per calendar quarter that can be used for approved over-the-counter items by mail order through NationsBenefits.
Fitness	The Silver&Fit® program (no cost; includes membership at participating fitness centers and at-home, digital options).	The Silver&Fit® program (no cost; includes membership at participating fitness centers and at-home, digital options).	The Silver&Fit® program (no cost; includes membership at participating fitness centers and at-home, digital options).
PRESCRIPTION DRUG BENEFITS			
You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or the phase of coverage you're in.			
Deductible	Prescription Drug Deductible: $300 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.	Prescription Drug Deductible: $200 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.	Prescription Drug Deductible: $100 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.

SECTION II - SUMMARY OF BENEFITS

Initial Coverage

VIVA MEDICARE *Plus*

You pay the following until your yearly out-of-pocket drug costs reach $2,000.

Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$12 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	29% Coinsurance

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$30 Copay
Tier 3 (Preferred Brand)	$117.50 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

VIVA MEDICARE *Prime*

You pay the following until your yearly out-of-pocket drug costs reach $2,000.

Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$12 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	30% Coinsurance

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$30 Copay
Tier 3 (Preferred Brand)	$117.50 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

VIVA MEDICARE *Premier*

You pay the following until your yearly out-of-pocket drug costs reach $2,000.

Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$8 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	31% Coinsurance

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$16 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$20 Copay
Tier 3 (Preferred Brand)	$117.50 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

SECTION II - SUMMARY OF BENEFITS

	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*

Standard Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$4 Copay
Tier 2 (Generic)	$12 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$8 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$12 Copay
Tier 2 (Generic)	$36 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Standard Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$4 Copay
Tier 2 (Generic)	$12 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$8 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$12 Copay
Tier 2 (Generic)	$36 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Standard Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$4 Copay
Tier 2 (Generic)	$8 Copay
Tier 3 (Preferred Brand)	$47 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$8 Copay
Tier 2 (Generic)	$16 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$12 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

SECTION II - SUMMARY OF BENEFITS

VIVA MEDICARE *Plus*

Preferred Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$39.50 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$20 Copay
Tier 3 (Preferred Brand)	$78.50 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	42% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

VIVA MEDICARE *Prime*

Preferred Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$39.50 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$20 Copay
Tier 3 (Preferred Brand)	$78.50 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$24 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	41% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

VIVA MEDICARE *Premier*

Preferred Mail Order

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$7 Copay
Tier 3 (Preferred Brand)	$39.50 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$13.50 Copay
Tier 3 (Preferred Brand)	$78.50 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$16 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	47% Coinsurance
Tier 5 (Specialty Tier)	Not Applicable

SECTION II - SUMMARY OF BENEFITS	VIVA MEDICARE *Plus*	VIVA MEDICARE *Prime*	VIVA MEDICARE *Premier*
	Your cost-sharing may be different if you use a Long Term Care pharmacy or an out-of-network pharmacy. Please call us or see the plan's "**Evidence of Coverage**" on our website (www.VivaHealth.com/ Medicare/Member-Resources) for complete information about your costs for covered drugs.	Your cost-sharing may be different if you use a Long Term Care pharmacy or an out-of-network pharmacy. Please call us or see the plan's "**Evidence of Coverage**" on our website (www.VivaHealth.com/ Medicare/Member-Resources) for complete information about your costs for covered drugs.	Your cost-sharing may be different if you use a Long Term Care pharmacy or an out-of-network pharmacy. Please call us or see the plan's "**Evidence of Coverage**" on our website (www.VivaHealth.com/ Medicare/Member-Resources) for complete information about your costs for covered drugs.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $2,000, you pay $0 for covered brand name and generic drugs.	After your yearly out-of-pocket drug costs reach $2,000, you pay $0 for covered brand name and generic drugs.	After your yearly out-of-pocket drug costs reach $2,000, you pay $0 for covered brand name and generic drugs.

DISCLAIMERS

[1]The $20 Part B Premium Buy-Down benefit is available on the *Plus* plan in the following service area: Baldwin, Bibb, Blount, Chambers, Dale, Dallas, Geneva, Henry, Houston, Jefferson, Lee, Mobile, Montgomery, Shelby, St. Clair, Talladega, Tuscaloosa, and Walker Counties. The $2 Part B Premium Buy-Down benefit is available on the *Plus* plan in the following service area: Autauga, Bullock, Calhoun, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Elmore, Etowah, Fayette, Franklin, Lauderdale, Lowndes, Macon, Pike, and Tallapoosa Counties. [2]The $900 annual dental allowance is available on the *Plus* plan in the following service area: Baldwin, Bibb, Blount, Chambers, Dale, Dallas, Geneva, Henry, Houston, Jefferson, Lee, Mobile, Montgomery, Shelby, St. Clair, Talladega, Tuscaloosa, and Walker Counties. The $835 annual dental allowance is available on the *Plus* plan in the following service area: Autauga, Bullock, Calhoun, Cherokee, Chilton, Colbert, Crenshaw, Cullman, Elmore, Etowah, Fayette, Franklin, Lauderdale, Lowndes, Macon, Pike, and Tallapoosa Counties This information is not a complete description of benefits. Call 1-888-830-8482 (TTY users dial 711) for more information. The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. VIVA MEDICARE is an HMO plan with a Medicare contract and a contract with the Alabama Medicaid Agency. Enrollment in VIVA MEDICARE depends on contract renewal. VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, color, national origin, age, disability, religion, or sex (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-830-8482 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-888-830-8482 (TTY: 711).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-830-8482 (TTY: 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.VivaHealth.com/Medicare/Member-Resources or call 1-888-830-8482 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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

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.

Portuguese: 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。