EmblemHealth VIP Dual Reserve (HMO D-SNP) offered by Health Insurance Plan of Greater New York (HIP)/EmblemHealth

Annual Notice of Changes for 2024

You are currently enrolled as a member of EmblemHealth VIP Dual Reserve (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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 **emblemhealth.com/medicare**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

What to do now

1. ASK: Which changes apply to you

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

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

☐ Check the changes in the 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 EmblemHealth VIP Dual Reserve (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with EmblemHealth VIP Dual Reserve (HMO D-SNP).
- Look in section 4 page 11 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at **1-877-344-7364** for additional information. (TTY users should call **711**.) Hours are 8 am to 8 pm, 7 days a week. This call is free.
- We can also provide information in a way that works for you (information in other alternate formats). Please call Customer Service at the number listed above if you need plan information in another format or language.
- **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 EmblemHealth VIP Dual Reserve (HMO D-SNP)

- Health Insurance Plan of Greater New York (HIP) is an HMO D-SNP plan with a Medicare contract and a contract with the New York State Department of Health. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.
- When this document says "we," "us," or "our," it means HIP/EmblemHealth. When it says "plan" or "our plan," it means EmblemHealth VIP Dual Reserve (HMO D-SNP).

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

Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for EmblemHealth VIP Dual Reserve (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. **If you are eligible for Medicare cost-sharing assistance under New York Medicaid you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher than this amount. (See Section 1.1 for details.)	**$0**	**$0**
Doctor office visits	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit
Inpatient hospital stays	**$0** copay for each Medicare-covered stay. Prior authorization is required.	**$0** copay for each Medicare-covered stay. Prior authorization is required.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: **$0** Copayment during the Initial Coverage Stage: Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** You pay **$0-$4.15** per prescription. **Tier 2 (Generic):** You pay **$0-$4.15** per prescription. **Tier 3 (Preferred Brand):** You pay **$0-$10.35** per prescription.	Deductible: **$0** Copayment during the Initial Coverage Stage: Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** You pay **$0-$4.50** per prescription. **Tier 2 (Generic):** You pay **$0-$4.50** per prescription. **Tier 3 (Preferred Brand):** You pay **$0-$11.20** per prescription.

(continued on next page)

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	**Tier 4 (Non-Preferred Drug):** You pay **$0-$10.35** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$10.35** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Once you have paid **$7,400** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	**Tier 4 (Non-Preferred Drug):** You pay **$0-$11.20** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$11.20** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Once you have paid **$8,000** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**$8,300** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$8,850** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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 unless it is paid for you by Medicaid.)	**$0**	**$0**

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 reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$8,300**	**$8,850** Once you have paid **$8,850** out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at **emblemhealth.com/medicare**. You may also call Customer Service 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 a part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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

Cost	2023 (this year)	2024 (next year)
Cardiac Rehabilitation Services	You pay a **$0** copay for Medicare-covered cardiac rehabilitation services.	You pay a **$0** copay for Medicare-covered cardiac rehabilitation services. **You have the option of getting these services through an in-person visit or by telehealth with a network provider who offers the service by telehealth.**
Over-the-Counter (OTC) Items	Our plan covers **$150** copay each month for Medicare-eligible over-the-counter (OTC) items, **including healthy foods and produce** at participating locations and online. This amount does not roll-over month-to-month and will expire at the end of each month.	Our plan covers **$20** copay each month for Medicare-eligible over-the-counter (OTC) items,**including healthy foods and produce** at participating locations and online. This amount does not roll-over month-to-month and will expire at the end of each month.
Remote Access Technologies/ Teladoc®	Teladoc® service **not covered**.	You pay a **$0** copay for each covered Teladoc® service

Section 1.5 – 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 Customer Service for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Customer Service 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	The deductible is **$0**	The deductible is **$0**

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** You pay **$0-$4.15** per prescription. **Tier 2 (Generic):** You pay **$0-$4.15** per prescription. **Tier 3 (Preferred Brand):** You pay **$0-$10.35** per prescription. **Tier 4 (Non-Preferred Drug):** You pay **$0-$10.35** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$10.35** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Once you have paid **$7,400** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** You pay **$0-$4.50** per prescription. **Tier 2 (Generic):** You pay **$0-$4.50** per prescription. **Tier 3 (Preferred Brand):** You pay **$0-$11.20** per prescription. **Tier 4 (Non-Preferred Drug):** You pay **$0-$11.20** per prescription. **Tier 5 (Specialty Tier):** You pay **$0-$11.20** per prescription. **Tier 6 (Select Care Drugs):** You pay **$0** per prescription. Once you have paid **$8,000** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

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 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Chiropractic, Physical and Occupational Therapy Services	EmblemHealth contracted with Palladian to provide these services and prior authorizations.	EmblemHealth provides these services and prior authorizations.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in EmblemHealth VIP Dual Reserve (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our EmblemHealth VIP Dual Reserve (HMO D-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change 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.

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 5), or call Medicare (see Section 7.2).

As a reminder, HIP/EmblemHealth 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 EmblemHealth VIP Dual Reserve (HMO D-SNP).

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from EmblemHealth VIP Dual Reserve (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Changing Plans

If you want to change to a different plan or 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.

Because you have New York Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

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 and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York State, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HIICAP at **1-800-701-0501**. You can learn more about HIICAP by visiting their website **(www.aging.ny.gov)**.

For questions about your New York State Medicaid benefits, contact New York State Department of Health, **1-800-541-2831**, TTY **711**. Hours are Monday to Friday, 8:00 am to 8:00 pm. Saturday, 9:00 am to 1:00 pm. You can also contact New York State Long Term Care Ombudsman Program, **1-855-582-6769**, TTY **711**. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Department of Health (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York State Uninsured Care Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **1-800-542-2437**.

SECTION 7 Questions?

Section 7.1 – Getting Help from EmblemHealth VIP Dual Reserve (HMO D-SNP)

Questions? We're here to help. Please call Customer Service at **1-877-344-7364** (TTY only, call **711**). We are available for phone calls 8 am to 8 pm, 7 days a week. 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 EmblemHealth VIP Dual Reserve (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **emblemhealth.com/medicare**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **emblemhealth.com/medicare**. 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid you can call the New York State Department of Health (Medicaid) at 1-800-541-2831. TTY users should call 711.