



HEALTH PLANS

VNS Health EasyCare (HMO)

2027

Summary of Benefits

Sales Representative

Telephone

Email



Benefits at a Glance

VNS Health EasyCare (HMO) is a Medicare Advantage plan that offers more than regular Medicare, including extra benefits. Plus, it offers easy access to healthy living services, along with personal support from your Care Management Team.

*Covered by LIS if you get Extra Help. If you lose Extra Help, your monthly premium may be \$25



More benefits than regular Medicare

\$0

\$0 monthly plan premium (Part C)*



As low as \$0 for monthly Part D premium*



\$50/quarter for OTC (over-the-counter) items



\$2,500/year for comprehensive dental care and implants



\$200/year for eye wear



\$1,000/every 3 years for hearing aids



Acupuncture, Podiatry, and more



5 round trips/year to approved health care locations



If you have questions, please call us at 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8 pm (Oct. – Mar.) Weekdays, 8 am – 8 pm (Apr. – Sept.). The call is free. **For more information**, visit vnshealthplans.org

Introduction

This document is a brief summary of the benefits and services covered by VNS Health EasyCare. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of VNS Health EasyCare. Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage*.

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Useful Information

Your Care Team

1-866-783-1444

7 days a week, 8 am – 8 pm (Oct. – Mar.)
Weekdays, 8 am – 8 pm (Apr. – Sept.)



Plan Effective Date

Primary Care Provider (PCP)

Interested in enrolling? Call:

1-866-414-6715 (TTY: 711)

7 days a week, 8 am – 8 pm, October 1, 2026 – March 31, 2027

Weekdays, 8 am – 8 pm, April 1, 2027 – September 30, 2027

Provider and Pharmacy Directory

The best way to find a doctor, specialist and/or pharmacy in the plan's network is to visit vnshealthplans.org/providers.

Formulary (List of Covered Drugs)

The *Formulary* is a list of prescription drugs covered by the plan. To search the *Formulary*, please visit vnshealthplans.org/formulary.

Medicare & You

Visit [Medicare.gov](https://www.medicare.gov) to view the handbook online or order a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. **(TTY: 1-877-486-2048)**. You can also download a copy by visiting [Medicare.gov](https://www.medicare.gov).



If you have questions, please call us at 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8 pm (Oct. – Mar.) Weekdays, 8 am – 8 pm (Apr. – Sept.). The call is free. **For more information**, visit vnshealthplans.org

C. Do You Need Extra Financial Help?

Medicare Beneficiaries that meet certain income and resource limits may qualify for the following financial assistance programs:

	Medicare Savings Programs (MSP) Administered by NY state	Extra Help/Low Income Subsidy (LIS) Administered by the Social Security Administration	Elderly Pharmaceutical Insurance Coverage Program (EPIC) Administered by NY State
How this program helps pay for your health care costs	• All programs pay for the Part B premium • Some programs pay Part A premium (if needed) • Some programs pay Medicare copays & coinsurances	• Pays Medicare Part D monthly premiums • Helps lower Medicare Part D copays or coinsurance	• Pays some Part D premiums & saves more money on your prescription drug costs
Are you eligible for other programs?	Beneficiaries with an MSP will automatically qualify for Extra Help Some beneficiaries with an MSP will also have incomes that qualify them for Medicaid	Some beneficiaries that get Extra Help, may qualify for Medicaid and/or MSPs	Some beneficiaries that get EPIC will also have incomes that qualify them for Extra Help

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Do You Need Extra Financial Help? Continued

	Medicare Savings Programs (MSP) Administered by NY state	Extra Help/Low Income Subsidy (LIS) Administered by the Social Security Administration	Elderly Pharmaceutical Insurance Coverage Program (EPIC) Administered by NY State
For more information, call VNS Health EasyCare 1-866-783-1444 (TTY: 711)	NYC Department of Social Services: 1-718-557-1399	Social Security Administration 1-800-772-1213	EPIC 1-800-332-3742 (TTY:1-800-290-9138)
	Westchester Department of Social Services: 1-914-995-3333 Nassau Department of Social Services: 1-516-227-8519		

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D. Low Income Subsidy Table

Monthly plan premium for people who get Extra Help from Medicare to help pay for their prescription drug costs

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare.

This table shows you what your monthly plan premium will be if you get Extra Help

Your level of extra help	Premium for VNS Health EasyCare (HMO)**
100%	\$0.00
0%	\$25

If you aren't getting Extra Help, you can see if you qualify by calling:

- a) **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)** (24 hours a day, 7 days a week),
- b) The Social Security Administration at **1-800-772-1213**. TTY users should call **1-800-325-0778** between **Monday – Friday, 8 am – 7 pm.**

**This does not include any Medicare Part B premium you may have to pay.

VNS Health EasyCare premium includes coverage for both medical services and prescription drug coverage.

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E. Disclaimers and Plan Overview

This is a summary of health services covered by VNS Health EasyCare for 2027. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits. If you'd like to request a printed copy of the *Evidence of Coverage*, call your Care Team at the numbers listed at the bottom of this page. Or to access it online visit, vnshealthplans.org/ec-eoc.

VNS Health Medicare is a Medicare Advantage Organization with Medicare and Medicaid contracts, offering HMO D-SNP and HMO plans. Enrollment in VNS Health Medicare depends on contract renewal.

VNS Health EasyCare is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

To be eligible for our plan, you:

- Must be eligible for Medicare Part A and Part B.
- Must live in the service area: Albany, Bronx, Dutchess, Erie, Kings (Brooklyn), Monroe, Nassau, New York (Manhattan), Niagara, Onondaga, Orange, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Suffolk, Sullivan, and Westchester Counties in New York State. You must live in one of these areas to join the plan.
- Are a United States citizen or national, or an eligible non-citizen.

For more information about **Medicare**, you can read the *Medicare & You Handbook*. Every year in the 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 booklet, you can access it online at the Medicare website [Medicare.gov](https://www.medicare.gov) or request a copy by calling 1-800-MEDICARE (1-800-633-4227). (TTY: 1-877-486-2048).

You can get this document for free in other formats, such as large print, braille, or audio.

Call 1-866-783-1444 (TTY: 711) 7 days a week, 8 am – 8 pm (Oct. – Mar.) Weekdays 8 am – 8 pm (Apr. – Sept.). The call is free.

This document is available for free in Spanish and Chinese.

Este documento está disponible sin cargo en inglés y chino.

本文件免費提供英文和西班牙文版本。

During your welcome call, we will confirm your language and/or format preference for future mailings and communications. If at any time you need to request a change, please call your Care Team.

F. Overview of Services

Monthly premium, deductible, and limits on how much you pay for covered services.		
Monthly Plan Premium including Part C and Part D Premium	\$0 or \$25	Your monthly premium for prescription drug coverage depends on your level of low income subsidy (LIS) or Extra Help. Members with Extra Help will have \$0 monthly premiums and a \$0 annual deductible. If you lose Extra Help, your monthly premium may be \$25.
Deductible	\$0 or \$650	Whether or not you pay a deductible for prescription drug coverage depends on your LIS or Extra Help. Members with Extra Help will have a \$0 annual deductible. If you lose full Extra Help, your Part D deductible will be \$650.
Maximum Out of Pocket (MOOP)	\$9,850	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit in this plan: • \$9,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, covered hospital and medical services will be paid in full for the rest of the year by the plan. You will still need to pay your monthly premiums.

G. List of Covered Services

The following chart is a quick overview of what services you may need, your costs, and rules about the benefits.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Inpatient hospital care	Days 1-5: \$490 copay per day of each benefit period. Days 6-90: \$0 copay per day of each benefit period. \$0 copay for days 91 and beyond	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital copay for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. Requires prior authorization. Except in an emergency, your health care provider must tell the plan of your hospital admission.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	\$200 copay	Plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Requires prior authorization.
Outpatient hospital observation	\$110 per stay	Requires prior authorization.
Ambulatory Surgical Center (ASC) services	\$200 copay	Requires prior authorization.
Doctor visits (including visits to Primary Care Providers)	\$0 copay	No prior authorization required.
Specialist care	\$35 copay	No prior authorization required.
Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	\$0 copay	No prior authorization required.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Emergency room services	\$115 copay	You may go to any emergency room when necessary. You do not have to be in-network. No prior authorization required. You are covered for up to \$50,000 per year in emergency care and urgently needed services outside of the United States and its territories.
Urgently needed care	\$40 copay	Urgently needed services in and outside of the United States. Urgently needed care is NOT emergency care. You do not have to be in-network. No prior authorization required. You are covered for up to \$50,000 per year in emergency care and urgently needed services outside of the United States and its territories.
Diagnostic Services & Imaging	Diagnostic Procedures/Tests (EEG): \$50 copay Advanced Radiological Services (CT scan, MRI): \$145 copay	Prior authorization required.
Radiological Service	Outpatient X-ray: \$15 copay	Requires prior authorization.

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Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Lab tests, such as blood work	\$0 copay	May require prior authorization.
Screening tests, such as genetic tests to check for cancer	\$0 copay	May require prior authorization.
Hearing exam	\$0 copay	1 routine exam per year to diagnose and treat hearing and balance issues. No prior authorization required.
Hearing aids	\$0 copay Plan coverage limit is \$1,000 for hearing aids limited to \$500 per ear (one right, one left) every 3 years.	Fitting/evaluation is limited to one per ear (one right, one left) every 3 years. The plan covers hearing services and products when medically necessary to alleviate hearing disabilities. No prior authorization required.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Dental care	\$0 copay	No maximum plan coverage amount for diagnostic and preventive dental services. \$2,500 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. There is no annual service category deductible for Medicare-covered benefits. Dental services (including but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, root canals, dentures, implants and endodontic and periodontal care). You do not need a referral from your PCP to see a dentist. May require prior authorization See page 31 for more information including preventive dental coverage.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Routine eye exam	\$0 copay	1 routine eye exam per year. A routine eye exam is to diagnose and treat diseases and conditions of the eye. 1 additional routine eye exam (every 2 years). Eye exam for the purpose of getting eyeglasses every two years. No prior authorization required.
Glasses or contact lenses	\$0 copay	Eyeglasses or contact lenses limited to one pair every 12 months unless medically necessary. The cost of standard lenses and frames is limited to \$200 for one set of eyeglasses or contact lenses, but not both. Standard lenses include single, bifocal, trifocal; does not include specialty lens (i.e., transition, tints, progressives, polycarbonate). Standard contact lenses include extended daily wear, disposables, standard daily wear, toric, or rigid gas permeable. No prior authorization required.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Mental or behavioral health services	\$0 copay	Plan covers Medicare-covered: • Individual or Group Sessions. No prior authorization required.
Inpatient care for people who need mental health services (voluntary or involuntary admissions)	Days 1-5: \$400 copay per day of each benefit period. Days 6-90: \$0 copay per day of each benefit period.	90 days for an inpatient hospital stay. Plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. Requires prior authorization.
Skilled nursing facility	For Medicare-covered SNF stays, you pay: • \$0 for the first 20 days of each benefit period. • \$218 copay per day for days 21-100 of each benefit period. You pay all costs for each day after day 100 of the benefit period.	Plan covers additional days beyond Medicare. No prior hospital stay is required. A "benefit period" starts the day you go into the hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. Requires prior authorization.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Occupational, physical, or speech therapy	\$35 copay	Plan covers Medicare-covered: • Physical Therapy visits, • Speech Language Therapy visits, and • Occupational Therapy visits. Requires prior authorization.
Ambulance services	\$300 copay	Ambulance services must be medically necessary. Prior authorization is required for non-emergency services. You do not have to be in-network.
Transportation to health care services	\$0 copay	Our plan covers 5 round trips to routine and non-emergent plan-approved locations for medical care and services. There is a maximum benefit of \$100 per round trip. Coverage includes: taxi, rideshare services, bus/subway, van and medical transport. Requires prior authorization.
Medicare Part B drugs	20% of the total cost	Read the <i>Evidence of Coverage</i> for more information on these drugs. Requires prior authorization.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Part D Drug Coverage (Continued on the next page)	Deductible: \$0 (if you have LIS) or \$650 (no LIS). You pay \$0 deductible for Tier 1 drugs, Tier 6 drugs, covered insulin products and most adult Part D vaccines. Your Part D costs are determined by the Part D Low-Income Cost-Share (LICS) (Extra Help) Level. Tier drugs are generic or Brand. See below for breakdown. Copayment / Coinsurance during the Initial Coverage Stage (30-day supply): • Drug Tier 1: \$0 copay • Drug Tier 2: \$20 copay You pay up to \$20 per month supply of each covered insulin product on this tier.	There may be limitations on the types of drugs covered. Please see the VNS Health EasyCare <i>Formulary</i> at vnshealthplans.org/formulary for more information. VNS Health EasyCare may require you to first try one drug to treat your condition before it will cover another drug for that condition. This is called Step Therapy (ST). Some drugs have Quantity Limits (QL). Some drugs known as opioids (commonly used for pain), and a few others (which are restricted by Medicare) may require additional prior authorizations to confirm diagnosis before coverage. Some drugs require that you use certain pharmacies. These drugs are listed in the <i>Formulary</i> as Specialty or Limited Distribution Drug (LDD). The <i>Formulary</i> is posted on the plan's website, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Part D Drug Coverage (Continued)	• Drug Tier 3: \$47 copay You pay up to \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 copay You pay up to \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 26% of the total cost You pay up to \$35 per month supply of each covered insulin product on this tier. • Drug Tier 6: \$0 copay You pay \$0 per month supply of each covered insulin product on this tier.	You can get long-term supplies through mail order or at a retail pharmacy. The amount you pay for long-term supplies (100-day) is the same for a one-month (30-day) supply (if you have LIS). Requires Prior Authorization (PA) for certain drugs.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Part D Drug Coverage (Continued)	If you have Extra Help, you will have 1 of 3 levels. Copayment / Coinsurance during the Initial Coverage Stage: If you are LICCS 1, your Part D costs are no more than: • \$5.80 for generics • \$14.40 for Brands If you are LICCS 2, your Part D costs are no more than: • \$1.65 for generics • \$5.00 for Brands If you are LICCS 3, your Part D costs are \$0 for all drugs, generics or Brands covered. For all members (with or without Extra Help) Catastrophic Coverage: During this payment stage, the plan pays the full cost	

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Part D Drug Coverage (Continued)	for your covered Part D drugs. You pay nothing. The plan covers certain additional drugs not typically covered under Medicare Part D, including select vitamins and cough medicine. Refer to the <i>Evidence of Coverage</i> for details.	
Routine Podiatry services	\$0 copay for routine foot care	Routine foot care (up to 6 visits every year). No prior authorization required
Podiatry services	\$25 copay for Medicare-covered Podiatry services	Medicare-covered Podiatry Services Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. Medicare-covered Podiatry services require prior authorization.
Durable medical equipment (DME) or supplies (Continued on the next page)	20% coinsurance	The plan covers wheelchairs, nebulizers, crutches, rollabout knee walkers, walkers, oxygen equipment and supplies, prosthetics, orthotics and orthopedic footwear, etc.

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Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Durable medical equipment (DME) or supplies (Continued)		Note: For a complete list of DME or supplies call your Care Team or read the <i>Evidence of Coverage</i> . Requires prior authorization.
Acupuncture	\$0 copay	Up to 10 visits every year are covered. No prior authorization required.
Acupuncture for chronic low back pain	\$0 copay	Up to 12 visits in 90 days are covered for Medicare beneficiaries meeting the criteria for lower back pain No prior authorization required.
Additional Telehealth Services (Continued on the next page)	\$0 to \$200 copay	Covers the following services: • Ambulatory Surgical Center (ASC) Services; • Diabetes Self-Management Training; • Group Sessions for Mental Health Specialty Services; • Group Sessions for Outpatient Substance Abuse; • Group Sessions for Psychiatric Services; • Individual Sessions for Mental Health Specialty Services;

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Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional Telehealth Services (Continued)		• Individual Sessions for Outpatient Substance Abuse; • Individual Sessions for Psychiatric Services; • Home Health Services; • Kidney Disease Education Services; • Occupational Therapy Services; • Opioid Treatment Program Services; • Outpatient Hospital Services; • Physician Specialist Services; • Physical Therapy and Speech-Language Pathology Services; • Primary Care Physician Services; • Urgently Needed Services. No prior authorization required.
Diabetic supplies	20% coinsurance	Ascensia/Bayer Diabetes Care (Contour or Contour Next) is the plan's chosen brand for diabetes monitoring and testing supplies when obtained at an in-network retail pharmacy. Shoes and inserts for diabetes-related conditions. Prior authorization is required.

Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Enhanced Disease Management	\$0 copay	Services include: • Home visits by a nurse to evaluate health, social, and home safety needs • Help finding doctors and making appointments • Help taking medicine the right way • Connections to community resources No prior authorization required.
Gym Membership	\$0 copay	You are covered for a health club membership through SilverSneakers®, a fitness program designed for Medicare beneficiaries. This includes group exercise classes at participating health club facilities and online. For more information, please visit silversneakers.com.
Healthy Extras Card (Continued on the next page)	\$0 copay	You'll receive \$50 maximum plan coverage amount every 3 months for OTC items. This amount will automatically be loaded onto a debit card called the Healthy Extras Card. Use your card allowance to buy health items, like pain relievers, toothpaste, bandages and more!

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Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Healthy Extras Card (Continued)		See the OTC catalog for a list of plan-approved items and participating OTC network locations, such as convenience stores, pharmacies, and grocery stores. Balances left over at the end of each quarter do not carry over. For more information, please see the OTC Catalog.
Meals (Post-Discharge)	\$0 copay	You can use this benefit to have meals delivered to your home after an acute inpatient hospital discharge. You are covered for 28 meals over a 2-week period up to 3 inpatient hospital visits a year. No prior authorization required.

The above summary of benefits is provided for informational purposes only and is not a complete list of benefits. Call your Care Team or read the *Evidence of Coverage* to find out about other covered services.

H. Frequently Asked Questions (FAQ)

The following table lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What is a Medicare Advantage plan?	Medicare Advantage plans combine Part A and Part B and often Part D into one plan with a network of providers. Medicare Advantage plans may also offer extra benefits, like vision, dental and hearing coverage and fitness programs like SilverSneakers.
Will I get the same Medicare benefits in VNS Health EasyCare that I get now?	If you are coming to VNS Health EasyCare from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get all your covered Medicare benefits directly from VNS Health EasyCare. When you enroll in VNS Health EasyCare, you and your Care Team will work together to develop an Individualized Plan of Care to address your health and support your needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that VNS Health EasyCare doesn't normally cover, you can get a temporary supply and we'll help you to transition to another drug or get an exception for VNS Health EasyCare to cover your drug if medically necessary. For more information call your Care Team at the numbers listed at the bottom of this page.

Frequently Asked Questions (FAQ)	Answers
Can I go to the same health care providers I see now?	If your providers (including doctors and pharmacies) work with VNS Health EasyCare and have a contract with us, you can keep going to them. • Providers with a contract with us are “in-network.” In most cases, you must use the providers in the VNS Health EasyCare network. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of the VNS Health EasyCare network. You may also use out-of-network providers when VNS Health EasyCare authorizes the use of out-of-network providers. To find out if your providers are in the plan’s network, call your Care Team or read the VNS Health EasyCare <i>Provider and Pharmacy Directory</i>. You can also visit our website at vnshealthplans.org/providers for the most current listing.
What happens if I need a service but no one in the VNS Health EasyCare network can provide it?	Most services will be provided by our network providers. If you need a covered service that cannot be provided within our network, such as a shortage of staff with the necessary expertise and/or availability to provide services, VNS Health EasyCare will authorize and pay for the cost of an out-of-network provider, with some limitations.
What is a Care Manager?	A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and makes sure you get what you need.

Frequently Asked Questions (FAQ)	Answers
Where is VNS Health EasyCare available?	The service area for this plan includes: Albany, Bronx, Dutchess, Erie, Kings (Brooklyn), Monroe, Nassau, New York (Manhattan), Niagara, Onondaga, Orange, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Suffolk, Sullivan, and Westchester Counties in New York State. You must live in one of these areas to join the plan.
What is service authorization or prior authorization?	Service authorization or prior authorization means that you must get approval from VNS Health EasyCare before you can get a specific service or drug or see an out-of-network provider. VNS Health EasyCare may not cover the service or drug if you don't get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. See Chapter 3 of the <i>Evidence of Coverage</i> to learn more about service authorization or prior authorization. See the Medical Benefits Chart in Chapter 4 of the <i>Evidence of Coverage</i> to learn which services require a service authorization or prior authorization.

I. Helpful Definitions

Home Health Services – Includes a wide range of services that can be given in your home for an illness or injury. Examples of services include skilled nursing care and/or physical, speech or occupational therapy and medical social services. A doctor must certify that you need these services in the home.

Skilled Nursing Facility – After being discharged from the hospital, you may need highly skilled care that's beyond what family or friends can provide. You can receive care in a skilled nursing facility for additional skilled nursing and/or rehabilitative services. To qualify, your doctor must certify that you need daily skilled care, for example, intravenous injections or physical therapy.

Emergency Services – You should go to the emergency room when you have a serious injury, a sudden illness or an illness that quickly gets much worse.

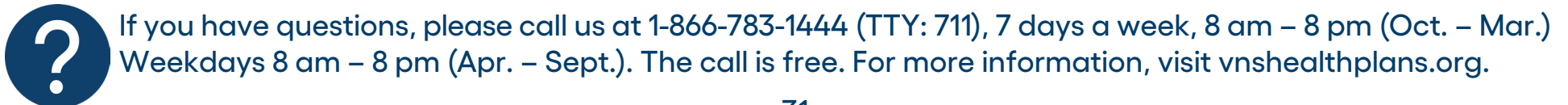
Urgent Care – If you have a minor injury or an illness that is not an emergency and cannot get a timely appointment with your PCP, an urgent care center can be a good option.

J. Dental Benefit Summary

Preventive dental services include oral exams, cleanings, and x-rays and are covered. Comprehensive services include fillings, extractions, root canals, bridges, crowns, dentures, and implants. Certain procedures may require prior authorization***.

If you need additional services such as for implants, periodontics or replacement dentures, you will need a recommendation from your dentist to determine if it is medically necessary.

Category	Covered Services	Copay ment	Frequency
Diagnostic & Preventive	Oral Exam	\$0	Unlimited
	Full Mouth Series or Panoramic X-Ray	\$0	Unlimited
	Single X-rays (periapical)	\$0	Unlimited
	Bitewing Series	\$0	Unlimited
	Prophylaxis (cleaning)	\$0	Unlimited
	Fluoride treatment	\$0	Unlimited
Restorative	Fillings (Silver or Tooth Colored)	\$0	Up to 2 per year
Oral Surgery	Extractions	\$0	Up to 2 per year
Endodontics	***Root Canal Therapy: Anterior/Bicuspid/Molar	\$0	Up to 2 per year
	***Scaling/Root Planing, per quadrant	\$0	Up to 2 per year
Prosthetics	***Single Crowns	\$0	Up to 2 per year
Crowns	Post	\$0	Up to 2 per year
	Recementation, Crown	\$0	Up to 2 per year
Prosthetics	***Complete Upper/Lower Denture	\$0	Up to 2 per year
Removable	***Partial Upper/Lower Denture	\$0	Up to 2 per year
	Denture Adjustments/Repairs	\$0	Up to 2 per year
	Denture Rebase/Relines	\$0	Up to 2 per year
	Implants	\$0	Up to once per year



If you have questions, please call us at 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8 pm (Oct. – Mar.) Weekdays 8 am – 8 pm (Apr. – Sept.). The call is free. For more information, visit vnshealthplans.org.

K. Healthy Extras Card Summary

The Healthy Extras Card is one preloaded debit card with the following allowance:

- **\$50/quarter for Over-the-Counter (OTC)**

Any remaining OTC balance will expire at the end of each quarter.

You can use your OTC allowance to buy health items (pain relievers, toothpaste, bandages) and food and beverages. See the OTC catalog for a list of approved items and stores that accept the card, like pharmacies and grocery stores.

Member Rewards Program

As a member of our plan, you are automatically enrolled in our Member Rewards Program. You can earn rewards when you complete eligible health activities!

How will I get my rewards?

We will confirm with your doctor that you have completed the health activity. Your rewards will be loaded onto your Healthy Extras card **three times a year** when you complete the health activities listed in your plan. Your rewards will be available for use once your OTC benefit is fully used each quarter.



L. Language Assistance Notice

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-866-783-1444 (TTY: 711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-866-783-1444 (TTY: 711).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-866-783-1444 (TTY: 711)。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-866-783-1444 (TTY: 711).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-866-783-1444 (TTY: 711) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-866-783-1444 (TTY: 711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-866-783-1444 (TTY: 711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-866-783-1444 (TTY : 711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-866-783-1444 (TTY: 711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועלעבל פאר אייך אומזיסט. 1-866-783-1444 (TTY: 711) רופט	Yiddish

UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-866-783-1444 (TTY: 711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-866-783-1444 (TTY: 711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-866-783-1444 (TTY: 711)-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-866-783-1444 (TTY: 711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-866-783-1444 (TTY: 711).	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-866-783-1444 (TTY: 711)۔	Urdu

M. Member Resources

You can access the following 2027 VNS Health EasyCare member materials **electronically**.

Evidence of Coverage (Downloadable PDF)	vnshealthplans.org/ec-eoc
Formulary (Downloadable PDF and Online Search Tool)	vnshealthplans.org/formulary
Provider and Pharmacy Directory (Online Search Tool)	vnshealthplans.org/providers
Joint HIPAA Notice of Privacy Practices (Downloadable PDF)	vnshealthplans.org/hipaa

If you'd like to request a printed copy of any of the materials above, please call your Care Team at the number below or email us at CareTeam@vnshealth.org.

N. Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to your Care Team at 1-866-783-1444 (TTY: 711).

Understanding the Benefits

- ☐ The *Evidence of Coverage* provides a complete list of all coverages and services. It is important to review plan coverage costs, and benefits before you enroll. Visit vnshealthplans.org/ec-eoc or call 1-866-783-1444 (TTY: 711) to view a copy of the *EOC*.
- ☐ Review the *Provider and Pharmacy Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the *Provider and Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the *Formulary* to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider and Pharmacy Directory*)
- ☐ **Effect on Current Coverage.** Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.



Any questions? Call us toll-free at:

1-866-783-1444 (TTY: 711)

October 1, 2026 – March 31, 2027

7 days a week, 8 am – 8 pm

April 1, 2027 – September 30, 2027

Weekdays, 8 am – 8 pm

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