VillageCareMAX Medicare Total Advantage Plan (HMO D-SNP) offered by Village Senior Services Corporation (dba VillageCareMAX)

Annual Notice of Changes for 2024

You are currently enrolled as a member of *VillageCareMAX Medicare Total Advantage (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 www.villagecaremax.org. You may also call Member Services 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 *VillageCareMAX Medicare Total Advantage Plan*.
- 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 *VillageCareMAX Medicare Total Advantage Plan*.
- Look in section 2, page 15 *Deciding Which Plan to Choose* 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 and Chinese.
- Please contact our Member Services number at 1-800-469-6292 for additional information. (TTY users should call 711.) Hours are 8:00 am to 8:00 pm, 7 days a week. This call is free.
- You can get this information for free in other formats, such as large print, braille, or audio. Call 1-800-469-6292, (TTY users should call 711). Hours are 8:00 am to 8:00 pm, 7 days a week. The call is free.
- **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 VillageCareMAX Medicare Total Advantage Plan (HMO-D-SNP)

- VillageCareMAX is an HMO plan with Medicare and New York State Medicaid contracts. Enrollment in VillageCareMAX depends on contract renewal. The plan also has a written agreement with the New York Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means *Village Senior Services Corporation (VillageCareMAX*). When it says "plan" or "our plan," it means *VillageCareMAX Medicare Total Advantage Plan*.

Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for VillageCareMAX Medicare Total Advantage Plan in several important areas. **Please note this is only a summary of costs**.

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 for your Part D prescription drug premium	$0 for your Part D prescription drug premium
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day	• $0 deductible for each benefit period • Days 1-60: $0 copay for each benefit period • Days 61-90: $0 copay for each benefit period • Days 91 and beyond: $0 copay per lifetime reserve day	• $0 deductible for each benefit period • Days 1-60: $0 copay for each benefit period • Days 61-90: $0 copay for each benefit period • Days 91 and beyond: $0 copayment each day while using your 60 lifetime reserve days.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay/coinsurance • Drug Tier 2: $0 copay/coinsurance Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay/coinsurance • Drug Tier 2: $0 copay/coinsurance • Drug Tier 3: $0 copay/coinsurance • Drug Tier 4: $0 copay/coinsurance • Drug Tier 5: $0 copay/coinsurance Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.

Cost	2023 (this year)	2024 (next year)
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 for your Part D prescription drug premium	$0 for your Part D prescription drug premium

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 and deductibles) 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 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 www.villagecaremax.org. You may also call Member Services 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 and Pharmacy 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 Provider and 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 Member Services 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)
Over-the-Counter (OTC) Health-Related Items	You are covered for up to $2,700 per year ($225 per month) on your OTC card to buy approved non-prescription drugs and health-related items at participating locations. Eligible members can also use their monthly benefit amount to get Food & Produce (grocery items). See below for "Special Supplemental Benefits for the Chronically Ill (SSBCI) – Food & Produce" The unused funds do not carry over from month to month	You are covered for up to $3,000 per year ($250 per month) on your OTC card to buy approved non-prescription drugs and health-related items at participating locations. Eligible members can also use their monthly benefit amount to get COVID-19 Tests & OTC Hearing Aids, Food, Produce (grocery items), and pay for Utilities. See below for "Special Supplemental Benefits for the Chronically Ill (SSBCI) – Food, Produce & Utilities" The unused funds carry over from month to month but must be used by the end of the year."

Cost	2023(this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Food, Produce & Utilities *Food, Produce (grocery items), & Utilities are a part of SSBCI and not all members may qualify.*	SSBCI – Utilities are not covered The unused funds do not carry over from month to month.	SSBCI – Food, Produce (grocery items) & Utilities are covered. Members who meet the criteria of chronically ill can use their OTC card to cover utilities as well. You are covered for up to $3,000 per year ($250 per month) on your OTC card to buy approved grocery items, utilities, non-prescription drugs and health-related items at participating locations. The benefits mentioned are a part of Special Supplemental Program for the Chronically Ill. Not all members will qualify. The unused funds carry over from month to month but must be used by the end of the year. You can call Member Services or refer to the *Evidence of Coverage* for more information about this benefit.
Comprehensive Dental	You are covered for up to $2,000 per year **($500 per quarter)** for comprehensive dental services: • Crowns, retainer crowns, and pontics	You are covered for up to $2,000 per year **($1,000 per every 6 months)** for comprehensive dental services: • Crowns, retainer crowns, and pontics

Cost	2023(this year)	2024 (next year)
Comprehensive Dental (continued)	(false teeth) are limited to one per tooth every 60 months • Resin-based composite (fillings) are limited to 1 per surface per tooth every 36 months • Endodontic services (root canal therapy) are limited to 1 per tooth in a lifetime • Periodontics (treatment of gum disease) are limited to 1 per site/quad every 24 months • Palliative (emergency) treatment/minor procedure limited to 1 every 12 months • House/extended care facility call limited to 1 every 6 months • Teledentistry services limited to 2 every calendar year • Extractions, non-routine and diagnostic services This benefit is limited to the dental procedure codes covered by the plan.	(false teeth) are limited to 1 per tooth every 60 months • Resin-based composite (fillings) are limited to 1 per surface per tooth every 36 months • Endodontic services (root canal therapy) are limited to 1 per tooth in a lifetime • Periodontics (treatment of gum disease) are limited to 1 per site/quad every 24 months • Palliative (emergency) treatment/minor procedure limited to 1 every 12 months • House/extended care facility call limited to 1 every 6 months • Teledentistry services limited to 2 every calendar year • Extractions, non-routine and diagnostic services This benefit is limited to the dental procedure codes covered by the plan. Unused amounts from the biannual limit carry over to the next 6 months and must be used by December 31, 2024.

Cost	2023(this year)	2024 (next year)
Vision Care (Non-Medicare-covered Eyewear)	You are covered for: • One (1) routine eye exam every year • Up to $350 every year for contact lenses or eyeglasses (lenses and frames) No limit to eyewear.	You are covered for: • One (1) routine eye exam every year • Up to $350 every year for eyewear with a limit Eyewear limits include: • contacts (unlimited) • eyeglasses (lenses + frames) — 1 per year • lenses (1 pair per year) • frames (1 per year)
Acupuncture (*Non-Medicare-Covered)*	You are covered for up to 5 visits per month with a maximum of 50 visits per year (up to $80 limit per visit)	You are covered for up to 5 visits per month with a maximum of 54 visits per year (up to $80 limit per visit)
Inpatient Hospital Acute Services ***(Non-Medicare Covered)***	You are covered for unlimited additional days.	Not Covered

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 Member Services 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 does not apply to you.** We have included 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 didn't receive this insert with this packet, please call Member Services 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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Generic Drugs*:** You pay $0 per prescription ***Brand Drugs:*** You pay $0 per prescription	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Tier 1: Preferred Generic Drugs*** You pay $0 per prescription ***Tier 2: Generic Drugs:*** You pay $0 per prescription ***Tier 3: Preferred Brand Drugs:*** You pay $0 per prescription ***Tier 4: Non- Preferred Drugs:*** You pay $0 per prescription ***Tier 5: Specialty Drugs:*** You pay $0 per prescription

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) 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".**	Once you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	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 and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in VillageCareMAX Medicare Total Advantage Plan

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 *VillageCareMAX Medicare Total Advantage Plan*.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change 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 4), or call Medicare (see Section 6.2).

As a reminder, *Village Senior Services Corporation (VillageCareMAX)* 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 *VillageCareMAX Medicare Total Advantage Plan*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *VillageCareMAX Medicare Total Advantage Plan*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services 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 3 Changing Plans

If you want to change to a different plan or 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 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 4 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, 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 (TTY: 711). You can learn more about HIICAP by visiting their website (www.aging.ny.gov/health-insurance-information-counseling-and-assistance).

For questions about your Medicaid benefits, contact New York Medicaid Choice at 1-800-401-6582 (TTY: 1-888-329-1541). The business hours are Monday through Friday from 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

SECTION 5 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 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 Uninsured Care Programs. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Uninsured Care Programs at 1-800-542-2437, Monday through Friday from 8:00 am to 5:00 pm.

SECTION 6 Questions?

Section 6.1 – Getting Help from *VillageCareMAX Medicare Total Advantage Plan*

Questions? We're here to help. Please call Member Services at 1-800-469-6292. (TTY only, call 711.) We are available for phone calls from 8:00 am to 8:00 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 *VillageCareMAX Medicare Total Advantage Plan*. 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 www.villagecaremax.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.villagecaremax.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our List of Covered Drugs (Formulary/"Drug List").

Section 6.2 – 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 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call New York State Department of Health Medicaid Help Line at 1-800-541-2831 The business hours are Monday through Friday from 8:00 am to 5:00 pm, and Saturday from 9:00 am to 1:00 pm. TTY users should call 1-800-662-1220.