Keystone First VIP Choice (HMO-SNP) offered by Vista Health Plan, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Keystone First VIP Choice. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.keystonefirstvipchoice.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 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 2023* 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, 2022, you will stay in Keystone First VIP Choice.
   - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Keystone First VIP Choice.
   - Look in section 3, page 15 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 Member Services number at 1-800-450-1166 for additional information. (TTY users should call 711.) Hours are from October 1 – March 31: 8 a.m. – 8 p.m., seven days a week and from April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday.
- **Please contact Member Services if you require this document in an alternative format such as large font, Braille or audio.**
- **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 Keystone First VIP Choice

- Keystone First VIP Choice is an HMO-SNP plan with a Medicare contract and a contract with the Pennsylvania Medicaid program. Enrollment in Keystone First VIP Choice depends on contract renewal. The plan also has a written agreement with the Pennsylvania Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Vista Health Plan, Inc. When it says "plan" or "our plan," it means Keystone First VIP Choice.

Annual Notice of Changes for 2023

Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Keystone First VIP Choice in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (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: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays	$0 copay	$0 copay
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 or $480 Copayment during the Initial Coverage Stage: • Drug Tier 1: You pay $0, $1.35, or $3.95 per prescription. • Drug Tier 2: You pay $0, $4.00, or $9.85 per prescription	Deductible: $0 or $505 Copayment during the Initial Coverage Stage: • Drug Tier 1: You pay $0, $1.45, or $4.15 per prescription. • Drug Tier 2: You pay $0, $4.30, or $10.35 per prescription

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 2.2 for details.)	$3,400 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered services.	$8,300 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium *There is no change for the upcoming benefit year.* (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 services for the rest of the year.

Cost	2022 (this year)	2023 (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. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$8,300 Once you have paid $8,300 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 also located on our website at www.keystonefirstvipchoice.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *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 2023 *Pharmacy Directory* to see which pharmacies are in our network**.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

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

Cost	2022 (this year)	2023 (next year)
Worldwide Emergency/Urgent Coverage	Worldwide Emergency/Urgent Coverage is not Covered	You pay a $0 copay for Worldwide Emergency Coverage, Worldwide Urgent Coverage and Worldwide Transportation services. $50,000 combined annual maximum plan benefit amount.
Transportation Services	You pay a $0 copay Up to 100 one-way trips every year to plan-approved locations. Prior authorization is required for trips that exceed 50 miles for a one-way ride. Other prior authorization and scheduling rules apply.	You pay a $0 copay Unlimited trips every year to plan-approved locations. Prior authorization is required for trips that exceed 50 miles for a one-way ride. Other prior authorization and scheduling rules apply.

Cost	2022 (this year)	2023 (next year)
Over-the-Counter Items (OTC)	You pay a $0 copay Benefit includes up to $300 allowance per quarter, which may be spent for over-the-counter items included in the OTC catalog. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan. Members may order up to 6 products per category per quarter. There is no limit on the number of total items in your order. OTC orders are limited to 3 orders per quarter. Additional limits may apply to some items.	You pay a $0 copay Benefit includes up to $315 allowance per quarter, which may be spent for over-the-counter items included in the OTC catalog, online ordering portal and/or qualified items at participating retail settings via a restricted spend debit card. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan. Members may order up to 6 products per category per quarter. There is no limit on the number of total items in your order. OTC orders are limited to 3 orders per quarter. Additional limits may apply to some items. Members who qualify under the Special Supplemental Benefits for the Chronically Ill Benefit (SSBCI) may also use up to $100 of the $315 quarterly allowance towards qualifying Food & Produce at participating retail locations and/or FarmBox mail-order, items limits may apply.

Cost	2022 (this year)	2023 (next year)
Meal Benefit	You pay a $0 copay The post discharge meal benefit covers 14 meals per week for 4 weeks (56 meals total) for qualified homebound members after each discharge from an inpatient facility or a skilled nursing facility. The medical condition meal benefit covers a COVID-19 diagnosis with 14 meals per week for 2 weeks (28 Meals total) for qualified homebound members. Benefit is available immediately following surgery or inpatient hospitalization for a medical condition or potential medical condition that requires the member to remain at home for a period of time. Referral is required.	You pay a $0 copay The post discharge meal benefit covers 14 meals per week for 4 weeks (56 meals total) for qualified homebound members after each discharge from an inpatient facility or a skilled nursing facility. Benefit is available immediately following surgery or inpatient hospitalization. Referral is required.
Preventive Dental Services	You Pay a $0 copay • Oral exams – one every six months: $0 copay. • Cleaning – one every six months: $0 copay. • Fluoride treatment – one every six months: $0 copay. • Dental X-rays – four every year: $0 copay. $1,000 plan coverage limit for preventive dental benefits every year.	You Pay a $0 copay • Oral exams – one every six months: $0 copay. • Cleaning – one every six months: $0 copay. • Fluoride treatment – one every six months: $0 copay. • Dental X-rays – four every year: $0 copay. No maximum plan coverage limit for preventive dental benefits every year.

Cost	2022 (this year)	2023 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Special Supplemental Benefits for the Chronically Ill (SSBCI) is not covered	You pay a $0 copay for SSBCI benefits. Members who qualify under the SSBCI chronic conditions outlined below may use up to $100 of the $315 quarterly allowance for Over-the-Counter (OTC) Benefits towards qualifying Food & Produce at participating retail locations and/or FarmBox Mail-order items via a restricted spend debit card. Limits may apply. Any unused balance will automatically expire at the end of each quarter or upon disenrollment from the plan. Qualifying chronic conditions include: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Obesity; Dermatological Disorders; Osteoporosis; Malnutrition and Endocrine disorders.

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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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

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

Starting in 2023, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug 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 that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We have 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 didn't receive this insert with this packet please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

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

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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 is $0 or $480. Your deductible amount is either $0 or $480, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $0 or $505. Your deductible amount is either $0 or $505, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic (Tier 1):** You pay $0, $1.35, or $3.95 per prescription. **Generic and Brand (Tier 2):** You pay $0, $4.00, or $9.85 per prescription _____ Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic (Tier 1):** You pay $0, $1.45, or $4.15 per prescription. **Generic and Brand (Tier 2):** You pay $0, $4.30, or $10.35 per prescription _____ Once you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin-You won't pay more than $35 for a one- month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on, even if you haven't paid your deductible. In most cases you will not pay more than $10.35 for a one-month supply of each insulin product covered by our plan.

SECTION 2 Administrative Changes

The information in the Administrative Changes grid below reflects year over year changes to your plan that do not directly impact benefits or cost-shares.

Description	2022 (this year)	2023 (next year)
Part D Retail/Mail Order drug quantity	Your plan allows for a 90-day supply of Tier 1 and Tier 2 maintenance medications	Your plan allows for a 100-day supply of Tier 1 and Tier 2 maintenance medications

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Keystone First VIP Choice

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 Keystone First VIP Choice.

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 2023 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 2023* 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 Keystone First VIP Choice.

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Keystone First VIP Choice.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

SECTION 4 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, 2023.

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, 2023, 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, 2023.

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 Pennsylvania, the SHIP is called PA MEDI.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. PA MEDI 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 PA MEDI at 1-800-783-7067 (TTY 711) between 8:30 a.m. and 4:45 p.m. Monday – Friday. You can learn more about PA MEDI by visiting their website (https://www.aging.pa.gov).

For questions about your Pennsylvania Medical Assistance benefits, contact The Office of Medical Assistance Programs (OMAP) at 1-800-692-7462 (TTY 711) between 8:30 a.m. and 4:45 p.m. Monday – Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Pennsylvania Medical Assistance 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, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called *PACE/PACENET* 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

Special Pharmaceutical Benefits Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:
Phone: 1-800-922-9384, Fax: 1-888-656-0372, E-mail: spbp@pa.gov or by mail at:

PA Department of Health Special Pharmaceutical Benefits Program
P.O. Box 8808
Harrisburg, PA 17105-8808

SECTION 7 Questions?

Section 7.1 – Getting Help from Keystone First VIP Choice

Questions? We're here to help. Please call Member Services at 1-800-450-1166. (TTY only, call 711.) We are available for phone calls from October 1 – March 31: 8 a.m. – 8 p.m., seven days a week and from April 1 – September 30: 8 a.m. – 8 p.m., Monday through Friday. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Keystone First VIP Choice. 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.keystonefirstvipchoice.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.keystonefirstvipchoice.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 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 2023*

Read the *Medicare & You 2023* 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 Pennsylvania Medical Assistance (Medicaid), you can call the Office of Medical Assistance at 1-800-692-7462. TTY users should call 711.