VNS Health EasyCare Plus (HMO D-SNP) offered by VNS Health Medicare

Annual Notice of Changes for 2025

You are currently enrolled as a member of VNS Health EasyCare Plus (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells you 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 vnshealthplans.org/easycareplus-eoc. You may also call your Care Team 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in VNS Health EasyCare Plus.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with VNS Health EasyCare Plus (HMO D-SNP).
- Look in section 3, page 22 to learn more about your choices.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish and Chinese.

  Este documento está disponible sin cargo en inglés y chino.

  本文件免費提供英文和西班牙文版本。

- Please contact your Care Team at 1-866-783-1444 for additional information. (TTY users should call 711.) Hours are 7 days a week, 8 am – 8 pm (Oct. – Mar.) and weekdays 8 am – 8 pm (Apr. – Sept.). This call is free.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8

pm (Oct. – Mar.), and weekdays, 8 am – 8 pm (Apr. – Sept.). This 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 VNS Health EasyCare Plus

- VNS Health Medicare is a Medicare Advantage organization with Medicare and Medicaid contracts, offering HMO D-SNP and HMO plans. Enrollment in VNS Health Medicare depends on contract renewal.
- When this document says "we," "us," or "our," it means VNS Health Medicare. When it says "plan" or "our plan," it means VNS Health EasyCare Plus (HMO D-SNP).

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Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for VNS Health EasyCare Plus in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$48.70	$72.30
Deductible	$230* except for insulin furnished through an item of durable medical equipment If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. *This amount may change.	$230* except for insulin furnished through an item of durable medical equipment If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. *This amount may change.
Doctor office visits	Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	0% coinsurance or: $1,632 deductible for each benefit period. • Days 1-60: $0 coinsurance per day of each benefit period. • Days 61-90: $408 coinsurance per day of each benefit period. • Days 91 and beyond: $816 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.	These are 2024 cost-sharing amounts and may change for 2025. 0% coinsurance or: $1,632 deductible for each benefit period. • Days 1-60: $0 coinsurance per day of each benefit period. • Days 61-90: $408 coinsurance per day of each benefit period. • Days 91 and beyond: $816 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.
Inpatient Mental Health Care	$0 copayment $0 deductible If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	$0 copayment $0 deductible If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued on next page) (See Section 1.5 for details.)	Value-Based Insurance Design not available. Deductible: either $0 or $545 except for covered insulin products and most adult Part D vaccines. Copayment / Coinsurance during the Initial Coverage Stage: Drug Tier 1: You pay: • $0 copay; or • $1.55 copay; or • $4.50 copay For all other drugs, either: • $0 copay; or • $4.60 copay; or • $11.20 copay Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility. (Look at the separate insert, the	Deductible, and Copayment / Coinsurance during the Initial Coverage Stage: Members who receive Extra Help qualify for participation in the Value-Based Insurance Design program which reduces the Part D cost shares in these phases to $0 for covered drugs. Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued)	"LIS Rider" for your deductible amount.)	
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.)	$8,850 If you are eligible for Medicare cost-sharing assistance 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.	$9,350 If you are eligible for Medicare cost-sharing assistance 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.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$48.70	$72.30

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	2024 (this year)	2025 (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.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, 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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,850	$9,350 Once you have paid $9,350 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may 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.

Updated directories are located on our website at vnshealthplans.org/providers. You may also call your Care Team 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 and pharmacies for next year. **Please review the 2025 *Provider and Pharmacy Directory* vnshealthplans.org/providers to see if your providers (primary care provider, specialists, hospitals, etc.) and 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 your Care Team 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	2024 (this year)	2025 (next year)
Emergency Care	You pay 20% of the total cost, up to a $100 maximum for each visit for Medicare-covered emergency care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay 20% of the total cost, up to a $110 maximum for each visit for Medicare-covered emergency care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Cost	2024 (this year)	2025 (next year)
Dental Services	$3,000 maximum coverage for comprehensive dental services.	$2,750 maximum plan coverage amount every year for diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit.
Flex Benefit	You get a $350 pre-loaded debit card benefit for the year. The benefit card may be used to help pay for certain utilities like electric, gas, telephone, and internet bills. It can also be used to cover items or services above the maximum covered amount for dental, hearing, and vision.	Please see OTC/Grocery and Flex for more information.
Hospice (continued on next page)	You pay $0 for a Medicare-certified hospice program. Hospice Care Support Allowance: If you are eligible for and elect hospice with an in-network hospice provider, you may be eligible for a $500 Hospice Care Support Allowance.	If you choose hospice services on or after January 1, 2025, hospice services will be covered by Original Medicare. Hospice supplemental benefits are no longer covered by the plan. There may be changes in the cost-sharing with Original Medicare. Transitional Concurrent Care (TCC) will no

Cost	2024 (this year)	2025 (next year)
Hospice (continued)	The allowance is a supplemental benefit that allows for the purchase of goods or services that are not covered by your health plan's benefits. These goods or services should be related to providing comfort and improving your quality of life while receiving hospice care. Some examples include but are not limited to home and bathroom safety devices/ modifications; Support for caregivers of enrollees, etc. Prior health plan approval for requested goods or services is required. Transitional Concurrent Care timeframe: If you are eligible for hospice, and elect hospice, you may be eligible for Transitional Concurrent Care (TCC). TCC are services necessary to address continuing care needs, as medically appropriate, for the treatment of your terminal condition. These services help provide a transition to hospice care and may include a	longer be covered by the plan. If you have questions about these changes or need further clarification, please contact your Care Team at 1-866-783-1444 (TTY: 711).

Cost	2024 (this year)	2025 (next year)
Hospice (continued)	phasing out of specific curative treatment over time. TCC requires prior authorization and is available for up to **60 days** after electing hospice, only if you elect an in-network hospice provider. See your Member Handbook (*Evidence of Coverage*) for more information on the full list of services covered by the plan.	
Over-the-Counter Items (OTC)/Grocery Card and Flex (continued on next page)	$0 Copay OTC/Grocery is a single benefit. You are covered for up to $225 per month for over-the-counter items and grocery items. Use your card to get health and grocery items. Home delivery of prepared meals and produce are also available. Any remaining balances do not carry over at the end of the month. The grocery benefit is a part of special supplemental program for the chronically ill and not all members qualify.	$0 Copay OTC/Grocery and Flex is a combined benefit package. You are covered up to $272.50 per month and will get one card with separate allowances: • $235 every month for OTC/Grocery; • $37.50 for Flex

Cost	2024 (this year)	2025 (next year)
Over-the-Counter Items (OTC)/Grocery Card and Flex (continued)		Use your OTC/Grocery allowance to get health and grocery items. Home delivery of prepared meals and produce are also available. Use your Flex allowance to help pay for certain utilities (electric, gas, internet, and phone). It may also be used to cover items or services above the maximum covered amount for Dental, Hearing, or Vision. Other types of services and goods are not eligible. Any remaining balances will carry over at the end of each month and all allowances must be used by the end of the calendar year (12/31/2025).

Cost	2024 (this year)	2025 (next year)
Over-the-Counter Items (OTC)/Grocery Card and Flex (continued)		Grocery and utility benefits are part of special supplemental benefits for the chronically ill and not all members qualify. Chronic illnesses include diabetes, dementia, heart failure, lung disorders, stroke, and other conditions. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.
Skilled Nursing Facility (SNF) Care (continued on next page)	There is no annual service category deductible. • $0 for the first 20 days of each benefit period. • $204 copay per day for days 21-100 of each benefit period. • You pay all costs for each day after day 100 of the benefit period.	These are 2024 cost-sharing amounts and may change for 2025. There is no annual service category deductible. • $0 for the first 20 days of each benefit period. • $204 copay per day for days 21-100 of each benefit period. • You pay all costs for each day after day

Cost	2024 (this year)	2025 (next year)
Skilled Nursing Facility (SNF) Care (continued)	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	100 of the benefit period. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Urgently Needed Services	You pay 20% of the total cost, up to a $20 maximum for each visit for Medicare-covered urgently needed services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay 20% of the total cost, up to a $45 maximum for each visit for Medicare-covered urgently needed services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Vision Care	$200 maximum plan coverage amount every year for all non-Medicare-covered eyewear.	$300 maximum plan coverage amount every year for all non-Medicare-covered eyewear.

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, we might make other changes that are allowed by Medicare rules that will affect you during the plan 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 are taking, we will send you a notice about the change.

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 your Care Team for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact your Care Team or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.**

We 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 your Care Team and ask for the *LIS Rider*.

Beginning in 2025, there are three **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 will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the 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 do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Value-Based Insurance Design not available. Your deductible is either $0 or $545, depending on the level of "Extra Help" you receive. Look at the separate "LIS Rider," for your deductible amount.	Members who receive Extra Help qualify for participation in the Value-Based Insurance Design program which reduces the Part D deductible to $0.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply look in Chapter 6, Section 5 of your *Evidence of Coverage*. Most adult Part D vaccines are covered at no cost to you.	Value-Based Insurance Design not available. Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: For generic drugs (including brand drugs treated as generics): You pay, either: $0 copay; or $1.55 copay; or $4.50 copay; or For all other drugs: You pay, either: $0 copay; or $4.60 copay; or $11.20 copay; or Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Members who receive Extra Help qualify for participation in the Value-Based Insurance Design program which reduces the Part D deductible to $0 and Part D cost-sharing to $0 for covered drugs.

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Member Rewards	The member rewards program has activities and reward amounts effective January 1, 2024 - December 31, 2024.	The member rewards program will have new activities and reward amounts effective January 1, 2025. Details will be mailed in December 2024.
Service Area	Albany, Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens, Rensselaer, Richmond (Staten Island), Schenectady, Suffolk, and Westchester Counties in New York State. You must live in one of these areas to join the plan.	Albany, Bronx, Erie (Pending Approval), Kings (Brooklyn), Monroe (Pending Approval), Nassau, New York (Manhattan), Queens, Rensselaer, Richmond (Staten Island), Schenectady, Suffolk and Westchester Counties in New York State. You must live in one of these areas to join the plan.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in VNS Health EasyCare Plus

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 VNS Health EasyCare Plus.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025, 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from VNS Health EasyCare Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from VNS Health EasyCare Plus.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact your Care Team if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have New York State Medicaid, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- 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 enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

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 (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. If you recently

moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York State, the SHIP is called Health 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. Health Information, Counseling and Assistance Program (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 Health Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You can learn more about Health Information, Counseling and Assistance Program (HIICAP) by visiting their website (https://aging.ny.gov/health-insurance-information-counseling-and-assistance-programs).

For questions about your New York State Medicaid benefits, contact New York State Medicaid at 1-800-541-2831 (TTY: 711). Hours are Monday – Friday (8:00AM – 8:00PM) and Saturday (9:00AM – 1:00PM). Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles and coinsurance. Because you qualify, you do not have a 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.

- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmacy 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.

SECTION 7 Questions?

Section 7.1 – Getting Help from VNS Health EasyCare Plus

Questions? We're here to help. Please call your Care Team at 1-866-783-1444. (TTY only, call 711.) We are available for phone calls 7 days a week, 8 am – 8 pm (Oct. – Mar.) and weekdays 8 am – 8 pm (Apr. – Sept.). Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for VNS Health EasyCare Plus. 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 vnshealthplans.org/easycareplus-eoc. You may also call your Care Team to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at vnshealthplans.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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid, you can call New York Medicaid at 1-800-541-2831. TTY users should call 711. Hours are Monday – Friday (8:00AM – 8:00PM) and Saturday (9:00AM – 1:00PM).