

SUMMARY OF *BENEFITS* 2027

January 1, 2027 – December 31, 2027



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

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 March 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 Classic**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **VIVA MEDICARE Classic** covers and what you pay.

- If you want to compare our plan 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 Classic**.
- 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).

Things to Know About **VIVA MEDICARE Classic**

Hours of Operation & Contact Information

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

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 March 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

Who can join?

To join **VIVA MEDICARE Classic**, 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 includes these counties in Alabama: Jackson, Limestone, Madison, Marshall, and Morgan.

Which doctors, hospitals, and pharmacies can I use?

VIVA MEDICARE Classic has 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.

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: Deductible, Initial Coverage, and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact
VIVA MEDICARE.**

SECTION II - SUMMARY OF BENEFITS

VIVA MEDICARE *Classic*

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	You do not pay a separate monthly plan premium for VIVA MEDICARE <i>Classic</i> . You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$450 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • \$9,250 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	<u>In-Network:</u> Days 1-4: \$385 Copay per day for each admission. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.
Outpatient Hospital	<u>In-Network:</u> Outpatient hospital: \$425 Copay. Outpatient observation: \$385 Copay. Medicare-covered colonoscopies: \$0 Copay. May require prior authorization.
Ambulatory Surgical Center	<u>In-Network:</u> Ambulatory Surgical Center: \$0 Copay. May require prior authorization.
Doctor's Office Visits	<u>In-Network:</u> Primary care provider (PCP) visit: \$0 Copay. Specialist visit: \$45 Copay (\$30 for Podiatry; \$0 for a specialist visit in a Skilled Nursing Facility).

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Preventive Care (e.g., flu vaccine, diabetic screenings)	<u>In-Network:</u> 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	<u>In-Network:</u> \$115 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: \$115 Copay. Worldwide emergency coverage outside the U.S. and its territories is limited to \$50,000 and does not include transportation.
Urgently Needed Services	<u>In-Network:</u> Medicare-covered urgently needed service from a PCP: \$0 Copay per visit. Medicare-covered urgently needed service from a specialist: \$45 Copay per visit. Medicare-covered urgently needed service from an urgent care clinic/facility: \$40 Copay per visit.
Diagnostic Services/ Labs/Imaging	<u>In-Network:</u> 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): \$0 - \$300 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.

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Hearing Services	<u>In-Network:</u> Exam to diagnose and treat hearing and balance issues: \$0 - \$35 Copay. Routine hearing exam (up to 1 visit per year): \$0 - \$35 Copay. Hearing Aids: Must be purchased through NationsHearing. <u>Over-the-counter (OTC) hearing aids</u>: Sold as a pair (member cost range is \$750 - \$2,850). <u>Prescription hearing aids</u>: 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	<u>In-Network:</u> 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 <i>Classic</i> also covers up to \$800 for preventive, diagnostic, and comprehensive dental benefits per year. You pay anything over \$800.
Vision Services	<u>In-Network:</u> Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 - \$35 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 \$125 for additional prescription eyewear (glasses, contacts, lenses, frames, and upgrades) and contact lens fitting exam once per calendar year.
Mental Health Care	<u>In-Network:</u> Outpatient group therapy visit: \$35 Copay. Individual therapy visit: \$35 Copay. Inpatient Mental Health Care: Days 1-4: \$385 Copay per day for each admission. Days 5-90: \$0 Copay per day. May require prior authorization.

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Skilled Nursing Facility (SNF)	<u>In-Network:</u> Days 1-20: \$0 Copay per day. Days 21-63: \$218 Copay per day. Days 64-100: \$0 Copay per day. May require prior authorization.
Outpatient Rehabilitation	<u>In-Network:</u> Occupational therapy visit: \$35 Copay. Physical therapy and speech and language therapy visit: \$35 Copay.
Ambulance	<u>In-Network:</u> Ground Ambulance: \$275 Copay per one-way trip. Air Ambulance: \$275 Copay per one-way trip. May require prior authorization.
Non-Emergency Transportation	<u>In-Network:</u> Not Covered.
Medicare Part B Drugs	<u>In-Network:</u> 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.
Telehealth Services	Plan covers telehealth services for PCP and certain specialist visits, urgently needed services, and outpatient mental health, substance use, 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.
Over-the-Counter (OTC) Drugs and Other Health-Related Items	Plan provides a \$30 allowance per calendar quarter that can be used for approved over-the-counter items by mail order through NationsBenefits.

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Fitness

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: \$450 for Tier 3, Tier 4, and Tier 5 drugs. The deductible does not apply to Tier 1 and Tier 2 drugs.

Initial Coverage

You pay the following until your yearly out-of-pocket drug costs reach \$2,400.

Retail Cost-Sharing

Tier	30-day supply	60-day supply	100-day supply
Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2 (Generic)	\$12 Copay	\$24 Copay	\$30 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	42% Coinsurance	42% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	28% Coinsurance	Not Applicable	Not Applicable

Standard Mail Order

Tier	30-day supply	60-day supply	100-day supply
Tier 1 (Preferred Generic)	\$4 Copay	\$8 Copay	\$12 Copay
Tier 2 (Generic)	\$12 Copay	\$24 Copay	\$36 Copay
Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance	20% Coinsurance
Tier 4 (Non-Preferred Drug)	42% Coinsurance	42% Coinsurance	42% Coinsurance
Tier 5 (Specialty Tier)	28% Coinsurance	Not Applicable	Not Applicable

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	Preferred Mail Order			
	Tier	30-day supply	60-day supply	100-day supply
	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	\$0 Copay
	Tier 2 (Generic)	\$10 Copay	\$20 Copay	\$24 Copay
	Tier 3 (Preferred Brand)	20% Coinsurance	20% Coinsurance	20% Coinsurance
	Tier 4 (Non-Preferred Drug)	42% Coinsurance	42% Coinsurance	42% Coinsurance
	Tier 5 (Specialty Tier)	28% Coinsurance	Not Applicable	Not Applicable
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 \$2,400, you pay \$0.			

DISCLAIMERS

Other Physicians/Providers are available in our network. 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.

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

- ☐ 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, 2028.
- ☐ 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.



Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English (English)

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-633-1542 (TTY: 711) or speak to your provider.

Español (Spanish)

ATENCION: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-633-1542 (TTY: 711) o hable con su proveedor.

中文 (Traditional Chinese)

注意：如果您說中文 (Chinese)，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-633-1542 (TTY : 711) 或與您的提供者討論。

中文 (Simplified Chinese)

注意：如果您說中文 (Chinese)，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-633-1542 (文本电话：711) 或咨询您的服务提供商。

한국어 (Korean)

주의: 한국어 (Korean) 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-633-1542 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Việt (Vietnamese)

LƯU Ý: Nếu bạn nói tiếng Việt (Vietnamese), chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-633-1542 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية (Arabic)، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-633-1542 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch (German) sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-633-1542 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Français (French)

ATTENTION : Si vous parlez Français (French), des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-633-1542 (TTY : 711) ou parlez à votre fournisseur.

ગુજરાતી (Gujarati)

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓકિઝવરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-633-1542 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Tagalog (Tagalog)

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-633-1542 (TTY: 711) o makipag-usap sa iyong provider.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-633-1542 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ລາວ (Lao)

ເລື່ອງສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາ ລາວ (Lao), ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາຕື 1-800-633-1542 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

РУССКИЙ (Russian)

ВНИМАНИЕ: Если вы говорите на русский (Russian), вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-633-1542 (TTY: 711) или обратитесь к своему поставщику услуг.

Português (Portuguese)

ATENÇÃO: Se você fala português (Portuguese), serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-633-1542 (TTY: 711) ou fale com seu provedor.

Türkçe (Turkish)

DİKKAT: Türkçe (Turkish) konuşuyorsanız, ücretsiz dil yardım hizmetleri sizin için mevcuttur. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak mevcuttur. 1-800-633-1542 (TTY: 711) numarasını arayın veya sağlayıcınızla görüşün.

日本語 (Japanese)

注：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-633-1542（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。