MVP DualAccess (HMO D-SNP) offered by MVP Health Plan, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of MVP DualAccess (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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 **mvphealthcare.com.** You may also call the MVP Member Services/Customer Care Center to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in MVP DualAccess (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with MVP DualAccess (HMO D-SNP).
- Look in section 3, page 13 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact the MVP Member Services/Customer Care Center number at 1-866-954-1872 for additional information. (TTY users should call 711.) Hours are Monday -Friday,

8am – 8pm Eastern Time. From October 1st – March 31st, call us seven days a week, 8am – 8pm. This call is free.

- This information is available in a different format, including braille and large print (phone numbers are available in Section 7 of this booklet).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) indi vidual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About MVP DualAccess (HMO D-SNP)

- MVP Health Plan is an HMO-POS/PPO/HMO D-SNP organization with a Medicare contract and a contract with New York State Medicaid program. Enrollment in MVP DualAccess (HMO D-SNP) depends on contract renewal.
- When this document says "we," "us," or "our," it means MVP HEALTH PLAN, INC. When it says "plan" or "our plan," it means MVP DualAccess (HMO D-SNP).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for MVP DualAccess (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *See Section 2.1 for details.	$0	$0
Doctor office visits	**Primary care visits:** You pay a $0 copayment per visit. **Specialist visits:** You pay a $0 copayment per visit.	**Primary care visits:** You pay a $0 copayment per visit. **Specialist visits:** You pay a $0 copayment per visit.
Inpatient hospital stays	You pay a $0 copayment per Medicare covered hospital stay.	You pay a $0 copayment per Medicare covered hospital stay.
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment as applicable during the Initial Coverage Stage: You pay a $0 copayment for all covered Part D drugs.	Deductible: $0 Copayment as applicable during the Initial Coverage Stage: You pay a $0 copayment for all covered Part D drugs.
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details)	$0 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket	$0 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket

Cost	2024 (this year)	2025 (next year)
	amount for covered Part A and Part B services.	amount for covered Part A and Part B services.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MVP DualAccess (HMO D-SNP) in 2025

If you do nothing in 2024, we will automatically enroll you in our MVP DualAccess (HMO D-SNP). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through **MVP DualAccess (HMO D-SNP)**. If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2025.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 2.2 – 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 Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays count toward your maximum out-of-pocket amount.	$0 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$0 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at **mvphealthcare.com**. You may also call the MVP Member Services/Customer Care Center for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory mvphealthcare.com/findadoctor* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* on mvphealthcare.com to see which pharmacies are in our network**.

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

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

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

Cost	2024 (this year)	2025 (next year)
Dental Services – Preventive and Comprehensive	Annual Maximum Plan Benefit Coverage Amount: $2,000 combined Preventive and Comprehensive services, per calendar year for benefits (services above the limit are your responsibility). Preventive Dental: (Oral Exams, Prophylaxis, Fluoride, X-Rays) You pay a $0 copayment. Comprehensive Dental: (Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, Oral/Maxillofacial Surgery, Other Services) You pay a $0 copayment. Payment limited to established Fee Schedule. Benefit available through in-network providers only. See the Evidence of Coverage for more information.	Preventive Dental: (Oral Exams, Prophylaxis, Fluoride, X-Rays, Other Preventive Dental Services) You pay a $0 copayment. Comprehensive Dental: (Restorative Services, Endodontics, Periodontics, Prosthodontics, Maxillofacial Prosthetics, Implant Services, Oral and Maxillofacial Surgery, Adjunctive General Services) You pay a $0 copayment. Service limitations apply based on established fee schedule, including type of service, number and frequency. Benefit available through in-network providers only. See the Evidence of Coverage for more information.

Cost	2024 (this year)	2025 (next year)
Over-the-counter (OTC)	$75 allowance per quarter. Allowance is received quarterly to be used towards eligible over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from quarter to quarter.	$150 flexible benefit allowance per month. Monthly allowance can be used towards eligible over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from month to month. The monthly allowance is a combined benefit with the VBID Additional Benefits - Food and Produce and General Supports for Living. See "VBID Additional Benefits - Food and Produce and General Supports for Living Flexible Benefit Card" in this section for further information.
Chronic Condition Food and Produce Benefit	Customers with an eligible chronic condition receive an allowance of $75 per month towards the purchase of food and produce through the plan approved vendor and/or retail location(s). Food and produce is restricted to vendor catalog offerings and are home delivered to the members residence, or through an approved retail location. Unused allowance does not rollover to the next month.	See "VBID Additional Benefits - Food and Produce and General Supports for Living Flexible Benefit Card" in this section for further information.

Cost	2024 (this year)	2025 (next year)
VBID Additional Benefits - Food and Produce and General Supports for Living Flexible Benefit Card	Not covered	$150 flexible benefit allowance per month. Allowance can be used towards the purchase of food and produce through the plan approved vendor and/or retail location(s), or for utility payments for electricity, water, heat, internet and/or telephone. Allowance amount does not carry over from month to month. This is a combined benefit with the Over-the-Counter (OTC) monthly allowance. See the Evidence of Coverage for more information. *Medicare approved MVP Health Plan, Inc. to provide these benefits as part of the Value-Based Insurance Design Program. This program lets Medicare try new ways to improve Medicare Advantage plans.*

Section 2.5 – 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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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

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

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

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

Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately add new restrictions.

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

Changes to Prescription Drug Benefits and Costs

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

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

Changes to the Deductible Stage	2024 (this year)	2025 (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	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: $0 You pay a $0 copayment for all covered Part D drugs. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: $0 You pay a $0 copayment for all covered Part D drugs. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

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

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Sections 6 in your *Evidence of Coverage.*

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MVP DualAccess (HMO D-SNP)

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 our MVP DualAccess (HMO D-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

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

As a reminder, MVP Health Plan, 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 MVP DualAccess (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MVP DualAccess (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact the MVP Member Services/Customer Care Center if you need more information on how to do so.

- – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have New York Medicaid, you may be able to end your membership in our plan any month of the year. You also have the option to enroll in another Medicare plan any month including:

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

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

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

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. HIICAP 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 HIICAP at 1-800-701-0501.

For questions about your New York Medicaid benefits, contact 1-800-541-2831. TTY users should call 711. Ask how joining another plan or returning to Original Medicare affects how you get your New York Medicaid coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, 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.
- **Help from your state's pharmaceutical assistance program.** New York has a program called Elderly Pharmaceutical Insurance Coverage Program (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York State Department of Health HIV Uninsured Care Programs. For information on eligibility criteria, covered

drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call New York State Department of Health HIV Uninsured Care Programs at **1-800-542-2437**. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

SECTION 7 Questions?

Section 7.1 – Getting Help from MVP DualAccess (HMO D-SNP)

Questions? We're here to help. Please call the MVP Member Services/Customer Care Center at 1-866-954-1872. (TTY only, call 711) We are available for phone calls Monday - Friday, 8 am - 8 pm Eastern Time. From Oct. 1 - Mar. 31, call us seven days a week, 8 am - 8 pm. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for MVP DualAccess (HMO D-SNP). 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 **mvphealthcare.com**. You may also call the MVP Member Services/Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **mvphealthcare.com**. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List).*

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

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

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid you can call New York Medicaid at 1-800-541-2831. TTY users should call 711.