

VillageCareMAX Medicare Health Advantage Plan (HMO D-SNP) offered by VillageCareMAX

Annual Notice of Change for 2026

You're enrolled as a member of VillageCareMAX Medicare Health Advantage FLEX Plan (HMO D-SNP).

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 VillageCareMAX Medicare Health Advantage Plan.
- 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 www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Albanian, Arabic, Bengali, Chinese, French, French Creole, Greek, Italian, Korean, Polish, Russian, Spanish, Spanish Creole, Tagalog, Urdu, and Yiddish.
- Our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.
- Call Member Services at 1-855-296-8800 (TTY users call 711) for more information. Hours are 7 days a week, 8 am to 8 pm. This call is free.
- This information is available in large print, braille, or audio.

About VillageCareMAX Medicare Health Advantage Plan

- 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 material says "we," "us," or "our," it means VillageCareMAX. When it says "plan" or "our plan," it means VillageCareMAX Medicare Health Advantage Plan.

- On January 1, 2026, VillageCareMAX will be combining VillageCareMAX Medicare Health Advantage FLEX Plan with one of our plans, VillageCareMAX Medicare Health Advantage Plan. This material tells you about the differences between your current benefits in VillageCareMAX Medicare Health Advantage FLEX Plan and the benefits you'll have on January 1, 2026 as a member of VillageCareMAX Medicare Health Advantage Plan.
- **If you do nothing by December 7, 2025**, you'll automatically be enrolled in VillageCareMAX Medicare Health Advantage Plan. Starting January 1, 2026, you'll get your medical and drug coverage through VillageCareMAX Medicare Health Advantage Plan. 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 than this amount. Go to Section 1.1 for details.	\$0	\$0
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.)	\$9,350 If you are eligible for Medicare cost-sharing help under Medicaid, 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.	\$9,250 If you are eligible for Medicare cost-sharing help under Medicaid, 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.
Primary care office visits	\$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.	\$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.
Specialist office visits	\$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.	\$0 per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.

	2025 (this year)	2026 (next year)
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.	\$0 If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.	\$0 If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.
Part D drug coverage deductible (Go to Section 1.7 for details.)	\$590 except for covered insulin products and most adult Part D vaccines.	\$615 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Sections 1.6 and 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: You can have a \$2 copay for drugs that are covered under our enhanced benefit. • Drug Tier 1: \$2 copay • Drug Tier 2: \$8 copay • Drug Tier 3: 25% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35. • Drug Tier 4: 30% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35.	Copayment/Coinsurance during the Initial Coverage Stage: You can have a \$4 copay for drugs that are covered under our enhanced benefit. • Drug Tier 1: \$4 copay • Drug Tier 2: \$8 copay • Drug Tier 3: 21% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35. • Drug Tier 4: 25% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35.

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	• Drug Tier 5: 25% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35. • Drug Tier 6: 15% of the total cost Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have a \$2 copay for drugs that are covered under our enhanced benefit.	• Drug Tier 5: 25% of the total cost Cost sharing for a 1 month supply of insulin is limited to \$35. • Drug Tier 6: \$0 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have a \$4 copay for drugs that are covered under our enhanced benefit.

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 unless it's paid for you by Medicaid.)	\$0	\$0 There is no change for the upcoming benefit year.

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 Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medicaid help with Part A and Part B copayments, 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 copayments) count toward your maximum out-of-pocket amount. Our costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$9,350	\$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

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

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 Member Services at 1-855-296-8800 (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.

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 Member Services at 1-855-296-8800 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

	2025 (this year)	2026 (next year)
Acupuncture (routine)	\$0 copay for each routine acupuncture visit (32 visits every year). \$80 maximum plan coverage amount	Routine acupuncture benefit is <u>not</u> covered.
Chronic pain management and treatment services	<u>In-Network</u> Medicare-covered chronic pain management and treatment services benefit is <u>not</u> covered.	<u>In-Network</u> Medicare-covered chronic pain management and treatment services benefit is covered.
Colorectal Cancer Screening (Barium Enemas)	<u>In-Network</u> \$0 for each Medicare-covered barium enema.	<u>In-Network</u> Medicare-covered barium enema benefit is <u>not</u> covered.

	2025 (this year)	2026 (next year)
Dental Services	<u>In-Network</u> Diagnostic, preventive and comprehensive dental services. You receive diagnostic, preventive and comprehensive dental benefits as part of your standard plan. \$0 copay for each maxillofacial prosthetics services visit (1 visit every year). Referral is required for non-Medicare-covered removable prosthodontics. Referral is required for non-Medicare-covered implant services. Referral is required for non-Medicare-covered fixed prosthodontics.	<u>In-Network</u> Diagnostic, preventive and comprehensive dental services. You receive diagnostic, preventive and comprehensive dental benefits as part of your standard plan. Some service and limitations have changed. For a complete list of covered services and limitations, please reference the New York State Policy and Procedure Codes Manual at https://www.emedny.org/ProviderManuals/Dental/. Maxillofacial prosthetics services are <u>not</u> covered. No referral required for non-Medicare-covered removable prosthodontics. No referral required for non-Medicare-covered implant services. No referral required for non-Medicare-covered fixed prosthodontics.

	2025 (this year)	2026 (next year)
FLEX Benefit	\$125 per month allowance towards additional dental, vision, or hearing benefits	FLEX Benefit is <u>not</u> covered.
Meal Benefit	<u>In-Network</u> Meal benefit is <u>not</u> covered.	<u>In-Network</u> \$0 copay per meal. 2 meals per day for 4 weeks (2 x 28 days = 56 meals total). There is no limit to the number of occurrences/discharges covered for the year. Benefit may be used immediately following surgery or inpatient hospitalization.

	2025 (this year)	2026 (next year)
Over-the-Counter Items Food & produce (grocery items), gas-at-the-pump, utilities, rent/mortgage assistance, pest control products, indoor air quality products, ride share, public transportation, transportation for non-medical needs are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). In order to be eligible to receive SSBCI benefits, enrollees must be determined to be chronically ill, have a chronic condition (e.g., diabetes, chronic heart failure, cardiovascular disorder, chronic and disabling mental health conditions, stroke, or other eligible conditions), and meet coverage criteria. Not all members may qualify.	Additional benefits covered under Value Based Insurance Design (VBID) benefit. \$195 maximum plan coverage amount every month for OTC items like OTC hearing aids. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities.	Additional benefits covered under the SSBCI benefit. \$220 maximum plan coverage amount every month for OTC items like OTC hearing aids. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities, indoor air quality products, pest control products, bus/subway transit fare.
Podiatry Services	No prior authorization required for Medicare-covered podiatry care services.	Prior authorization is required for Medicare-covered podiatry care services.
Pre-exposure prophylaxis (PrEP) for HIV prevention	<u>In-Network</u> Medicare-covered pre-exposure prophylaxis (PrEP) for HIV prevention benefit is <u>not</u> covered.	<u>In-Network</u> There is no coinsurance, copayment, or deductible for the PrEP benefit.

	2025 (this year)	2026 (next year)
Remote Access Technologies	<u>In-Network</u> Remote access technologies (nurse hotline) benefit is <u>not</u> covered.	<u>In-Network</u> \$0 copay for each visit using the remote access technologies (nurse hotline) benefit.
Screening for Hepatitis C Virus infection	<u>In-Network</u> Medicare-covered screening for Hepatitis C Virus infection benefit is <u>not</u> covered.	<u>In-Network</u> There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

	2025 (this year)	2026 (next year)
Special Supplemental Benefits for the Chronically Ill Food & produce (grocery items), gas-at-the-pump, utilities, rent/mortgage assistance, pest control products, indoor air quality products, ride share, public transportation, transportation for non-medical needs are part of Special Supplemental Benefits for the Chronically Ill (SSBCI). In order to be eligible to receive SSBCI benefits, enrollees must be determined to be chronically ill, have a chronic condition (e.g., diabetes, chronic heart failure, cardiovascular disorder, chronic and disabling mental health conditions, stroke, or other eligible conditions), and meet coverage criteria. Not all members may qualify.	Supplemental benefit is covered under Value-Based Insurance Design (VBID). Combined with OTC Benefit. \$195 maximum plan coverage amount every month for OTC items like OTC hearing aids. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities.	Supplemental benefit is covered. Combined with OTC Benefit. \$220 maximum plan coverage amount every month for OTC items like OTC hearing aids. Unused funds roll over month to month but expire at the end of the year. Includes OTC drugs, groceries, gas, rental assistance, utilities, indoor air quality products, pest control products, bus/subway transit fare. Non-Medical transportation is 32 one way trips (16 round trips) per year.
Telehealth Benefits (additional)	Intensive outpatient program services <u>not</u> covered under telehealth benefit.	\$0 copay for Intensive outpatient program services covered under telehealth benefit with a \$0 copay.
Vision Care	\$300 maximum plan coverage amount every year for all non-Medicare-covered eyewear.	\$350 maximum plan coverage amount every year for all non-Medicare-covered eyewear.

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 haven't made any changes to our Drug List at this time for next year. However, we might make other changes that are allowed by Medicare rules. 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.

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 does not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and didn't get this material with this packet, call Member Services at 1-855-296-8800 (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 enhanced drugs until you reach the \$615 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 total out-of-pocket costs reach 2026 out-of-pocket threshold \$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 can have cost sharing for drugs that are covered under our enhanced benefit. You 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	During this stage, you pay for Enhanced drugs until you've reached the \$590 yearly deductible. Then, Enhanced drugs will have a \$2 copay.	During this stage, you pay for Enhanced drugs until you've reached the \$615 yearly deductible. Then, Enhanced drugs will have a \$4 copay. During this stage, you pay \$0 cost sharing for drugs on <i>Select Care Drugs (Tier 6)</i> and the full cost of drugs on <i>Preferred Generic (Tier 1), Generic (Tier 2), Preferred Brand (Tier 3), Non-Preferred Drug (Tier 4), and Specialty Tier (Tier 5)</i> until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on *Select Care Drugs*, your cost sharing in the Initial Coverage Stage is changing from coinsurance to a copayment. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard 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; at a network pharmacy that offers preferred cost sharing; 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)
Preferred Generic:	\$2 copay	\$4 copay
Generic:	\$8 copay	\$8 copay
Preferred Brand:	25% of the total cost	21% of the total cost
Non-Preferred Drug:	30% of the total cost	25% of the total cost
Specialty Tier:	25% of the total cost	25% of the total cost
Select Care Drugs:	15% of the total cost	\$0 copay

Changes to your VBID Part D Benefit

The Value Based Insurance Design (VBID) benefits offered in 2025 included covered Medicare Part D drugs at a \$0 copay. VBID is not a covered benefit in 2026 and cost-sharing for Medicare Part D Drugs is listed above, and may vary based on Low Income Subsidy level.

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

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)
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 1-855-296-8800 (TTY users call 711) or visit www.Medicare.gov .
Notice of Privacy Practices The items listed here have been added to the Notice of Privacy Practices. Visit www.villagecare.org for the most up-to-date notice.		1. Information about special protections for certain types of protected health information, like reproductive health care information, for example 2. Updated timeframes to match VillageCareMAX policies and requirements 3. A section for a member's right to choose someone to act on their behalf 4. Information about VillageCareMAX's potential use of advanced technology to improve the quality and efficiency of services we provide

SECTION 3 How to Change Plans

To stay in VillageCareMAX Medicare Health Advantage Plan, 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 VillageCareMAX Medicare Health Advantage Plan.

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 VillageCareMAX Medicare Health Advantage Plan.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from VillageCareMAX Medicare Health Advantage Plan.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-855-296-8800 (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).

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 3.1 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

Because you have New York State Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

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 separate Medicare drug coverage) or switch to Original Medicare (with or without 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 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 AIDS Drug Assistance 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 New York State AIDS Drug Assistance Program at 1-800-542-2437. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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, regardless of income level. To learn more about this payment option, call us at 1-855-296-8800 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from VillageCareMAX Medicare Health Advantage Plan

- **Call Member Services at 1-855-296-8800. (TTY users call 711.)**

We're available for phone calls 7 days a week, 8 am to 8 pm. 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 VillageCareMAX Medicare Health Advantage Plan. 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 www.villagecaremax.org or call Member Services at 1-855-296-8800 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.villagecaremax.org**

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 State Health Insurance Assistance Program.

Call New York State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call New York State Health Insurance Assistance Program at 1-800-701-0501. Learn more about New York State Health Insurance Assistance Program by visiting (<https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs>).

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.

Get Help from Medicaid

To get information from Medicaid, you can call New York State Medicaid Program at 1-800-541-2831 Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM (TTY 711). You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at www.health.ny.gov/health_care/medicaid.

Call New York State Medicaid at 800-541-2831 for help with Medicaid enrollment or benefit questions.