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

Annual Notice of Changes for 2023

You are currently enrolled as a member of MVP DualAccess with Part D (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 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 DualAccess with Part D (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, 2023.** This will end your enrollment with MVP DualAccess with Part D (HMO D-SNP).
- Look in section 3.2, page 16 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.
- Please contact our MVP Member Services/Customer Care Center number at **1-866-954-1872** 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 DualAccess with Part D (HMO D-SNP)

- MVP Health Plan, Inc. is an HMO-POS/PPO/HMO D-SNP organization with a Medicare contract and a contract with the New York State Medicaid program. Enrollment in MVP Health Plan 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 with Part D (HMO D-SNP).

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Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for MVP DualAccess with Part D (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 New York Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. 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 2.6 for details.)	Your deductible amount is either $0 or $99, depending on the level of "Extra Help" you receive. Copayment/Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1**: $0.00, $1.35, $3.95 or 15% per prescription*	Your deductible amount is either $0 or $104, depending on the level of "Extra Help" you receive. Copayment/Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1**: $0.00, $1.45, $4.15 or 15% per prescription*

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)	• **Drug Tier 2**: $0.00, $1.35, $3.95 or 15% per prescription* • **Drug Tier 3**: For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription* • **Drug Tier 4**: For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription* • **Drug Tier 5**: For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription*	• **Drug Tier 2**: $0.00, $1.45, $4.15 or 15% per prescription* • **Drug Tier 3**: For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription* • **Drug Tier 4**: For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription* • **Drug Tier 5**: For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* • For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription*

Cost	2022 (this year)	2023 (next year)
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 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.

*The amount you pay is based on your level of "Extra Help"

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MVP DualAccess with Part D (HMO D-SNP) in 2023

If you do nothing in 2022, we will automatically enroll you in our MVP DualAccess with Part D (HMO D-SNP). This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through MVP DualAccess with Part D (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, 2023.

SECTION 2 Changes to Benefits and Costs 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 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 services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from New York 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 and deductibles) count toward your maximum out-of-pocket amount.	$0	$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

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.

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 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	2022 (this year)	2023 (next year)
Chronic Condition Food and Produce Benefit	Not covered.	Customers with an eligible chronic condition receive an allowance of $50 per month towards the purchase of food and produce through the plan approved vendor. Food and produce is restricted to vendor catalog offerings and are home delivered to the customers residence. Customer will attest to an eligible chronic condition to receive the food and produce benefit. Unused allowance does not rollover to the next month.

Cost	2022 (this year)	2023 (next year)
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 shoe laces and long handled shower sponge through our approved contracted vendor.
Routine Eyewear	Not covered.	Covered for eyeglasses, lenses, frames, and contact lenses. $200 maximum allowance per calendar year.

Cost	2022 (this year)	2023 (next year)
Preventive and 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. You pay no deductible and no cost share for the following covered services. • Diagnostic exams • X-rays • Simple extractions • Fillings • Oral surgery • Endodontics (root canals) • Periodontics • Prosthodontics (partial dentures, crowns) Orthodontics is not a covered benefit.

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

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 Member Services/Customer Care Center for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **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 Member Services/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 During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $99, depending on the level of "Extra Help" you receive.	Your deductible amount is either $0 or $104, depending on the level of "Extra Help" you receive.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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.** 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*. 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1- Preferred Generic Drugs:** $0.00, $1.35, $3.95 or 15% per prescription* **Tier 2- Generic Drugs:** $0.00, $1.35, $3.95 or 15% per prescription* **Tier 3- Preferred Brand Drugs:** For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription* **Tier 4- Non-Preferred Drugs:** For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription* **Tier 5- Specialty Drugs:** For generic drugs: $0.00, $1.35, $3.95 or 15% per prescription* For brand name drugs: $0.00, $4.00, $9.85 or 15% per prescription*	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1- Preferred Generic Drugs:** $0.00, $1.45, $4.15 or 15% per prescription* **Tier 2- Generic Drugs:** $0.00, $1.45, $4.15 or 15% per prescription* **Tier 3- Preferred Brand Drugs:** For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription* **Tier 4- Non-Preferred Drugs:** For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription* **Tier 5- Specialty Drugs:** For generic drugs: $0.00, $1.45, $4.15 or 15% per prescription* For brand name drugs: $0.00, $4.30, $10.35 or 15% per prescription*

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	_____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

*The amount you pay is based on your level of "Extra Help"

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MVP DualAccess with Part D (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 with Part D (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 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.

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 6), 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 with Part D (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 with Part D (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 Changing Plans

If you want to change to a different plan or 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 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 New York Medicaid at **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, 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 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 DualAccess with Part D (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 *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 DualAccess with Part D (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 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.

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.