UVM Health Advantage Select (PPO) offered by MVP Health Plan, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of UVM Health Advantage Select (PPO). 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 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 **mvphealthcare.com.** You may also call the MVP Medicare Customer Care Center to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 the 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 UVM Health Advantage Select (PPO).
- 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 UVM Health Advantage Select (PPO).
- 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

- Please contact our MVP Medicare Customer Care Center number at **1-800-665-7924** for additional information. (TTY users should call 711.) Hours are Monday - Friday, 8 am - 8 pm Eastern Time. From Oct. 1 - Mar. 31, call us seven days a week, 8 am - 8 pm. This call is free.
- This information is available in a different format, including braille and large print (phone numbers are in Section 8 of this booklet).
- **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 UVM Health Advantage Select (PPO)

- UVM Health Advantage Select (PPO) is a PPO plan with a Medicare contract. Enrollment in UVM Health Advantage Select (PPO) depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means MVP Health Plan, Inc. When it says “plan” or “our plan,” it means UVM Health Advantage Select (PPO).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for UVM Health Advantage Select (PPO) 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 than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details)	From network providers: $6,700 From network and out-of-network providers combined: $6,700	From network providers: $7,900 From network and out-of-network providers combined: $9,000
Doctor office visits	**Primary care visits:** **In-Network** You pay a $0 copayment per visit **Out-of-Network** You pay a $5 copayment per visit **Specialist visits:** **In-Network** You pay a $35 copayment per visit **Out-of-Network** You pay a $50 copayment per visit	**Primary care visits:** **In-Network** You pay a $0 copayment per visit **Out-of-Network** You pay a $5 copayment per visit **Specialist visits:** **In-Network** You pay a $35 copayment per visit **Out-of-Network** You pay a $50 copayment per visit
Inpatient Hospital stays	**In-Network** You pay a $355 copayment for a	**In-Network** You pay a $375 copayment for a

Cost	2024 (this year)	2025 (next year)
	Medicare-covered inpatient hospital stay per day for days 1 - 3 You pay a $0 copayment for a Medicare-covered inpatient hospital stay per day for days 4 - 90 $1,065 maximum out-of-pocket per Medicare-covered inpatient hospital stay **Out-of-Network** You pay a $500 copayment for a Medicare-covered inpatient hospital stay per day for days 1 - 5 $0 copayment for a Medicare-covered inpatient hospital stay per day for days 6 - 90	Medicare-covered inpatient hospital stay per day for days 1 - 3 You pay a $0 copayment for a Medicare-covered inpatient hospital stay per day for days 4 - 90 $1,125 maximum out-of-pocket per Medicare-covered inpatient hospital stay **Out-of-Network** You pay a $500 copayment for a Medicare-covered inpatient hospital stay per day for days 1 - 5 $0 copayment for a Medicare-covered inpatient hospital stay per day for days 6 - 90
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $250 for Tiers 3-5 except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Standard cost sharing: You pay $0 per prescription **Drug Tier 2**: Standard cost sharing:	Deductible: $350 for Tiers 3-5 except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** Standard cost sharing: You pay $0 per prescription **Drug Tier 2**: Standard cost sharing:

Cost	2024 (this year)	2025 (next year)
	You pay $10 per prescription **Drug Tier 3**: Standard cost sharing: You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier **Drug Tier 4**: Standard cost sharing: You pay $100 per prescription You pay $35 per month supply of each covered insulin product on this tier **Drug Tier 5**: Standard cost sharing: You pay 28% of the total cost You pay $35 per month supply of each covered insulin product on this tier **Catastrophic Coverage:** During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing	You pay $10 per prescription **Drug Tier 3**: Standard cost sharing: You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier **Drug Tier 4**: Standard cost sharing: You pay 25% of the total cost You pay $35 per month supply of each covered insulin product on this tier **Drug Tier 5**: Standard cost sharing: You pay 28% of the total cost You pay $35 per month supply of each covered insulin product on this tier **Catastrophic Coverage:** During this payment stage, you pay nothing for your covered Part D drugs

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in UVM Health Advantage Select (PPO) in 2025

If you do nothing by December 7, 2024, we will automatically enroll you in our UVM Health Advantage Select (PPO)**.** This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through UVM Health Advantage Select (PPO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – 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.)	$0	$0
Part B premium reduction	You will receive a $0 credit toward your Medicare Part B premium	You will receive a $9.80 credit toward your Medicare Part B premium

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – 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. These limits are called the maximum out-of-pocket amounts. 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)
In-network Maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	From network providers: $6,700	From network providers: $7,900 Once you have paid $7,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copay) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	From in-network and out-of-network providers combined: $6,700	From in-network and out-of-network providers combined: $9,000 Once you have paid $9,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year

Section 2.3 – 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 **mvphealthcare.com**. You may also call the MVP Medicare Customer Care Center 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 2025 *Provider Directory* mvphealthcare.com/findadoctor 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 2025 *Pharmacy Directory* mvphealthcare.com 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 part of your plan during the year. If a mid-year change in our providers affects you, please contact the MVP Medicare Customer Care Center so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

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)
Additional Acupuncture / Chiropractic Services for Chronic Conditions	Additional 10 chiropractor or acupuncture visits per calendar year for eligible chronic conditions. Benefit is a combined total and can be used in any combination Autoimmune disorders/Rheumatoid Arthritis; Cancer; Cardiovascular disorders/Hypertension; Coronary Artery Disease; Congestive Heart Failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Chronic lung disorders/COPD; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Inflammatory Disorders; Post-infection conditions; for example Long Covid, Lyme Disease; Chronic fatigue syndrome; Musculoskeletal disorders	Additional chiropractor or acupuncture visits for eligible chronic conditions are not covered
Ambulance services	**In- and Out-of-Network** You pay a $225 copayment for each Medicare-covered ground ambulance service You pay a $225 copayment for each Medicare-covered air ambulance service	**In- and Out-of-Network** You pay a $300 copayment for each Medicare-covered ground ambulance service You pay a $300 copayment for each Medicare-covered air ambulance service

Cost	2024 (this year)	2025 (next year)
Dental services	**Preventive Dental** You are covered for 2 preventive oral exams, 2 preventive adult prophylaxis (cleanings) and 2 preventive x-ray sets per calendar year. **Comprehensive Dental** $1,250 annual maximum benefit per calendar year for in-network and out-of-network services	**Preventive and Comprehensive Dental** You receive a $1,500 allowance per year on a prepaid debit card that can be used for any preventive or comprehensive dental service. Allowance can be used at any dental provider

Diabetes self-management training, diabetic services and supplies	**In- Network** You pay a $0 copayment per item for each 30-day supply of FreeStyle, OneTouch, Precision, and Prodigy brand blood glucose test strips or non-preferred strips that have prior authorization You pay a $0 copayment for Medicare covered diabetic supplies You pay 5% of the total cost for diabetic related therapeutic shoes You pay 5% of the total cost for diabetic related custom molded shoe inserts (must be used with diabetic shoes) You pay a $0 copayment for Medicare-covered diabetes self-management training **Out-of-Network** You pay 40% of the total cost per item for each 30-day supply of FreeStyle, OneTouch, Precision, and Prodigy brand blood glucose test strips or non-preferred strips that have prior authorization You pay 40% of the total cost for Medicare covered diabetic supplies You pay 40% of the total cost for diabetic related therapeutic	**In- Network** You pay a $0 copayment per item for each 30-day supply of FreeStyle, OneTouch, Precision, and Prodigy brand blood glucose test strips or non-preferred strips that have prior authorization You pay a $0 copayment for Medicare covered diabetic supplies You pay 10% of the total cost for diabetic related therapeutic shoes You pay 10% of the total cost for diabetic related custom molded shoe inserts (must be used with diabetic shoes) You pay a $0 copayment for Medicare-covered diabetes self-management training **Out-of-Network** You pay 40% of the total cost per item for each 30-day supply of FreeStyle, OneTouch, Precision, and Prodigy brand blood glucose test strips or non-preferred strips that have prior authorization You pay 40% of the total cost for Medicare covered diabetic supplies You pay 40% of the total cost for diabetic related therapeutic

Cost	2024 (this year)	2025 (next year)
	shoes You pay 40% of the total cost for diabetic related custom molded shoe inserts (must be used with diabetic shoes) You pay a $0 copayment for Medicare-covered diabetes self-management training	shoes You pay 40% of the total cost for diabetic related custom molded shoe inserts (must be used with diabetic shoes) You pay a $0 copayment for Medicare-covered diabetes self-management training
Emergency care	**In- and Out-of-Network** You pay a $95 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital as an Inpatient within 24 hours for the same condition	**In- and Out-of-Network** You pay a $110 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital as an Inpatient within 24 hours for the same condition
Emergency Transportation	You pay a $225 copayment for Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility Transportation back to the United States from another country is not covered	You pay a $300 copayment for Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility Transportation back to the United States from another country is not covered

Cost	2024 (this year)	2025 (next year)
Inpatient hospital care	**In-Network** You pay a $355 copayment per day for days 1 - 3 of a Medicare-covered inpatient hospital stay You pay a $0 copayment per day for days 4 - 90 $1,065 maximum out-of-pocket per Medicare-covered inpatient hospital stay	**In-Network** You pay a $375 copayment per day for days 1 - 3 of a Medicare-covered inpatient hospital stay You pay a $0 copayment per day for days 4 - 90 $1,125 maximum out-of-pocket per Medicare-covered inpatient hospital stay
Inpatient services in a psychiatric hospital	**In-Network** You pay a copayment of $355 for Medicare-covered Inpatient hospital stays for days 1 - 3 You pay a $0 copayment per day for days 4 - 90 $1,065 maximum out-of-pocket per Medicare-covered inpatient hospital stay	**In-Network** You pay a copayment of $375 for Medicare-covered Inpatient hospital stays for days 1 - 3 You pay a $0 copayment per day for days 4 - 90 $1,125 maximum out-of-pocket per Medicare-covered inpatient hospital stay

Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** You pay a $0 copayment for each Medicare-covered lab service You pay a $35 copayment for each Medicare-covered diagnostic procedure/test You pay a $10 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a $25 copayment for each Medicare-covered ultrasound You pay a $35 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 20% of the total cost for each Medicare-covered radiation therapy service You pay a $160 copayment for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service **Out-of-Network** You pay 40% of the total cost for each Medicare-covered lab service You pay a $50 copayment for each Medicare-covered diagnostic procedure/test You pay a $10 copayment for each Medicare-covered X-ray or diagnostic mammogram service	**In-Network** You pay a $0 copayment for each Medicare-covered lab service You pay a $35 copayment for each Medicare-covered diagnostic procedure/test You pay a $35 copayment for each Medicare-covered X-ray or diagnostic mammogram service You pay a $35 copayment for each Medicare-covered ultrasound You pay a $35 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 20% of the total cost for each Medicare-covered radiation therapy service You pay a $200 copayment for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service **Out-of-Network** You pay 40% of the total cost for each Medicare-covered lab service You pay a $50 copayment for each Medicare-covered diagnostic procedure/test You pay a $35 copayment for each Medicare-covered X-ray or diagnostic mammogram service

Cost	2024 (this year)	2025 (next year)
	You pay 40% of the total cost for each Medicare-covered ultrasound You pay a $50 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 40% of the total cost for each Medicare-covered radiation therapy service You pay 40% of the total cost for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service	You pay 40% of the total cost for each Medicare-covered ultrasound You pay a $50 copayment for each Medicare-covered EKG, EEG, echocardiogram or stress test You pay 40% of the total cost for each Medicare-covered radiation therapy service You pay 40% of the total cost for each Medicare-covered diagnostic radiology PET, CAT, MRI, MRA or NUC service
Outpatient hospital observation	**In-Network** You pay a $225 copayment for each Medicare-covered outpatient hospital observation service **Out-of-Network** You pay a $285 copayment for each Medicare-covered outpatient hospital observation service	**In-Network** You pay a $325 copayment for each Medicare-covered outpatient hospital observation service **Out-of-Network** You pay a $400 copayment for each Medicare-covered outpatient hospital observation service

Cost	2024 (this year)	2025 (next year)
Outpatient rehabilitation services	**In-Network** You pay a $20 copayment for each Medicare-covered physical therapy and speech and language therapy visit You pay a $20 copayment for each Medicare-covered occupational therapy visit	**In-Network** You pay a $30 copayment for each Medicare-covered physical therapy and speech and language therapy visit You pay a $30 copayment for each Medicare-covered occupational therapy visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $175 copayment for each Medicare-covered ambulatory surgical center visit You pay a $225 copayment for each Medicare-covered outpatient hospital visit **Out-of-Network** You pay a $250 copayment for each Medicare-covered ambulatory surgical center visit You pay a $285 copayment for each Medicare-covered outpatient hospital visit	**In- Network** You pay a $225 copayment for each Medicare-covered ambulatory surgical center visit You pay a $325 copayment for each Medicare-covered outpatient hospital visit **Out-of-Network** You pay a $325 copayment for each Medicare-covered ambulatory surgical center visit You pay a $400 copayment for each Medicare-covered outpatient hospital visit

Cost	2024 (this year)	2025 (next year)
Skilled nursing facility (SNF)	**In-Network** You pay a copayment of $0 in a network skilled nursing facility for days 1 - 20 You pay a copayment of $196 in a network skilled nursing facility for days 21 - 55 You pay a copayment of $0 in a network skilled nursing facility for days 56 - 100	**In-Network** You pay a copayment of $0 in a network skilled nursing facility for days 1 - 20 You pay a copayment of $214 in a network skilled nursing facility for days 21 - 55 You pay a copayment of $0 in a network skilled nursing facility for days 56 - 100
Transportation Benefit (non-emergency)	**In-Network** You pay a $0 copayment of the cost of eligible trips 24 One-way Rides, 60 miles max per year to a plan approved health-related location via taxi, rideshare services, van or medical transport.	**In-Network** You pay a $0 copayment of the cost of eligible trips 12 One-way Rides, 60 miles max per year to a plan approved health-related location via taxi, rideshare services, van or medical transport.
Urgently needed services	**In- and Out-of-Network** You pay a $30 copayment for each Medicare-covered urgently needed care visit in the United States and its territories You pay a $95 copayment for each non-Medicare covered urgently needed care visit outside the United States and its territories	**In- and Out-of-Network** You pay a $40 copayment for each Medicare-covered urgently needed care visit in the United States and its territories You pay a $110 copayment for each non-Medicare covered urgently needed care visit outside the United States and its territories

Cost	2024 (this year)	2025 (next year)
Vision care – extra benefits	Allowance of $175 toward non-Medicare covered eyewear (such as eyeglass frames and lenses and/or contact lenses) annually	Allowance of $225 toward non-Medicare covered eyewear (such as eyeglass frames and lenses and/or contact lenses) annually

Section 2.5 – 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 the MVP Medicare Customer Care Center for more information.

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 the 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 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 Member services or ask your health care provider, prescriber, or pharmacist for more information.

Starting in 2025, we may immediately remove a brand name drugs or original biological products on our Drug List, if we replace them with new generics or certain biosimilar versions of the brand name drug or biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or 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 that are discussed throughout this Chapter, 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 Member services 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 sent you 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 you haven't received this insert by September 30, 2024, please call the MVP Medicare Customer Care Center 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	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 Preferred Brand Drugs, Tier 4 Non-Preferred Drugs and Tier 5 Specialty 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.	Deductible: $250 for Tiers 3-5 except for covered insulin products and most adult Part D vaccines During this stage, you pay $0 cost sharing for drugs on Tier 1 Preferred Generic Drugs, You pay $10 for cost sharing for drugs on Tier 2 Generic Drugs and pay the full cost of drugs on Tier 3 Preferred Brand Drugs, Tier 4 Non-Preferred Drugs and Tier 5 Specialty Drugs until you have reached the yearly deductible.	Deductible: $350 for Tiers 3-5 except for covered insulin products and most adult Part D vaccines During this stage, you pay $0 cost sharing for drugs on Tier 1 Preferred Generic Drugs, You pay $10 for cost sharing for drugs on Tier 2 Generic Drugs and pay the full cost of drugs on Tier 3 Preferred Brand Drugs, Tier 4 Non-Preferred Drugs and Tier 5 Specialty Drugs until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 4, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

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.** For 2024, you paid a $100 copayment at a standard pharmacy for drugs on Tier 4. For 2025, you will pay a 25% coinsurance at a standard pharmacy for drugs on this tier. The costs in this chart 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	Your cost for a one-month supply at a network pharmacy: **Tier 1 – Preferred Generic Drugs:** You pay $0 per prescription **Tier 2 – Generic Drugs:** You pay $10 per prescription **Tier 3 – Preferred Brand Drugs:** You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier **Tier 4 – Non-Preferred Drugs:** You pay $100 per prescription You pay $35 per month supply of each covered insulin product on this tier **Tier 5 – Specialty Drugs:** You pay 28% of the total cost You pay $35 per month supply of each covered insulin product on this tier Once your total drug costs	Your cost for a one-month supply at a network pharmacy: **Tier 1 – Preferred Generic Drugs:** You pay $0 per prescription **Tier 2 – Generic Drugs:** You pay $10 per prescription **Tier 3 – Preferred Brand Drugs:** You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier **Tier 4 – Non-Preferred Drugs:** You pay 25% of the total cost You pay $35 per month supply of each covered insulin product on this tier **Tier 5 – Specialty Drugs:** You pay 28% of the total cost You pay $35 per month supply of each covered insulin product on this tier Once you have paid $2,000

Stage	2024 (this year)	2025 (next year)
the Drug List. Most adult Part D vaccines are covered at no cost to you.	have reached $5,030, you will move to the next stage (the Coverage Gap Stage)	out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage)

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 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December) To learn more about this payment option, please contact us at 1-844-889-9792 or visit Medicare.gov.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in UVM Health Advantage Select (PPO)

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 UVM Health Advantage Select (PPO).

Section 4.2 – 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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

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 6), or call Medicare (see Section 8.2).

As a reminder, MVP Health Plan, Inc. 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 UVM Health Advantage Select (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from UVM Health Advantage Select (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact the MVP Medicare Customer Care Center 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.

SECTION 5 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.

If you enrolled in a Medicare Advantage Plan for January 1, 2025, 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, 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 the opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

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**.

SECTION 7 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.** 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 prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, 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 has a program called Elderly Pharmaceutical Insurance Coverage Program (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. To be eligible for the ADAP operating in your State, 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 New York State Department of Health HIV Uninsured Care Programs. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call New York State Department of Health HIV Uninsured Care Programs 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 new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **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 this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment plan. To learn more about this payment option, please contact us at 1-844-889-9792 or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from UVM Health Advantage Select (PPO)

Questions? We're here to help. Please call the MVP Medicare Customer Care Center at **1-800-665-7924.** (TTY only, call 711.) We are available for phone calls Monday - Friday, 8 am - 8 pm Eastern Time. From Oct. 1 - Mar. 31, call us seven days a week, 8 am - 8 pm. 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 UVM Health Advantage Select (PPO) 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 **mvphealthcare.com**. You may also call the MVP Medicare Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 8.2 – 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.