



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

Annual Notice of Change for 2027

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, 2026, you'll stay in EmblemHealth VIP Gold Plus (HMO).
- 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 emblemhealth.com/medicare or call Customer Service at **1-877-344-7364** (TTY users call **711**) to get a copy by mail.

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 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, 2026, you'll automatically be enrolled in EmblemHealth VIP Gold Plus (HMO).** Starting January 1, 2027, you'll get your medical and

drug coverage through EmblemHealth VIP Gold Plus (HMO). Go to Section 2 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.	\$252	\$216
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.)	\$9,250	\$9,850
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 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.	\$195 copay each day for days 1 to 10 and \$0 copay each day for days 11 to 90 for Medicare-covered hospital care.	\$195 copay each day for days 1 to 10 and \$0 copay each day for days 11 to 90 for Medicare-covered hospital care.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible \$200 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$0 copay	Part D drug coverage deductible \$200 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: \$0 copay

	2026 (this year)	2027 (next year)
	Drug Tier 2: \$10 copay Drug Tier 3: You pay 25% coinsurance You pay the lesser of \$35 or 25% per one-month supply of each covered insulin product on this tier. Drug Tier 4: 28% coinsurance Drug Tier 5: 29% coinsurance Drug Tier 6: \$0 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	Drug Tier 2: \$10 copay Drug Tier 3: 24% coinsurance You pay the lesser of \$35 or 24% per one-month supply of each covered insulin product on this tier. Drug Tier 4: 27% coinsurance You pay the lesser of \$35 or 25% per one-month supply of each covered insulin product on this tier. Drug Tier 5: 29% coinsurance Drug Tier 6: \$0 copay 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

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$252	\$216

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 3 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.

	2026 (this year)	2027 (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.	\$9,250	\$9,850 Once you've paid \$9,850 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 2027 *Provider Directory* at emblemhealth.com/medicare 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. 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.

There are no changes to our network of pharmacies for next year.

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

	2026 (this year)	2027 (next year)
Additional acupuncture services - Cost-Sharing	Not covered	You pay a \$0 copay.
Additional acupuncture services - Periodicity	Not covered	Limited to 15 visit(s) every year.
Dental services - Preventive dental services - Other Services - Periodicity	Limited to 1 visit for other preventive dental services every six months.	Unlimited other preventive dental service(s) every year.
Dental services - Preventive dental services - Dental X-Rays - Periodicity	Standard x-ray: Limited to 1 every six months Intraoral complete series, panoramic and vertical bitewings: Limited to 1 every 36 months.	Unlimited x-rays every year.
Dental services - Preventive dental services - Fluoride Treatment - Periodicity	Limited to 1 fluoride treatment every six months.	Unlimited fluoride treatments every year.
Dental services - Preventive dental services - Oral Exams - Periodicity	Limited to 1 oral exam every six months.	Unlimited oral exams every year.
Dental services - Preventive dental services - Prophylaxis (Cleaning) - Periodicity	Limited to 1 cleaning every six months.	Unlimited cleanings every year.

	2026 (this year)	2027 (next year)
Emergency care - Cost-Sharing	You pay a \$115 copay for each Medicare-covered service. Copay is waived if you are admitted to a hospital within 1 day.	You pay a \$75 copay for each Medicare-covered service. Copay is waived if you are admitted to a hospital within 1 day.
Hearing services - Hearing aids - Maximum plan amount	Up to a \$3,000 credit for both ears combined every three years for hearing aids.	Up to a \$1,500 credit for both ears combined every year for hearing aids.
Inpatient services in a psychiatric hospital - Cost-Sharing	You pay a \$2,080 copay for each Medicare-covered hospital stay. \$0 copay for an additional 60 lifetime reserve days. Medicare hospital benefit periods do not apply. For inpatient mental health care, the cost-sharing described above applies each time you are admitted to the hospital.	You pay a \$2,091 copay for each Medicare-covered hospital stay. \$0 copay for an additional 60 lifetime reserve days. Medicare hospital benefit periods do not apply. For inpatient mental health care, the cost-sharing described above applies each time you are admitted to the hospital.
Meal benefit - Cost-Sharing	Not covered	You pay a \$0 copay. Home delivery of 2 meals per day over a 7 day period (up to 14 meals) following at least a 2-day inpatient stay at an Acute Hospital, Psychiatric Hospital, or Skilled Nursing Facility. Meals must be dispensed within 30 days after discharge.

	2026 (this year)	2027 (next year)		
Skilled nursing facility (SNF) care - Cost-Sharing	You pay a \$0 copay each day for days 1 to 20 and \$218 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. Medicare hospital benefit periods apply.	You pay a \$0 copay each day for days 1 to 20 and \$221 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. Medicare hospital benefit periods apply.		
Vision care - Additional routine eyewear - Maximum plan amount	Up to a \$150 combined credit every year for all additional eyewear.	Up to a \$300 combined credit every year for all additional eyewear.		
Prior Authorizations	The following in-network benefits have a change in prior authorization requirements. <table><tr><td> - Acupuncture supplemental benefits not covered. - Meal benefit is not covered. </td><td> - Acupuncture supplemental benefits prior authorization is not required. - Meal benefit prior authorization is required. </td></tr></table>		- Acupuncture supplemental benefits not covered. - Meal benefit is not covered.	- Acupuncture supplemental benefits prior authorization is not required. - Meal benefit prior authorization is required.
- Acupuncture supplemental benefits not covered. - Meal benefit is not covered.	- Acupuncture supplemental benefits prior authorization is not required. - Meal benefit 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.

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, 2026, 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.

- **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, Tier 4, and Tier 5 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	\$200 During this stage, you pay \$0 cost sharing for drugs on Tier 1: Preferred Generic, \$10 cost sharing for drugs on Tier 2: Generic, and \$0 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 have reached the yearly deductible.	\$200 During this stage, you pay \$0 cost sharing for drugs on Tier 1: Preferred Generic, \$10 cost sharing for drugs on Tier 2: Generic, and \$0 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 have 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 with standard and preferred cost sharing.

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	You pay \$0.	You pay \$0.

	2026 (this year)	2027 (next year)
Tier 2: Generic	You pay \$10 for retail locations and for standard mail order. You pay \$0 for preferred mail order.	You pay \$10 for retail locations and for standard mail order. You pay \$0 for preferred mail order.
Tier 3: Preferred Brand	You pay 25% of the total cost for retail locations or standard mail order. You pay 22% of the cost for preferred mail order. You pay the lesser of \$35 or (25% of the cost for retail locations and standard mail order or 22% of the cost for preferred mail order) per one-month supply of each covered insulin product on this tier.	You pay 24% of the total cost for retail locations and standard mail order. You pay 22% of the cost for preferred mail order. You pay the lesser of \$35 or (24% of the total cost for standard retail locations and standard mail order, or 22% of the cost for preferred mail order) per one-month supply of each covered insulin product on this tier.
Tier 4: Non-Preferred Drug	You pay 28% of the total cost at retail locations and from standard mail order. You pay 25% of the cost for preferred mail order.	You pay 27% of the total cost at standard retail locations and from standard mail order. You pay 25% of the total cost for preferred mail order. You pay the lesser of \$35 or 25% per one-month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Tier 5: Specialty Tier	You pay 29% of the total cost.	You pay 29% of the total cost.
Tier 6: Select Care Drugs	You pay \$0.	You pay \$0 .

SECTION 2 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 type of Medicare health 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 2027, 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). 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 separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be 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 1.1).
- **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 4), 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 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 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 3 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 has a program called New York State 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 New York AIDS Drug Assistance Program (ADAP). 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. 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, and 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 **1-833-746-5914** (TTY users call **711**) or visit Medicare.gov.

SECTION 4 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 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 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 New York 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 <https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap>.

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.