EmblemHealth VIP Gold Plus (HMO) offered by Health Insurance Plan of Greater New York (HIP)/EmblemHealth

Annual Notice of Change for 2026

You're enrolled as a member of EmblemHealth VIP Gold Plus (HMO).

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 EmblemHealth VIP Gold Plus (HMO).
- 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*. Get a copy at **emblemhealth.com/medicare** or call Customer Service at **1-877-344-7364** (TTY users call **711**) to get a copy by mail. More information about costs, benefits, and rules is in the Evidence of Coverage.

More Resources

- This material is available for free in Spanish.
- Call Customer Service at **1-877-344-7364**. (TTY users call **711**) for more information. Hours are 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday - Saturday, April 1 to September 30. This call is free.
- We can also provide information in a way that works for you (information in alternate formats). Please call Customer Service at the number listed above if you need plan information in another format or language.

About EmblemHealth VIP Gold Plus (HMO)

- Health Insurance Plan of Greater New York (HIP) is an HMO/HMO-POS plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.
- When this material says “we,” “us,” or “our,” it means HIP/EmblemHealth. When it says “plan” or “our plan,” it means EmblemHealth VIP Gold Plus (HMO).
- **If you do nothing by December 7, 2025, you’ll automatically be enrolled in EmblemHealth VIP Gold Plus (HMO).** Starting January 1, 2026, you’ll get your medical and drug coverage through EmblemHealth VIP Gold Plus (HMO). 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 for details.)	**$223.00**	**$252.00**
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 for details.)	**$8,850**	**$9,250**
Primary care office visits	**$0** copay per visit	**$0** copay per visit
Specialist office visits	**$0** copay per visit	**$0** copay per visit
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.	Days 1-10: **$195** copay per day; **$0** copay per day for each additional day; for each inpatient stay. Unlimited days. Prior authorization is required.	Days 1-10: **$195** copay per day; **$0** copay per day for each additional day; for each inpatient stay. Unlimited days. Prior authorization is required.
Part D drug coverage deductible (Go to Section 1 for details.)	**$200** except for covered insulin products and most adult Part D vaccines	**$200** 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 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 **$7** per prescription. *Preferred cost sharing:* You pay **$2** per prescription. Drug Tier 2: *Standard cost sharing:* You pay **$20** per prescription. *Preferred cost sharing:* You pay **$10** per prescription. Drug Tier 3: *Standard cost sharing:* You pay **$47** per prescription. *Preferred cost sharing:* You pay **$40** per prescription. You pay **$35** per one-month supply of each covered insulin product on this tier. Drug Tier 4: *Standard cost sharing:* You pay **$100** per prescription. *Preferred cost sharing:* You pay **$95** per prescription. Drug Tier 5: *Standard cost sharing:* You pay **29%** of the total cost. *Preferred cost sharing:* You pay **29%** of the total cost. Drug Tier 6: *Standard cost sharing:* You pay **$0** per prescription. *Preferred cost sharing:* You pay **$0** per prescription.	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: You pay **$0** per prescription. Drug Tier 2: You pay **$10** per prescription. Drug Tier 3: You pay **25%** of the total cost. You pay the lower of **$35** or **25%** per one-month supply of each covered insulin product on this tier. Drug Tier 4: You pay **28%** of the total cost. Drug Tier 5: You pay **29%** of the total cost. Drug Tier 6: You pay **$0** per prescription.

(continued on next page)

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	Catastrophic Coverage Stage: 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.)	**$223.00**	**$252.00**

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 1 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 services and other health services not covered by Medicare for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) **count** toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	**$8,850**	**$9,250** Once you've paid **$9,250** out of pocket for covered Part A and Part B services, you'll 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 Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* 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 ***emblemhealth.com/medicare***.
- Call Customer Service at **1-877-344-7364** (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 Customer Service at **1-877-344-7364** (TTY users call **711**) for help. 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 2026 *Pharmacy Directory* to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at ***emblemhealth.com/medicare***.
- Call Customer Service at **1-877-344-7364** (TTY users call **711**) to get 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 Customer Service at **1-877-344-7364** (TTY users call **711**) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Ambulatory Surgery Centers	You pay a **$225** copay for ambulatory surgery centers. You pay $0 for Diagnostic Colonoscopy. Prior authorization is required.	You pay a **$225** copay for ambulatory surgery centers. You pay $0 for Diagnostic Colonoscopy. Prior authorization is not required.
Emergency Care / Post Stabilization Services	You pay a **$110** copay for Medicare-covered emergency care/post stabilization services. Copay waived if admitted within 1 day.	You pay a **$115** copay for Medicare-covered emergency care/post stabilization services. Copay waived if admitted within 1 day.
Inpatient Services in a Psychiatric Hospital	You pay a **$2,036** copay per admission for each Medicare-covered inpatient stay. No additional days covered. Prior authorization is required.	You pay a **$2,080** copay per admission for each Medicare-covered inpatient stay. No additional days covered. Prior authorization is required.
Mental Health Services	You pay a **$0** copay for mental health services. Prior authorization is required.	You pay a **$0** copay for mental health services. Prior authorization is not required.

	2025 (this year)	2026 (next year)
Outpatient Substance Abuse Services	You pay a **$0** copay for outpatient substance abuse services. Prior authorization is required.	You pay a **$0** copay for outpatient substance abuse services. Prior authorization is not required.
Psychiatric Services	You pay a **$0** copay for psychiatric services. Prior authorization is required.	You pay a **$0** copay for psychiatric services. Prior authorization is not required.
Skilled Nursing Facility (SNF) Care	You pay a **$0** copay per day for Medicare-covered days 1-20, **$214** copay per day for Medicare-covered days 21-100; each benefit period. Prior authorization is required.	You pay a **$0** copay per day for Medicare-covered days 1-20, **$218** copay per day for Medicare-covered days 21-100; each benefit period. Prior authorization is required.

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 Customer Service at **1-877-344-7364** (TTY users call **711**) for more information.

Starting in 2026, we may immediately remove brand name drugs or original biological products on our Drug List if, we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately add new restrictions.

For example: if you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients.You can also call Customer Service at **1-877-344-7364** (TTY users call **711**) or ask your health care provider, prescriber, or pharmacist 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 December 31, 2025, call Customer Service at **1-877-344-7364** (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 Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) 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 **$2,100**.

- **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	**$200** During this stage, you pay **$7** standard cost sharing and **$2** preferred cost sharing for drugs on Tier 1 (Preferred Generic); **$20** standard cost sharing and **$10** preferred cost sharing for drugs on Tier 2 (Generic); **$0** standard cost sharing and **$0** preferred cost sharing for drugs on Tier 6 (Select Care Drugs); and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) until you've reached the yearly deductible.	**$200** During this stage, you pay **$0** standard cost sharing on Tier 1 (Preferred Generic); **$10** standard cost sharing on Tier 2 (Generic); **$0** standard cost sharing on Tier 6 (Select Care Drugs); and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy and mail order pharmacy with standard and preferred 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):	*Standard retail/mail order cost sharing:* You pay **$7** *Preferred retail cost sharing:* You pay **$2** *Preferred mail order cost sharing:* **$0**	*Retail/standard mail order cost sharing:* You pay **$0** *Preferred mail order cost sharing:* You pay **$0**
Tier 2 (Generic):	*Standard retail/mail order cost sharing:* You pay **$20** *Preferred retail cost sharing:* You pay **$10** *Preferred mail order cost sharing:* **$0**	*Retail/standard mail order cost sharing:* You pay **$10** *Preferred mail order cost sharing:* You pay **$0**
Tier 3 (Preferred Brand):	*Standard retail/mail order cost sharing:* You pay **$47** You pay **$35** per month supply of each covered insulin product on this tier. *Preferred retail cost sharing:* You pay **$40** You pay **$35** per month supply of each covered insulin product on this tier. *Preferred mail order cost sharing:* You pay **$40** You pay **$35** per month supply of each covered insulin product on this tier.	*Retail/standard mail order cost sharing:* You pay **25%** of the total cost You pay the lesser of **$35** or **25%** per month supply of each covered insulin product on this tier. *Preferred mail order cost sharing:* You pay **22%** of the total cost You pay the lesser of **$35** or **22%** per month supply of each covered insulin product on this tier.
Tier 4 (Non-Preferred Drug):	*Standard retail/mail order cost sharing:* You pay **$100** *Preferred retail cost sharing:* You pay **$95** *Preferred mail order cost sharing:* You pay **$95**	*Retail/standard mail order cost sharing:* You pay **28%** of the total cost *Preferred mail order cost sharing:* You pay **25%** of the total cost

	2025 (this year)	2026 (next year)
Tier 5 (Specialty Tier):	*Standard retail cost sharing:* You pay **29%** of the total cost. *Preferred retail cost sharing:* You pay **29%** of the total cost.	*Retail cost sharing:* You pay **29%** of the total cost. *Preferred retail cost sharing:* You pay **29%** of the total cost
Tier 6 (Select Care Drugs):	*Standard retail/mail order cost sharing:* You pay **$0** *Preferred retail cost sharing:* You pay **$0** *Preferred mail order cost sharing:* You pay **$0**	*Retail/standard mail order cost sharing:* You pay **$0** *Preferred mail order cost sharing:* You pay **$0.**

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)
Diabetes self-management training, diabetic services, and supplies	Covered diabetic supplies are limited to Abbott Diabetes Care and LifeScan products. Quantity limits apply to lancets and test strips (5 strips and lancets per day for insulin-users and 4 strips and lancets per day for non-insulin users).	Covered diabetic supplies are limited to Abbott Diabetes Care and Ascensia products. Quantity limits apply to lancets and test strips (204 test strips and lancets per 30 days).

	2025 (this year)	2026 (next year)
Medicare Part D pharmacy benefit manager	Express Scripts manages Part D prescription drug benefit including mail order delivery. Some Part D drugs are subject to step therapy.	Prime Therapeutics manages Part D prescription drug benefit. You can get preferred mail order through Amazon or Express Scripts. When you get your new ID card, ask your pharmacist to update your prescription information. Part D drugs are not subject to step therapy.
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 1-833-746-5914 (TTY users call 711 or visit www.Medicare.gov.
Provider Network	You have access to the ConnectiCare Medicare Choice network.	You do not have access to the ConnectiCare Medicare Choice network. See your new ID card for more information.

SECTION 3 How to Change Plans

To stay in EmblemHealth VIP Gold Plus (HMO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our EmblemHealth VIP Gold Plus (HMO).

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 EmblemHealth VIP Gold Plus (HMO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from EmblemHealth VIP Gold Plus (HMO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at **1-877-344-7364** (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, HIP/EmblemHealth offers other Medicare health plans. These other plans can have different coverage, monthly plan 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 separate 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 may 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 4 Get Help Paying for Prescription Drugs

You may 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 can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** 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 (SHIP). 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 people 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 Uninsured Care Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call **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 payment option. To learn more about this payment option, call us at **1-833-746-5914** (TTY users call **711**) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from EmblemHealth VIP Gold Plus (HMO)

- **Call Customer Service at 1-877-344-7364. (TTY users call 711).**

  We're available for phone calls 8 am to 8 pm 7 days a week from October 1 to March 31 and 8 am to 8 pm Monday- Saturday, April 1 to September 30. 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 EmblemHealth VIP Gold Plus (HMO). 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 **emblemhealth.com/medicare** or call Customer Service at **1-877-344-7364** (TTY users call **711**) to ask us to mail you a copy.

- **Visit emblemhealth.com/medicare**

  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 HIICAP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call HIICAP at **1-800-701-0501**. Learn more about HIICAP by visiting their website at **www.aging.ny.gov**.

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.