Univera Medicare Dual (HMO D-SNP) offered by Univera Healthcare

Annual Notice of Changes for 2024

You are currently enrolled as a member of Univera Medicare Dual (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. *Please see page 1 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 www.UniveraMedicare.com. You may also call Customer Care 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 Medicare care costs (doctor, hospital).
  - ☐ Review the changes to our drug coverage, including authorization requirements and costs.
  - ☐ Think about how much you will spend on premiums, deductibles, and cost sharing.
- ☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.
- ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.
- ☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

- ☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your Medicare & You 2024 handbook.
- ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Univera Medicare Dual (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start **January 1, 2024.** This will end your enrollment with Univera Medicare Dual (HMO D-SNP).
- Look in Section 4, page 11 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Care number at 1-866-862-7087 for additional information. (TTY users should call 1-800-662-1220.) Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. This call is free.
- This information may be available in a different format, including large print, audio, and braille.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Univera Medicare Dual (HMO D-SNP)

- Univera Healthcare is an plan with a Medicare contract. Enrollment in Univera Healthcare depends on contract renewal.
- The plan also has a written agreement with the New York Medicaid program to coordinate your Medicaid benefits.
- When this document says "we", "us", or "our", it means Univera Healthcare. When it says "plan" or "our plan," it means Univera Medicare Dual (HMO D-SNP).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. (See Section 1.1 for details.)	$0	$0
Doctor office visits	**Primary care visits:** You pay a $0 copayment in-network per visit. **Specialist visits:** You pay a $0 copayment in-network per visit.	**Primary care visits:** You pay a $0 copayment in-network per visit. **Specialist visits:** You pay a $0 copayment in-network per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network:** You pay a $0 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission.	**In-network:** You pay a $0 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission.

Part D prescription drug coverage (See Section 1.5 for details)	Deductible:	Deductible:
	Tier 1 (Preferred Generic): During this stage you pay $0 copayment	**Tier 1** (Preferred Generic): During this stage you pay $0 copayment
	Tier 2 (Generic): During this stage you pay $1.45 or $4.15 copayment	**Tier 2** (Generic): During this stage you pay $1.55 or $4.50 copayment
	Tier 3 (Preferred Brand): During this stage you pay $4.30 or $10.35 copayment	**Tier 3** (Preferred Brand): During this stage you pay $4.60 or $11.20 copayment
	Tier 4 (Non-Preferred Drug): During this stage you pay $4.30 or $10.35 copayment	**Tier 4** (Non-Preferred Drug): During this stage you pay $4.60 or $11.20 copayment
	Tier 5 (Specialty): During this stage you pay **Specialty Generics:** $1.45 or $4.15 copayment **Specialty Brands:** $4.30 or $10.35 copayment	**Tier 5** (Specialty): During this stage you pay **Specialty Generics:** $1.55 or $4.50 copayment **Specialty Brands:** $4.60 or $11.20 copayment
	Catastrophic Coverage: □ During this payment stage, the plan pays most of the cost for your covered drugs.	**Catastrophic Coverage:** □ During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	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.	You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	From network providers: $8,300	From network providers: $8,850 Once you have paid $8,850 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.UniveraMedicare.com. You may also call Customer Care for updated provider and pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the Annual Notice of Changes tells you about changes to your Medicare benefits and costs. "

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Health Education Program	Not Available	$0 copayment This benefit is for members who have stage 4 or 5 chronic kidney disease. If you qualify for this program we will reach out to you. Once you enter the program, you will be assigned a multi-disciplinary care team who will focus on evidence-based, guideline-driven patient education, patient engagement, self-management, management of comorbidities, coordination of care, as well as behavior change counseling and patient navigation services. The goal of the education program is to prolong kidney function, decrease the progression of chronic kidney disease and enable engaged members requiring and selecting renal replacement therapy to experience an optimal transition. The program is offered virtually and in-person.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill Our plan offers additional benefits for certain members at no cost to you. To qualify for these benefits, you must meet specific criteria, including being under care management for a qualifying chronic condition and determined to be a high-risk for hospitalization. For a complete list of eligibility criteria, please visit Chapter 4, Section 2.1.	$38 allowance per month toward the purchase of healthy food.	$43 allowance per month toward the purchase of healthy food. Healthy foods such as fruits, vegetables, dairy and meats can be purchased at participating retailers using a plan provided flex card.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you.

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, 2023, please call Customer Care and ask for the LIS Rider.

There are four **drug payment stages.**

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (**Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)**

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.
Stage 2: Initial Coverage Stage	During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. Most adults Part D vaccines are covered at no cost to you.	
Tier 1 (Preferred Generic)	During this stage you pay $0 copayment	During this stage you pay $0 copayment
Tier 2 (Generic)	During this stage you pay $1.45 or $4.15 copayment	During this stage you pay $1.55 or $4.50 copayment
Tier 3 (Preferred Brand) **Tier 4** (Non-Preferred Drug)	During this stage you pay $4.30 or $10.35 copayment	During this stage you pay $4.60 or $11.20 copayment
Tier 5 (Specialty)	During this stage you pay **Specialty Generics:** $1.45 or $4.15 copayment **Specialty Brands:** $4.30 or $10.35 copayment	During this stage you pay **Specialty Generics:** $1.55 or $4.50 copayment **Specialty Brands:** $4.60 or $11.20 copayment
	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

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

SECTION 2 Administrative Changes

Cost	2023 (this year)	2024 (next year)
Opt out of phone calls	Please call Customer Care, if you would like to opt out of receiving phone calls from us.	Please call Customer Care, if you would like to opt out of receiving phone calls from us.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Univera Medicare Dual (HMO D-SNP)

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 Univera Medicare Dual (HMO D-SNP) for 2024.

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 for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- OR -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the Medicare & You 2024 handbook call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Univera Healthcare 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 Univera Medicare Dual (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Univera Medicare Dual (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this.
  - *– 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 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

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

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

Because you have New York State Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage at any time. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 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, 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. You can learn more about HIICAP by visiting their website (aging.ny.gov/programs/medicare-and-health-insurance).

For questions about your New York State Medicaid benefits, contact New York State's Medicaid program at 1-800-541-2831 (TTY 711). Available 8:00 am to 8:00 pm, Monday through Friday, 9:00 am to 1:00 pm, Saturday. 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

Because you may qualify, you do not have a coverage gap or a late enrollment penalty. If you have qusdtions 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 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications);

- **Help from your state's pharmaceutical assistance program.** New York has a program called Elderly Pharmaceutical Insurance 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. 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 HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052. You can learn more about the ADAP in New York State by visiting their website (www.health.ny.gov/diseases/aids/general/resources/adap/). For information on eligibility criteria, covered drugs, or how to enroll in the program:
  - call 1-800-542-2437 or 1-844-682-4058 (in-state, toll free); 1-518-459-1641 (out of state); 1-518-459-0121 (TDD) Monday through Friday, 8:00 am - 5:00 pm. or
  - email adap@health.ny.gov

SECTION 7 Questions?

Section 7.1 – Getting Help from Univera Medicare Dual (HMO D-SNP)

Questions? We're here to help. Please call Customer Care at 1-866-862-7087. (TTY only, call 1-800-662-1220.) We are available for phone calls Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. Calls to these numbers are free.

Read your 2024 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 Evidence of Coverage for Univera Medicare Dual (HMO D-SNP). The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A

copy of the Evidence of Coverage is located on our website at www.UniveraMedicare.com. You may also call Customer Care to ask us to mail you an Evidence of Coverage.

Visit our Website

You can also visit our website at www.UniveraMedicare.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 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 Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read Medicare & You 2024

Read the Medicare & You 2024 handbook. Every fall, this booklet 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 State Medicaid agency at 1-800-541-2831. Available 8:00 am to 8:00 pm, Monday through Friday, 9:00 am to 1:00 pm, Saturday. TTY users should call New York State Medicaid at 711.