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

Annual Notice of Change for 2026

You're enrolled as a member of MVP Medicare Secure Plus with Part D (HMO-POS).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in MVP Medicare Secure Plus with Part D (HMO-POS).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in 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*.

More Resources

- Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.
- Call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) for more information. 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).

About MVP Medicare Secure Plus with Part D (HMO-POS)

- MVP Medicare Secure Plus with Part D (HMO-POS) is an (HMO-POS) plan with a Medicare contract. Enrollment in MVP Medicare Secure Plus with Part D (HMO-POS) depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means . When it says “plan” or “our plan,” it means MVP Medicare Secure Plus with Part D (HMO-POS).
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in MVP Medicare Secure Plus with Part D (HMO-POS).** Starting January 1, 2026, you’ll get your medical and drug coverage through MVP HEALTH PLAN, INC. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$96.20	$116
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $6,000	From network providers: $6,000
Primary care office visits	**In-Network** You pay a $0 copayment per visit **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 $0 copayment per visit **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
Specialist office visits	**In-Network** You pay a $40 copayment per visit **Out-of-Network** You pay 30% coinsurance of the total cost. Once out-of-	**In-Network** You pay a $35 copayment per visit **Out-of-Network** You pay 30% coinsurance of the total cost. Once out-of-

	2025 (this year)	2026 (next year)
	network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services	network (POS) annual limit of $4,000 is reached you pay 100% of the cost for out-of-network services
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**In-Network** You pay a $350 copayment for a Medicare-covered inpatient hospital stayper day for days 1 - 5 You pay a $0 copayment for a Medicare-covered inpatient hospital stay per day for days 6 - 90 $1,750 maximum out-of-pocket per Medicare-covered inpatient hospital stay **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 $350 copayment for a Medicare-covered inpatient hospital stay per day for days 1 - 5 You pay a $0 copayment for a Medicare-covered inpatient hospital stay per day for days 6 - 90 $1,750 maximum out-of-pocket per Medicare-covered inpatient hospital stay **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
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	$400 for Tiers 2-5 except for covered insulin products and most adult Part D vaccines

	2025 (this year)	2026 (next year)
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Standard cost sharing: You pay $0 per prescription **Drug Tier 2**: Standard cost sharing: You pay $15 per prescription **Drug Tier 3**: Standard cost sharing: You pay $45 per prescription You pay a maximum of $35 per month supply of each covered insulin product on this tier **Drug Tier 4**: Standard cost sharing: You pay 25% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier **Drug Tier 5**: Standard cost sharing: You pay 33% of the total cost You pay a maximum of $35 per month supply of	Copayment/ Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Standard cost sharing: You pay $0 per prescription **Drug Tier 2**: Standard cost sharing: You pay $2 per prescription **Drug Tier 3**: Standard cost sharing: You pay 16% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier **Drug Tier 4**: Standard cost sharing: You pay 25% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier **Drug Tier 5**: Standard cost sharing: You pay 25% of the total cost You pay a maximum of $35 per month supply of

	2025 (this year)	2026 (next year)
	each covered insulin product on this tier **Catastrophic Coverage:** During this payment stage, you pay nothing for your covered Part D drugs .	each covered insulin product on this tier **Catastrophic Coverage:** During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$96.20	$116

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 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've paid this amount, you generally pay nothing for covered Part A and Part B for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward yourin-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	From network providers: $6,000	From network providers: $6,000 Once you've paid $6,000 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* **mvphealthcare.com/findadoctor** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at **mvphealthcare.com**.
- Call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) for help.

Section 1.4 Changes to the Pharmacy Network

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

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* **mvphealthcare.com** to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*.

- Visit our website at **mvphealthcare.com**.
- Call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Additional Acupuncture	**In-Network** Additional 10 acupuncture visits per calendar year for a diagnosis other than chronic low back pain. Coinsurance is not applied to your maximum out-of-pocket amount	**In-Network** Additional 12 acupuncture visits per calendar year for a diagnosis other than chronic low back pain. Coinsurance is not applied to your maximum out-of-pocket amount
Ambulance services	**In- and Out-of-Network** You pay a $175 copayment for each Medicare-covered ground ambulance service You pay a $300 copayment for each Medicare-covered air ambulance service	**In- and Out-of-Network** You pay a $200 copayment for each Medicare-covered ground ambulance service You pay a $300 copayment for each Medicare-covered air ambulance service

	2025 (this year)	2026 (next year)
Dental services	**Preventive and Comprehensive Dental** Annual Maximum Plan Benefit Coverage Amount: $2,000 combined Preventive and Comprehensive services, per calendar year for in and out-of-network benefits (services above the limit are your responsibility)	**Preventive and Comprehensive Dental** Annual Maximum Plan Benefit Coverage Amount: $1,500 combined Preventive and Comprehensive services, per calendar year for in and out-of-network benefits (services above the limit are your responsibility)
Emergency care	**In- and Out-of-Network** You pay a $95 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital as an Inpatient within 24 hours for the same condition	**In- and Out-of-Network** You pay a $100 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital as an Inpatient within 24 hours for the same condition
Emergency Transportation	You pay a $175 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	You pay a $200 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

	2025 (this year)	2026 (next year)
Help with Certain Chronic Conditions	**In-Network** Not Covered	**In-Network** You pay $0 copayment for Medicare-covered eye exams for diabetic retinopathy screening by a network provider are covered once annually.

	2025 (this year)	2026 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** You pay a $0 copayment for each Medicare-covered lab service You pay a $10 copayment for each Medicare-covered diagnostic procedure/test You pay a $40 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a $40 copayment for each Medicare-covered ultrasound You pay a $10 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 20% of the total cost for each Medicare-covered radiation therapy service You pay a $225 copayment for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service	**In-Network** You pay a $0 copayment for each Medicare-covered lab service You pay a $10 copayment for each Medicare-covered diagnostic procedure/test You pay a $40 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a $40 copayment for each Medicare-covered ultrasound You pay a $10 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 20% of the total cost for each Medicare-covered radiation therapy service You pay a $250 copayment for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service

	2025 (this year)	2026 (next year)
Outpatient rehabilitation services	**In-Network** You pay a $20 copayment for each Medicare-covered physical therapy and speech and language therapy visit You pay a $20 copayment for each Medicare-covered occupational therapy visit	**In-Network** You pay a $15 copayment for each Medicare-covered physical therapy and speech and language therapy visit You pay a $15 copayment for each Medicare-covered occupational therapy visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $175 copayment for each Medicare-covered ambulatory surgical center visit You pay a $300 copayment for each Medicare-covered outpatient hospital visit	**In- Network** You pay a $200 copayment for each Medicare-covered ambulatory surgical center visit You pay a $300 copayment for each Medicare-covered outpatient hospital visit
Over-the-Counter (OTC) catalog	**In-Network** $75 allowance per quarter. Allowance is received quarterly to be used towards eligible over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from quarter to quarter.	**In-Network** $50 allowance per quarter. Allowance is received quarterly to be used towards eligible over-the-counter medicine and health-related purchases from select pharmacies or by mail order. Allowance amount does not carry over from quarter to quarter.

	2025 (this year)	2026 (next year)
Partial Hospitalization	**In-Network** You pay a $40 copayment for each Medicare-covered partial hospitalization services	**In-Network** You pay a $50 copayment for each Medicare-covered partial hospitalization services
Partial Hospitalization Intensive Outpatient Services	**In-Network** You pay a $40 copayment for each Medicare-covered partial hospitalization services	**In-Network** You pay a $50 copayment for each Medicare-covered partial hospitalization services
Physician/Practitioner services, including doctor's office visits	**In-Network** You pay a $0 copayment for each Medicare-covered PCP office or telehealth visit You pay a $40 copayment for each Medicare-covered specialist office or telehealth visit You pay a $0 copayment for each Medicare-covered hearing exam You pay a $40 copayment for each Medicare-covered dental service You pay a $10 copayment for each Medicare-covered outpatient mental health individual or group therapy visit	**In-Network** You pay a $0 copayment for each Medicare-covered PCP office or telehealth visit You pay a $35 copayment for each Medicare-covered specialist office or telehealth visit You pay a $0 copayment for each Medicare-covered hearing exam You pay a $35 copayment for each Medicare-covered dental service You pay a $10 copayment for each Medicare-covered outpatient mental health individual or group therapy visit

	2025 (this year)	2026 (next year)
Podiatry services	**In-Network** You pay a $40 copayment for each Medicare-covered podiatry visit	**In-Network** You pay a $35 copayment for each Medicare-covered podiatry visit
Supplemental Benefit-Post discharge In-home Medication Reconciliation	**In-Network** You pay a $0 copayment	**In-Network** Not Covered
Urgently needed services	**In- and Out-of-Network** You pay a $30 copayment for each Medicare-covered urgently needed care visit in the United States and its territories You pay a $95 copayment for each non-Medicare covered urgently needed care visit outside the United States and its territories	**In- and Out-of-Network** You pay a $20 copayment for each Medicare-covered urgently needed care visit in the United States and its territories You pay a $100 copayment for each non-Medicare covered urgently needed care visit outside the United States and its territories

	2025 (this year)	2026 (next year)
Vision care – extra benefits	**In- and Out-of-Network** Allowance of $225 toward non-Medicare covered eyewear (such as eyeglass frames and lenses and/or contact lenses) annually **Out-of-Network** $300 toward non-Medicare covered routine eye exam, annually	**In- and Out-of-Network** Allowance of $175 toward non-Medicare covered eyewear (such as eyeglass frames and lenses and/or contact lenses) annually **Out-of-Network** $70 toward non-Medicare covered routine eye exam, annually

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

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

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

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to

find a new drug. Call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial

Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you	$400 for Tiers 2-5 except for covered insulin products and most adult Part D vaccines During this stage, you pay $0 cost sharing for drugs on Tier 1 Preferred Generic Drugs and pay the full cost of drugs on Tier 2 Generic Drugs Tier 3 Preferred Brand Drugs, Tier 4 Non-Preferred Drugs and Tier 5 Specialty Drugs until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard cost sharing.

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. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1 – Preferred Generic Drugs:	You pay $0 per prescription	You pay $0 per prescription
Tier 2 – Generic Drugs:	You pay $15 per prescription	You pay $2 per prescription
Tier 3 – Preferred Brand Drugs:	You pay $45 per prescription You pay a maximum of $35 per month supply of each covered insulin product on this tier	You pay 16% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier
Tier 4 – Non-Preferred Drugs:	You pay 25% of the total cost	You pay 25% of the total cost

	2025 (this year)	2026 (next year)
	You pay a maximum of $35 per month supply of each covered insulin product on this tier	You pay a maximum of $35 per month supply of each covered insulin product on this tier
Tier 5 – Specialty Drugs:	You pay 33% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier	You pay 25% of the total cost You pay a maximum of $35 per month supply of each covered insulin product on this tier

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at 1-844-889-9792 (TTY users call 711) or visit Medicare.gov.**

SECTION 3 How to Change Plans

To stay in MVP Medicare Secure Plus with Part D (HMO-POS), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our MVP Medicare Secure Plus with Part D (HMO-POS).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from MVP Medicare Secure Plus with Part D (HMO-POS).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from MVP Medicare Secure Plus with Part D (HMO-POS).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you

don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 4).

- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (Go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). 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.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in 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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
- Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
- Your State Medicaid Office.

- **Help from your state's pharmaceutical assistance program.** New York has a program called Elderly Pharmaceutical Insurance Coverage Program (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program. To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS**. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the New York State Department of Health HIV Uninsured Care Programs. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you are currently enrolled, how to continue getting help, call New York State Department of Health HIV Uninsured Care Programs at **1-800-542-2437**. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All

members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-844-889-9792 (TTY users should call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from MVP Medicare Secure Plus with Part D (HMO-POS)

- **Call MVP Medicare Customer Care Center at 1-800-665-7924. (TTY users call 711.)**

  We're 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 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for MVP Medicare Secure Plus with Part D (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at **mvphealthcare.com** or call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) to ask us to mail you a copy.

- **Visit mvphealthcare.com**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get 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).

Call New York Health Insurance Information Counseling and Assistance Program (HIICAP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call New York Health Insurance Information Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2026**

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.