VNS Health Total (HMO D-SNP) offered by VNS Health Medicare

Annual Notice of Changes for 2024

You are currently enrolled as a member of VNS Health Total. 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 you 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 vnshealthplans.org/2024-total. You may also call us 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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care 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 2024* 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, 2023 you will stay in VNS Health Total.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with VNS Health Total.
- Look in Section 4.2, page 17 to learn more about your choices.
- 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

- This document is available for free in Spanish and Chinese.

  Este documento está disponible sin cargo en inglés y chino.

  本文件免費提供英文和西班牙文版本。

- Please contact your Care Team at 1-866-783-1444 (TTY: 711) for additional information. Hours are 7 days a week, 8 am – 8 pm (Oct. – Mar.), and weekdays, 8 am – 8 pm (Apr. – Sept.). This call is free.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8 pm (Oct. – Mar.), and weekdays, 8 am – 8 pm (Apr. – Sept.).

- **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 VNS Health Total

- VNS Health Medicare is a Medicare Advantage Organization with Medicare and Medicaid contracts, offering HMO D-SNP and HMO plans. Enrollment in VNS Health Medicare depends on contract renewal.
- When this document says "we," "us," or "our," it means VNS Health Health Plans. When it says "plan" or "our plan," it means VNS Health Total.

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Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for VNS Health Total 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	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0 plan premium	$0 plan premium
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $0 copayment per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: $0 copayment per visit Specialist visits: $0 copayment per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.
Inpatient hospital stays	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 No copayment/coinsurance during the Initial Coverage Stage for generic, brand name, and specialty drugs. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: $0 No copayment/coinsurance during the Initial Coverage Stage for generic, brand name, and specialty drugs. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
Maximum out-of-pocket amount 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 If you are eligible for Medicare cost-sharing assistance under Medicaid, 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 If you are eligible for Medicare cost-sharing assistance under Medicaid, 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 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in VNS Health Total in 2024

If you do nothing in 2023, we will automatically enroll you in VNS Health Total. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through VNS Health Total. 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, 2024.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	No change. $0 premium	No change. $0 premium

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	2023 (this year)	2024 (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.** If you are eligible for Medicaid assistance with Part A and Part B copays 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. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$0	$0 Once you have paid $0 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at vnshealthplans.org/providers. You may also call your Care Team for updated provider and/or pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the *2024 Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, hospice providers etc.) 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 your Care Team 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 and Medicaid benefits and costs.

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

Cost	2023 (this year)	2024 (next year)
Acupuncture	You pay $0 copay per visit, up to 30 visits per year. Requires prior authorization.	You pay $0 copay per visit, up to 30 visits per year. No prior authorization required.

Cost	2023 (this year)	2024 (next year)
Flex	A $750 pre-loaded debit card benefit for the year. During the first quarter of the year (January – March), you may use up to $187.50 to pay for eligible items or services. From April – December, you may use $62.50 per month to pay for eligible items or services. The card balance rolls over after each accrual period but must be used by the end of the calendar year (January 1, 2023, through December 31, 2023.) See your Member Handbook (*Evidence of Coverage*) for more information.	A $760 pre-loaded debit card benefit for the year. During the first quarter of the year (January – March), you may use up to $193 to pay for eligible items or services. From April – December, you may use $63 per month to pay for eligible items or services. The card balance rolls over after each accrual period but must be used by the end of the calendar year (January 1, 2024, through December 31, 2024.) The benefit card may be used to help pay for certain utilities (electric, gas, internet, and phone). The benefit card may also be used to cover items or services above the maximum covered amount for Dental (Diagnostic and Restorative Dental Services; Prosthodontics, Other Maxillofacial Surgery), Hearing (Hearing Aids - all types); or Vision (Eyeglasses - lenses and frames). Other types of services and goods are not eligible. See your Member Handbook (*Evidence of Coverage* for more information.)

Cost	2023 (this year)	2024 (next year)
Hearing	2 supplemental hearing aids every three years. $1,500 plan coverage limit for supplemental hearing aids limited to $750 per year (one right, one left) every three years. Requires prior authorization.	2 supplemental hearing aids every three years. $1,500 plan coverage limit for supplemental hearing aids limited to $750 per year (one right, one left) every three years. No prior authorization required.

Cost	2023 (this year)	2024 (next year)
Hospice care	$0 copay Transitional Concurrent Care timeframe: If you are eligible for hospice, and elect hospice, you may be eligible for Transitional Concurrent Care (TCC). TCC are services necessary to address continuing care needs, as medically appropriate, for the treatment of your terminal condition. These services help provide a transition to hospice care and may include a phasing out of specific curative treatment over time. TCC requires prior authorization and is available for up to **one month** after electing hospice, only if you elect an in-network hospice provider. See your Member Handbook (*Evidence of Coverage*) for more information on the full list of services covered by the plan.	$0 copay Transitional Concurrent Care timeframe: If you are eligible for hospice, and elect hospice, you may be eligible for Transitional Concurrent Care (TCC). TCC are services necessary to address continuing care needs, as medically appropriate, for the treatment of your terminal condition. These services help provide a transition to hospice care and may include a phasing out of specific curative treatment over time. TCC requires prior authorization and is available for up to **60 days** after electing hospice, only if you elect an in-network hospice provider. See your Member Handbook (*Evidence of Coverage*) for more information on the full list of services covered by the plan.

Cost	2023 (this year)	2024 (next year)
Meals (Post-Discharge)	Meals benefit is not covered.	You can use this benefit to have meals delivered to your home after an acute inpatient hospital discharge. You are covered for 28 meals over a 2-week period up to 3 inpatient hospital visits a year. Requires prior authorization. See your Member Handbook (*Evidence of Coverage* for more information.)
Over-the-Counter (OTC) and Grocery Card	$0 copay You are covered for up to $232 per month for over-the-counter items and grocery items. You can also use this benefit to have meals or fresh produce delivered to your home. No prior authorization required. The grocery benefit is a part of special supplemental program for the chronically ill and not all members qualify.	$0 copay You are covered for up to $266 per month for over-the-counter items and grocery items. You can also use this benefit to have meals or fresh produce delivered to your home. No prior authorization required. The grocery benefit is a part of special supplemental program for the chronically ill and not all members qualify.
Routine Podiatry	You pay a $0 copay per visit, up to 6 visits per year. Requires prior authorization.	You pay a $0 copay per visit, up to 6 visits per year. No prior authorization required.

Cost	2023 (this year)	2024 (next year)
Vision	You pay a $0 copay. • 1 Routine eye exam per year. • 1 Eye exam for glasses every 2 years. A routine eye exam is to check vision, screen for eye disease, and/or update eyeglass or contact lens prescriptions.	You pay a $0 copay. • 1 Routine eye exam per year. • 1 Additional routine eye exam every 2 years. A routine eye exam is to check vision, screen for eye disease, and/or update eyeglass or contact lens prescriptions.

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. An updated formulary is located on our website at vnshealthplans.org/formulary. You may also call your Care Team at 1-866-783-1444 (TTY: 711) for updated drug information or to ask us to mail you a formulary.

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, 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 your Care Team 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 your Care Team 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.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **For generic drugs** (including brand drugs treated as generic): You pay: $0 copay **For all other drugs:** You pay: $0 copay *Specialty Drugs are limited to a 30-day supply.* Once your total drug costs have reached $4,660, 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: **For generic drugs** (including brand drugs treated as generic): You pay: $0 copay **For all other drugs**: You pay: $0 copay *Specialty Drugs are limited to a 30-day supply.* Once your total drug costs have reached $5,030 you will move to the next stage (the Coverage Gap Stage).
Standard Retail and Mail Order Supply	Multi-tier Formulary. 90-day supply for all tiers, except Tier 5 Specialty drugs.	Single-tier Formulary. 100-day supply for all drugs, except Specialty drugs.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2023 (this year)	2024 (next year)
Member Rewards Program	The member rewards program has activities and reward amounts effective January 1, 2023 - December 31, 2023.	The member rewards program will have new activities and reward amounts effective January 1, 2024. Details will be mailed in December.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in VNS Health Total

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 VNS Health Total.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from VNS Health Total.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from VNS Health Total.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact your Care Team 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 5 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, 2024.

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 or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

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 coverage) at any time.

SECTION 6 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 and 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. You can learn more about HIICAP by visiting their website (https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap).

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

SECTION 7 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, annual 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 (applications).
- **Help from your state's pharmaceutical assistance program.** New York has a program called Elderly Pharmaceutical Insurance Coverage (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. 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 HIV Uninsured programs. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

SECTION 8 Questions?

Section 8.1 – Getting Help from VNS Health Total

Questions? We're here to help. Please call your Care Team at 1-866-783-1444 (TTY: 711). We are available for phone calls 7 days a week, 8 am – 8 pm (Oct. – Mar.), and weekdays, 8 am – 8 pm (Apr. – Sept.). Calls to these numbers are free.

Read your *2024 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 2024. For details, look in the 2024 *Evidence of Coverage* for VNS Health Total. 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 vnshealthplans.org/2024-total. You may also call your Care Team to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 8.2 – 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 2024*

Read the *Medicare & You 2024* 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 8.3 – Getting Help from Medicaid

To get information from Medicaid, you can call New York Medicaid Program at 1-800-541-2831 (TTY: 711).