MVP Medicare Preferred Gold with Part D (HMO-POS) offered by MVP Health Plan, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of MVP Medicare Preferred Gold with Part D (HMO-POS). 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 Medicare Customer Care Center to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

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

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

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

☐ Check to see if your 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 2023* handbook.

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

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

- If you don't join another plan by December 7, 2022, you will stay in MVP Medicare Preferred Gold with Part D (HMO-POS).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with MVP Medicare Preferred Gold with Part D (HMO-POS).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact the MVP Medicare Customer Care Center at **1-800-665-7924** for additional information. (TTY users should call 711.) Hours are Monday - Friday, 8 am - 8 pm Eastern Time. From Oct. 1 - Mar. 31, call us seven days a week, 8 am - 8 pm.
- This information is available in a different format, including braille and large print. (phone numbers are 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) 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 MVP Medicare Preferred Gold with Part D (HMO-POS)

- MVP Medicare Preferred Gold with Part D (HMO-POS) is an HMO-POS plan with a Medicare contract. Enrollment in MVP Medicare Preferred Gold with Part D (HMO-POS) 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 Medicare Preferred Gold with Part D (HMO-POS).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for MVP Medicare Preferred Gold with Part D (HMO-POS) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$211	$211
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.)	$7,550	$6,500
Doctor office visits	**Primary care visits:** In-network: You pay a $0 copayment per visit. Out-of-network: You pay 30% coinsurance of the total cost per visit. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.	**Primary care visits:** In-network: You pay a $0 copayment per visit. Out-of-network: You pay 30% coinsurance of the total cost per visit. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.

Cost	2022 (this year)	2023 (next year)
Doctor office visits (continued)	**Specialist visits:** In-network: You pay a $40 copayment per visit. Out-of-network: You pay 30% coinsurance of the total cost per visit. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.	**Specialist visits:** In-network: You pay a $40 copayment per visit. Out-of-network: You pay 30% coinsurance of the total cost per visit. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.
Inpatient hospital stays	In-network: You pay a $365 copayment per day for days 1 through 5. You pay a $0 copayment for days 6+. Out-of-network: You pay 30% coinsurance of the total cost. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.	In-network: You pay a $365 copayment per day for days 1 through 5. You pay a $0 copayment for days 6+. Out-of-network: You pay 30% coinsurance of the total cost. Once out-of-network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	There is no deductible for this plan. Copayment/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: • Drug Tier 1: $0 copayment. • Drug Tier 2: $10 copayment. • Drug Tier 3: $40 copayment. • Drug Tier 4: 27% coinsurance. • Drug Tier 5: 33% coinsurance.	There is no deductible for this plan. Copayment/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: • Drug Tier 1: $0 copayment. • Drug Tier 2: $10 copayment. • Drug Tier 3: $40 copayment. • Drug Tier 4: 26% coinsurance. • Drug Tier 5: 33% coinsurance. • Plan-covered Insulin: $35 copayment.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MVP Medicare Preferred Gold with Part D (HMO-POS) in 2023

If you do nothing by December 7, 2022, we will automatically enroll you in our MVP Medicare Preferred Gold with Part D (HMO-POS). This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through MVP Medicare Preferred Gold with Part D (HMO-POS). If you want to change plans or switch to Original Medicare you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefit and Cost for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$211	$211
Optional Supplemental Dental Benefit (Monthly premium)	$25	Comprehensive Dental benefits are now included at no additional premium.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550	$6,500 Once you have paid $6,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B 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 **mvphealthcare.com**. You may also call the MVP Medicare Customer Care Center for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

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

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

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

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Emergency Services	You pay a $90 copayment for each emergency room visit. Copayment also applies to worldwide emergency and worldwide urgent care visits.	You pay a $95 copayment for each emergency room visit. Copayment also applies to worldwide emergency and worldwide urgent care visits.
Hearing Services	Up to two TruHearing branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. TruHearing Advanced - $499 copayment per hearing aid TruHearing Premium - $799 copayment per hearing aid Hearing aid purchases includes: • 3 provider visits within first year of hearing aid purchase • 60-day trial period • 3-year extended warranty	Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for no additional cost. You must see a TruHearing provider to use this benefit. TruHearing Advanced - $699 copayment per hearing aid TruHearing Premium - $999 copayment per hearing aid -OR-

Cost	2022 (this year)	2023 (next year)
Hearing Services (continued)	• 80 batteries per aid Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Extra batteries • Hearing aids that are not the TruHearing branded hearing aids • Hearing aid return fees • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. Hearing aid copayments are not subject to the maximum out-of-pocket.	Up to $600 toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog every year (limit 1 hearing aid per ear). After the plan-paid benefit, you are responsible for the remaining costs in excess of the allowance. Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 3-year supply of batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries, batteries when a rechargeable hearing aid is purchased • Hearing aids that are not in the applicable TruHearing product formulary

Cost	2022 (this year)	2023 (next year)
Hearing Services (continued)		• Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. Costs you pay for hearing services, including routine hearing exam copayments and hearing aid copayments or costs, will not count toward or be subject to your out-of-pocket maximum.
Joint Replacement Care Kit	Not covered.	Customers who have a prior authorization or have undergone a joint replacement within the plan year with a diagnosis of Rheumatoid Arthritis or Osteoarthritis, can receive a customizable care kit with items such as, but not limited to, a reacher, shoehorn, non-slip bathmat, tieless shoelaces, and long handled shower sponge through our approved contracted vendor.

Cost	2022 (this year)	2023 (next year)
Preventive and Comprehensive Dental	**Preventive Dental:** You pay $0, benefit is limited to 2 oral exams, 2 cleanings, and 2 sets of x-rays per calendar year. Payments are limited to an established fee schedule. Services above the limit are your responsibility. **Comprehensive Dental:** Not covered.	**Preventive Dental:** You pay $0, benefit is limited to 2 oral exams, 2 cleanings, and 2 sets of x-rays per calendar year. Payments are limited to an established fee schedule. Services above the limit are your responsibility. **Comprehensive Dental:** Benefit is limited to a maximum of $1,000 per calendar year for in-network and out-of-network benefits. There is a $100 deductible per calendar year. You pay $0 for Emergency Dental, not subject to the deductible. You pay 20% of the allowed amount after the deductible for routine dental (exams, x-rays, simple extractions, fillings) for in-network and out-of-network. You pay 50% of the allowed amount after the deductible for oral surgery for in-network and out-of-network.

Cost	2022 (this year)	2023 (next year)
Preventive and Comprehensive Dental (continued)		You pay 50% of the allowed amount after the deductible for endodontics (root canals), Periodontics, Prosthodontics (partial dentures, crowns) in-network and out-of-network. Orthodontics is not a covered benefit.
Skilled Nursing Facility	You pay a $0 copayment for days 1-20. You pay a $188 copayment per day for days 21-100 in-network.	You pay a $0 copayment for days 1-20. You pay a $196 copayment per day for days 21-100 in-network.
Step Therapy	Step therapy is not required for Medicare Part B prescription drugs.	Step therapy applies to Medicare Part B prescription drugs. Step therapy means that you may be required to try a different, less expensive drug that treats the same condition before we will cover a more expensive drug.

Cost	2022 (this year)	2023 (next year)
Telehealth Services	You pay a $0 copayment for telehealth services through the plan approved virtual care provider for the following services. • Emergency care/post-stabilization services • Urgent Care • Individual sessions for mental health and psychiatry specialty services • Nutrition consultation • Physical therapy • Occupational therapy	You pay a $0 copayment for telehealth services through the plan approved virtual care provider for the following services. • Emergency care/post-stabilization services • Urgent Care • Individual sessions for mental health and psychiatry specialty services • Nutrition consultation
Transportation Services - Non-Medicare Covered	You pay a $0 copayment per ride. Maximum 12 one-way rides per year for medical appointments to health plan approved locations (30-mile one-way maximum per ride). Must use the plan-approved provider for transportation services.	You pay a $0 copayment per ride. Maximum 24 one-way rides per year for medical appointments to health plan approved locations (30-mile one-way maximum per ride). Must use the plan-approved provider for transportation services.
Urgently Needed Services	You pay a $65 copayment for each urgent care visit.	You pay a $60 copayment for each urgent care visit.

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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact the MVP Medicare Customer Care Center 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 may not apply to you.** We sent you 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 you haven't received this insert by September 30, 2022, please call the MVP Medicare Customer Care Center 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	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy 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: **Tier 1- Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2- Generic Drugs:** You pay $10 per prescription. **Tier 3- Preferred Brand Drugs:** You pay $40 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1- Preferred Generic Drugs:** You pay $0 per prescription. **Tier 2- Generic Drugs:** You pay $10 per prescription. **Tier 3- Preferred Brand Drugs:** You pay $40 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued) We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Tier 4- Non-Preferred Drugs:** You pay 27% of the total cost. **Tier 5- Specialty Drugs:** You pay 33% of the total cost. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Tier 4- Non-Preferred Drugs:** You pay 26% of the total cost. **Tier 5- Specialty Drugs:** You pay 33% of the total cost. **Plan-covered Insulin:** You pay $35 per prescription. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call the MVP Medicare Customer Care Center for more information.

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

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800- MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY 711) for additional information. Representatives are available seven days a week from 8 am-8 pm Eastern Time between October 1 and

March 31. From April 1 through September 30, representatives are available Monday through Friday from 8 am-8 pm Eastern Time.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MVP Medicare Preferred Gold with Part D (HMO-POS)

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 Medicare Preferred Gold with Part D (HMO-POS).

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 for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 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 Medicare Preferred Gold with Part D (HMO-POS).

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MVP Medicare Preferred Gold with Part D (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact the MVP Medicare 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.

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, 2023.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In 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**.

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.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 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 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. 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, or how to enroll in the program, please call **1-800-542-2437**.

SECTION 7 Questions?

Section 7.1 – Getting Help from MVP Medicare Preferred Gold with Part D (HMO-POS)

Questions? We're here to help. Please call the MVP Medicare Customer Care Center at **1-800-665-7924**. (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 *2023 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for MVP Medicare Preferred Gold with Part D (HMO-POS). 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 Medicare 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 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet 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.

MVP HEALTH CARE
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February 28, 2023

Member Notice

Changes to Medicare Part B Due to the Inflation Reduction Act

The Inflation Reduction Act, signed in August of 2022, affects the cost of drugs covered under Medicare Part B in two ways:

- Beginning April 1, 2023, the Centers for Medicare and Medicaid Services will review the price of certain Part B drugs each quarter. If your plan has a co-insurance for Part B drugs, what you pay for your prescription could change quarterly based on the cost of the drug. Your co-insurance will never exceed 20%.
- Beginning July 1, 2023, the cost-share for insulin covered by Part B will not exceed $35 for a one-month supply.

If you have any questions, please call the MVP Medicare Customer Care Center at the phone number on the back of your MVP Member ID card.