



MVP Medicare Complete Wellness with Part D (PPO) offered by MVP HEALTH PLAN, INC.

Annual Notice of Change for 2027

You're enrolled as a member of MVP Medicare Complete Wellness with Part D (PPO).

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, 2026, you'll stay in MVP Medicare Complete Wellness with Part D (PPO).
- To change to a **different plan**, visit [Medicare.gov](https://www.medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at mvphealthcare.com or call MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- This information is available in a different format, including braille and large print.
- 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.

About MVP Medicare Complete Wellness with Part D (PPO)

- MVP Medicare Complete Wellness with Part D (PPO) is a PPO plan with a Medicare contract. Enrollment in MVP Medicare Complete Wellness with Part D (PPO) depends on contract renewal.
- When this material says "we," "us," or "our," it means MVP HEALTH PLAN, INC. When it says "plan" or "our plan," it means MVP Medicare Complete Wellness with Part D (PPO).

- **If you do nothing by December 7, 2026, you'll automatically be enrolled in MVP Medicare Complete Wellness with Part D (PPO).** Starting January 1, 2027, 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 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$15	\$54
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$9,250 From network and out-of-network providers combined: \$13,900	From network providers: \$9,850 From network and out-of-network providers combined: \$14,800
Primary care office visits	In-Network You pay a \$0 copayment per visit Out-of-Network 30% of the cost per visit	In-Network You pay a \$0 copayment per visit Out-of-Network 30% of the cost per visit
Specialist office visits	In-Network You pay a \$55 copayment per visit Out-of-Network 40% of the cost per visit	In-Network You pay a \$60 copayment per visit Out-of-Network 40% of the cost per visit

Inpatient hospital stays

Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.

In-Network

You pay a \$445 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

Out-of-Network

You pay a coinsurance of 40% per Medicare-covered inpatient hospital stay

In-Network

You pay a \$490 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

Out-of-Network

You pay a coinsurance of 40% per Medicare-covered inpatient hospital stay

Part D drug coverage

(Go to Section 1 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)

Part D drug coverage deductible

\$615 for Tiers 2-5 except for covered insulin products and most adult Part D vaccines

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

Part D drug coverage deductible

\$700 for Tiers 2-5 except for covered insulin products and most adult Part D vaccines

**Copayment/
Coinsurance during the Initial Coverage Stage:**

**Drug Tier 1:
Standard cost sharing:
You pay \$0 per prescription**

**Drug Tier 2:
Standard cost sharing:**

Drug Tier 3:

Standard cost sharing:
You pay 16% of the total cost

You pay no more than \$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 no more than \$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 no more than \$35 per month supply of each covered insulin product on this tier

Catastrophic Coverage:

During this payment stage, you pay nothing for your covered Part D drugs.

You pay \$2 per prescription

Drug Tier 3:

**Standard cost sharing:
You pay 16% of the total cost**

You pay no more than \$35 per month supply of each covered insulin product on this tier

Drug Tier 4:

**Standard cost sharing:
You pay 43% of the total cost**

You pay no more than \$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 no more than \$35 per month supply of 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

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$15	\$54

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 Part D or 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.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from	From network providers: \$9,250	From network providers: \$9,850 Once you've paid \$9,850

	2026 (this year)	2027 (next year)
network providers count toward your in-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.		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
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	From in-network and out-of-network providers combined: \$13,900	From in-network and out-of-network providers combined: \$14,800 Once you've paid \$14,800 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 or out-of-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 2027 *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. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your Evidence of Coverage.

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 2027 *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

	2026 (this year)	2027 (next year)
Cardiac rehabilitation services	In-Network You pay 25% of the total cost for each Medicare-covered cardiac rehabilitation service	In-Network You pay 30% of the total cost for each Medicare-covered cardiac rehabilitation service

Dental services**Supplemental Preventive and Comprehensive Dental**

Annual Maximum Plan Benefit Coverage Amount: \$750 combined allowance per calendar year for services in the following categories.

Preventive Dental: Oral Exams, Prophylaxis (cleanings), Fluoride Treatments, X-rays, Other Diagnostic Dental Services and Other Preventive Dental Services.

Comprehensive Dental: Restorative Services, Endodontics, Periodontics, Prosthodontics, Maxillofacial Prosthetics, Implant Services, Oral and Maxillofacial Surgery and Adjunctive General Services.

Benefit can be used at in and out-of-network providers. Once the annual maximum benefit is used, you are responsible for 100% of the cost of any supplemental dental services.

Supplemental Preventive and Comprehensive Dental**Preventive Dental:**

In-network: Annual maximum benefit is 2 Oral Exams, 2 Prophylaxis (cleanings) and 1 X-ray per calendar year.

Out-of-network: Preventive dental services are available through in and out-of-network providers. Out-of-network providers are not required to accept the plan's payment as payment in full for covered services.

Covered services received through an out-of-network provider will be reimbursed up to the plans allowed amount per the fee schedule. You will be responsible for charges above the allowed amount, and the provider may balance bill you.

Coverage is limited to specific dental codes. See the Evidence of Coverage for more information.

		Comprehensive Dental: In and Out-of-network: Not Covered
Fitness Benefit	There is no coinsurance, copayment, or deductible for the SilverSneakers® Fitness program and classes.	In-Network There is no coinsurance, copayment, or deductible for the SilverSneakers® Fitness program and classes. Out-of-Network You pay 50% of the total cost of your fitness facility membership cost, up to a total monthly benefit limit of \$70. You are responsible for all costs above \$70. The plan will reimburse up to \$35 per month. You must pay the fitness facility in full and submit your receipt for reimbursement within 60 days of payment.
Hearing services – extra benefits	Hearing Exams You pay a \$0 copayment for a routine hearing exam. Benefit is limited to 1 exam every year. You pay a \$0 copayment for a hearing aid fitting/evaluation.	Hearing Exams In-Network You pay a \$0 copayment for a routine hearing exam. Benefit is limited to 1 exam every year. You pay a \$0 copayment for a hearing aid fitting/evaluation.

Hearing Aids

Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids. You pay a \$699 copayment per aid for TruHearing Advanced Aids or a \$999 copayment for TruHearing Premium Aids

OR

Up to \$600 per ear toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog every year limit 1 hearing aid per ear. After plan-paid benefit, you are responsible for the remaining costs.

Out-of-Network

You pay 50% coinsurance for a routine hearing exam. Benefit is limited to 1 exam every year.

You pay 50% coinsurance for a hearing aid fitting/evaluation.

Hearing Aids**In-Network**

Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids. You pay a \$699 copayment per aid for TruHearing Advanced Aids or a \$999 copayment for TruHearing Premium Aids

OR

Up to \$600 per ear toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog every year limit 1 hearing aid per ear. After plan-paid benefit, you are responsible for the remaining costs.

Out-of-Network

You pay 80% coinsurance for a prescription hearing aid. Benefit is limited to two aids per year (one per ear per year).

Inpatient hospital care	In-Network You pay a \$445 copayment per day for days 1 - 5 of a Medicare-covered inpatient hospital stay You pay a \$0 copayment per day for days 6 - 90	In-Network You pay a \$490 copayment per day for days 1 - 5 of a Medicare-covered inpatient hospital stay You pay a \$0 copayment per day for days 6 - 90
Outpatient diagnostic tests and therapeutic services and supplies	In-Network You pay a \$0 copayment for each Medicare-covered lab service You pay 20% of the total cost for each Medicare-covered diagnostic procedure/test You pay a \$55 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a \$55 copayment for each Medicare-covered ultrasound You pay 20% of the total cost 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 \$400 copayment for each Medicare-covered diagnostic radiology PET, CAT,	In-Network You pay a \$0 copayment for each Medicare-covered lab service You pay 20% of the total cost for each Medicare-covered diagnostic procedure/test You pay a \$45 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a \$55 copayment for each Medicare-covered ultrasound You pay 20% of the total cost 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 \$410 copayment for each Medicare-covered

	MRI, MRA or NUC service	diagnostic radiology PET, CAT, MRI, MRA or NUC service
Over-the-Counter (OTC) catalog	In-Network \$25 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 Over the counter (OTC) items are not covered
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 \$55 copayment for each Medicare-covered specialist office or telehealth visit You pay a \$0 copayment for each Medicare-covered hearing exam You pay a \$50 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 \$60 copayment for each Medicare-covered specialist office or telehealth visit You pay a \$0 copayment for each Medicare-covered hearing exam You pay a \$50 copayment for each Medicare-covered dental service You pay a \$10 copayment for each Medicare-covered outpatient mental health individual or group therapy visit

Podiatry services	In-Network You pay a \$55 copayment for each Medicare-covered podiatry visit	In-Network You pay a \$60 copayment for each Medicare-covered podiatry visit
Pulmonary rehabilitation services	In-Network You pay 25% of the total cost for each Medicare-covered pulmonary rehabilitation service	In-Network You pay 30% of the total cost for each Medicare-covered pulmonary rehabilitation service
Skilled nursing facility (SNF)	In-Network You pay a copayment of \$0 in a network skilled nursing facility for days 1 - 20 You pay a copayment of \$218 in a network skilled nursing facility for days 21 - 100	In-Network You pay a copayment of \$0 in a network skilled nursing facility for days 1 - 20 You pay a copayment of \$221 in a network skilled nursing facility for days 21 - 100
Supervised exercise therapy (SET)	In-Network You pay 25% of the total cost for each Medicare-covered supervised exercise therapy session	In-Network You pay 30% of the total cost for each Medicare-covered supervised exercise therapy session

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.

You can get the complete Drug List by calling MVP Medicare Customer Care Center at 1-800-665-7924 (TTY users call 711) or visiting our website at mvphealthcare.com.

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, 2026, 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.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your 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.

- **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 \$2,400.

- **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.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2026 (this year)	2027 (next year)
Yearly Deductible	\$615 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.	\$700 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

Go to the following table for the changes from 2026 to 2027.

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 \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1 – Preferred Generic Drugs:	You pay \$0 per prescription	You pay \$0 per prescription
Tier 2 – Generic Drugs:	You pay \$2 per prescription	You pay \$2 per prescription
Tier 3 – Preferred Brand Drugs:	You pay 16% of the total cost 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 a maximum of \$35 per month supply of each	You pay 43% of the total cost You pay a maximum of \$35 per month supply of

	2026 (this year)	2027 (next year)
	covered insulin product on this tier	each covered insulin product on this tier
Tier 5 – Specialty Drugs:	You pay 25% 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 How to Change Plans

To stay in MVP Medicare Complete Wellness with Part D (PPO), you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our MVP Medicare Complete Wellness with Part D (PPO).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from MVP Medicare Complete Wellness with Part D (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with Medicare separate drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from MVP Medicare Complete Wellness with Part D (PPO).
- **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 [Medicare.gov](https://www.medicare.gov), check the *Medicare & You 2027* 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 2.1 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, 2027, 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 separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 2.2 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 separate 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 3 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. 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 2027 you do not need to submit a new election request to continue participating in 2027. **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. To learn more about this payment option, call us at 1-844-889-9792 (TTY users should call 711) or visit [Medicare.gov](https://www.medicare.gov).

SECTION 4 Questions?

Get Help from MVP Medicare Complete Wellness with Part D (PPO)

- **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 2027 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for MVP Medicare Complete Wellness with Part D (PPO). 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 [Medicare.gov](https://www.medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

- **Write to Medicare**

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

- **Visit [Medicare.gov](https://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 2027***

The *Medicare & You 2027* 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 [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.