



UVM Health Advantage Preferred (PPO) offered by MVP Health Plan, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of UVM Health Advantage Preferred (PPO). 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 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 UVM Health Advantage Preferred (PPO).
- 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 UVM Health Advantage Preferred (PPO).
- 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 our MVP Medicare Customer Care Center number 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 call is free.
- This information is available in a different format, including braille and large print. (phone numbers are in Section 8 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 UVM Health Advantage Preferred (PPO)

- UVM Health Advantage Preferred (PPO) is a PPO plan with a Medicare contract. Enrollment in UVM Health Advantage Preferred (PPO) 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 UVM Health Advantage Preferred (PPO).

Y0051_8496_M

Annual Notice of Changes for 2024

Table of Contents

Summary of Important Costs for 2024.....		5
SECTION 1	Unless You Choose Another Plan, You Will Be Automatically Enrolled in UVM Health Advantage Preferred (PPO)in 2024.....	7
SECTION 2	Changes to Benefits and Costs for Next Year.....	8
Section 2.1 – Changes to the Monthly Premium.....		8
Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts		9
Section 2.3 – Changes to the Provider and Pharmacy Networks.....		10
Section 2.4 – Changes to Benefits and Costs for Medical Services		10
Section 2.5 – Changes to Part D Prescription Drug Coverage		17
SECTION 3	Deciding Which Plan to Choose.....	21
Section 3.1 – If you want to stay in UVM Health Advantage Select (PPO).....		21
Section 3.2 – If you want to change plans.....		21
SECTION 4	Deadline for Changing Plans	22
SECTION 5	Programs That Offer Free Counseling about Medicare.....	22
SECTION 6	Programs That Help Pay for Prescription Drugs	23
SECTION 7	Questions?.....	24
Section 7.1 – Getting Help from UVM Health Advantage Select (PPO).....		24
Section 7.2 – Getting Help from Medicare		24

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for UVM Health Advantage Preferred (PPO) in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher or lower than this amount. See Section 2.1 for details.</p>	\$130	\$127.40
<p>Maximum out-of-pocket amounts</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</p>	<p>From network providers: \$5,000 From network and out-of-network providers combined: \$6,000</p>	<p>From network providers: \$5,000 From network and out-of-network providers combined: \$6,000</p>
<p>Doctor office visits</p>	<p>Primary care visits: You pay \$0 per visit.</p> <p>Out-of-network: You pay \$5 per visit.</p> <p>Specialist visits: \$25 per visit</p> <p>Out-of-network: You pay \$35 per visit.</p>	<p>Primary care visits: You pay \$0 per visit.</p> <p>Out-of-network: You pay \$5 per visit.</p> <p>Specialist visits: \$25 per visit</p> <p>Out-of-network: You pay \$35 per visit.</p>
<p>Inpatient hospital stays</p>	<p>In-network: You pay a \$350 copayment per day for</p>	<p>In-network: You pay a \$350 copayment per day for</p>

Cost	2023 (this year)	2024 (next year)
	<p>days 1 through 2. You pay a \$0 copayment for days 3+.</p> <p>Out-of-network: You pay a \$325 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>	<p>days 1 through 3. You pay a \$0 copayment for days 4+.</p> <p>Out-of-network: You pay a \$350 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>
<p>Part D prescription drug coverage (See Section 2.5 for details.)</p>	<p>There is no deductible for this plan.</p> <p>Copayment/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 copayment. • Drug Tier 2: \$10 copayment. • Drug Tier 3: \$40 copayment. You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 copayment. You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 27% coinsurance. You 	<p>There is no deductible for this plan.</p> <p>Copayment/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 copayment. • Drug Tier 2: \$10 copayment. • Drug Tier 3: \$40 copayment. You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 copayment. You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 27% coinsurance. You

Cost	2023 (this year)	2024 (next year)
	<p>pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.). 	<p>pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in UVM Health Advantage Preferred (PPO) in 2024

If you do nothing by December 7, 2023, we will automatically enroll you in our UVM Health Advantage Preferred (PPO). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through UVM Health Advantage Preferred (PPO). 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 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.)	\$130	\$127.40

- 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 Amounts

Cost	2023 (this year)	2024 (next year)
<p>In-network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	<p>\$5,000</p>	<p style="text-align: center;">\$5,000</p> <p>Once you have paid \$5,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.</p>	<p>\$6,000</p>	<p style="text-align: center;">\$6,000</p> <p>Once you have paid \$6,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.</p> <p>This is not a change from 2023.</p>

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the 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, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *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 2024 *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 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	2023 (this year)	2024 (next year)
<p>Acupuncture / Chiropractic Services</p>	<p>In-network and Out-of-network You pay 50% of the total cost for acupuncture services.</p> <p>In-network: You pay a \$10 copayment for each chiropractic visit.</p> <p>Out-of-network: You pay a \$40 copayment for each chiropractic visit.</p>	<p>In-network and Out-of-network You pay 50% of the total cost for acupuncture services.</p> <p>In-network: You pay a \$10 copayment for each chiropractic visit.</p> <p>Out-of-network: You pay a \$40 copayment for each chiropractic visit.</p> <p>Additional 20 chiropractor or Acupuncture visits per calendar year for eligible chronic conditions. Benefit is a combined total and can be used in any combination.</p> <p>Autoimmune disorders/Rheumatoid Arthritis; Cancer; Cardiovascular disorders/Hypertension; Coronary Artery Disease; Congestive Heart Failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Chronic lung disorders/COPD; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Inflammatory Disorders;</p>

Cost	2023 (this year)	2024 (next year)
		Post-infection conditions; for example Long Covid, Lyme Disease; Chronic fatigue syndrome; Musculoskeletal disorders
Diabetes Care Kit	Members with a diagnosis of Diabetes can request a customizable care kit and choose from items on a selected list including a digital bluetooth scale and travel insulin cooler from the contracted vendor.	Members with a diagnosis of Diabetes can request a customizable care kit and choose from items on a selected list including a digital bluetooth scale, travel cooler, informational placemat, portion plate and water bottle from the contracted vendor.
Inpatient Hospital Care	<p>In-network: You pay a \$350 copayment per day for days 1 through 2. You pay a \$0 copayment for days 3+.</p> <p>Out-of-network: You pay a \$325 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>	<p>In-network: You pay a \$350 copayment per day for days 1 through 3. You pay a \$0 copayment for days 4+.</p> <p>Out-of-network: You pay a \$350 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>
Inpatient Psychiatric Hospital Care	<p>In-network: You pay a \$350 copayment per day for days 1 through 2. You pay a \$0 copayment for days 3+.</p>	<p>In-network: You pay a \$350 copayment per day for days 1 through 3. You pay a \$0 copayment for days 4+.</p>

Cost	2023 (this year)	2024 (next year)
	<p>Out-of-network: You pay a \$325 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>	<p>Out-of-network: You pay a \$350 copayment per day for days 1 through 4. You pay a \$0 copayment for days 5+.</p>
<p>Preventive and Comprehensive Dental</p>	<p>Preventive Dental: You pay a \$0 copay, benefit is limited to 2 oral exams, 2 cleanings, and 2 sets of x-rays per calendar year.</p> <p>Payments are limited to an established fee schedule. Services above the limit are your responsibility.</p> <p>Comprehensive Dental: Benefit is limited to a maximum of \$1,000 per calendar year for in-network and out-of-network benefits.</p> <p>There is a \$100 deductible per calendar year.</p> <p>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.</p> <p>You pay 50% of the allowed amount after the deductible for</p>	<p>Preventive Dental: You pay a \$0 copay, benefit is limited to 2 oral exams, 2 cleanings, and 2 sets of x-rays per calendar year.</p> <p>Payments are limited to an established fee schedule. Services above the limit are your responsibility.</p> <p>Comprehensive Dental: Benefit is limited to a maximum of \$2,000 per calendar year for in-network and out-of-network benefits.</p> <p>There is no deductible.</p> <p>You pay a 0% coinsurance of the allowed amount for Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, Oral/Maxillofacial Surgery and</p>

Cost	2023 (this year)	2024 (next year)
	<p>oral surgery for in-network and out-of-network.</p> <p>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.</p> <p>Orthodontics is not a covered benefit.</p>	<p>Other Services in-network and out-of-network.</p> <p>Orthodontics is not a covered benefit.</p> <p>Payment limited to established Fee Schedule. If your provider does not participate in the Plan’s network and charges more than the maximum allowable benefit, you will be responsible for the additional cost. Service category maximums may apply. See the Evidence of Coverage for more information.</p>
<p>Meal Benefit</p>	<p>Post-Hospitalization meals are covered through contracted vendor and set-up thru Care Management program. 14 meals per 7 days benefit. No limit to number of times benefit can be accessed in a calendar year so long as it is preceded by a hospitalization.</p> <p>For diagnosis of Congestive Heart Failure benefit is up to 14 meals per 7 days for a duration of up to 12 weeks post hospitalization or post hospital observation stay.</p> <p>Diagnosis of Diabetes benefit is up to 14 meals per 7 days for a duration of 12 weeks post</p>	<p>Post-Hospitalization meals are covered through contracted vendor and set-up thru Care Management program. 14 meals per 7 days benefit. No limit to number of times benefit can be accessed in a calendar year so long as it is preceded by a hospitalization.</p> <p>For diagnosis of Congestive Heart Failure benefit is up to 14 meals per 7 days for a duration of up to 12 weeks post hospitalization or post hospital observation stay.</p> <p>Diagnosis of Diabetes benefit is up to 14 meals per 7 days for a duration of 12 weeks for a new</p>

Cost	2023 (this year)	2024 (next year)
	<p>hospitalization or post hospital observation stay.</p> <p>Post inpatient hospital stay for depression, schizophrenia and/or other psychotic disorders receive a benefit of up to 14 meals per 7 days for a duration of 12 weeks post hospitalization</p>	<p>diagnosis, post hospitalization or post hospital observation stay.</p> <p>Post inpatient hospital stay for depression, schizophrenia and/or other psychotic disorders receive a benefit of up to 14 meals per 7 days for a duration of 12 weeks post hospitalization or post hospital observation stay.</p>
<p>Outpatient Mental Health Care</p>	<p>In-network:</p> <p>You pay a \$25 copayment for each individual Medicare-covered therapy visit.</p> <p>You pay a \$15 copayment for each group Medicare-covered therapy visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered therapy visit.</p>	<p>In-network:</p> <p>You pay a \$0 copayment for each individual Medicare-covered therapy visit.</p> <p>You pay a \$0 copayment for each group Medicare-covered therapy visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered therapy visit.</p>
<p>Outpatient Psychiatric Services</p>	<p>In-network:</p> <p>You pay a \$25 copayment for each individual Medicare-covered Psychiatric visit.</p>	<p>In-network:</p> <p>You pay a \$0 copayment for each individual Medicare-covered Psychiatric visit.</p>

Cost	2023 (this year)	2024 (next year)
	<p>You pay a \$15 copayment for each group Medicare-covered Psychiatric visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered Psychiatric visit.</p>	<p>You pay a \$0 copayment for each group Medicare-covered Psychiatric visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered Psychiatric visit.</p>
<p>Outpatient Substance Abuse Services</p>	<p>In-network:</p> <p>You pay a \$25 copayment for each individual Medicare-covered substance abuse visit.</p> <p>You pay a \$15 copayment for each group Medicare-covered substance abuse visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered substance abuse visit.</p>	<p>In-network:</p> <p>You pay a \$0 copayment for each individual Medicare-covered substance abuse visit.</p> <p>You pay a \$0 copayment for each group Medicare-covered substance abuse visit.</p> <p>Out-of-network:</p> <p>You pay a \$35 copayment for each individual/group Medicare-covered substance abuse visit.</p>
<p>Over-the-Counter Medications</p>	<p>\$35.00 allowance per quarter.</p> <p>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.</p>	<p>\$50.00 allowance per quarter.</p> <p>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.</p>

Cost	2023 (this year)	2024 (next year)
Podiatry Services	<p>In-network: You pay a \$30 copayment per podiatry service.</p> <p>Out-of-network: You pay a \$35 copayment per podiatry service</p>	<p>In-network: You pay a \$25 copayment per podiatry service.</p> <p>Out-of-network: You pay a \$35 copayment per podiatry service.</p>
Worldwide Emergency Transportation	<p>In 2023 Worldwide Emergency Transportation is not a covered benefit.</p>	<p>In and Out-of-network: You pay a \$150 copayment for Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered.</p>

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, 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, 2023, 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	2023 (this year)	2024 (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	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1- Preferred Generic Drugs: You pay \$0 per prescription.</p> <p>Tier 2- Generic Drugs: You pay \$10 per prescription.</p> <p>Tier 3 Preferred Brand Drugs: You pay \$40 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4- Non-Preferred Drugs: You pay \$100 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5- Specialty Drugs: You pay 27% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.</p> <hr/>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1- Preferred Generic Drugs: You pay \$0 per prescription.</p> <p>Tier 2- Generic Drugs: You pay \$10 per prescription.</p> <p>Tier 3 Preferred Brand Drugs: You pay \$40 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4- Non-Preferred Drugs: You pay \$100 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5- Specialty Drugs: You pay 27% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.</p> <hr/>

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage (continued)</p> <p>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; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>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.”</p>	<p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>

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 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in UVM Health Advantage Preferred (PPO)

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 **UVM Health Advantage Preferred (PPO)**.

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 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. 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 UVM Health Advantage Preferred (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from UVM Health Advantage Preferred (PPO).
- 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, 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.

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 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). In Vermont, the SHIP is called The Vermont State Health Insurance Assistance Program.

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

OMB Approval 0938-1051 (Expires: February 29, 2024)
24MVPDBAE18

Medicare plan choices and answer questions about switching plans. You can call HIICAP at **1-800-701-0501**. You can call The Vermont State Health Insurance Assistance Program at **1-800-642-5119**.

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. Vermont has a program called V-Pharm. 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, or the Vermont Medication Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **1-800-542-2437** (New York) or **1-802-863-7240** (Vermont).

SECTION 7 Questions?

Section 7.1 – Getting Help from UVM Health Advantage Preferred (PPO)

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 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 UVM Health Advantage Preferred (PPO). 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 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.