



HEALTH PLANS

VNS Health Total (HMO D-SNP)

2027

Summary of Benefits

Sales Representative

Telephone

Email



Two-in-one Medicare-Medicaid plan for New Yorkers with long-term care needs

VNS Health Total combines your Medicare and Medicaid benefits into one integrated plan. This includes long-term care, prescription drugs, doctor and hospital coverage.

You also receive important extra benefits not covered by regular Medicare. This makes it easier to access healthy living services and personal support from your Care Team.



Two-in-one Medicare-Medicaid plan with one phone number, one ID card and one Care Management Team



\$0 cost to you for health care, like \$0 premiums, \$0 copays, \$0 prescription drugs



\$318/month for OTC (over-the-counter), groceries*, home utilities and certain dental, hearing, or vision expenses.



\$3,500/year for Dental Care and Implants Additional coverage available under Medicaid based on medical necessity. Authorization may be required.



\$350/year for eye wear



Long-term services and supports to help you live safely and independently in your home (such as Home Health Aide, nursing, social work and more)



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 Total. 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 Total. 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

B. Disclaimers and Plan Overview

This is a summary of health services covered by VNS Health Total 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 number listed at the bottom of this page. Or to access it online visit, vnshealthplans.org/total-eoc.

- VNS Health Total is a plan for people who need Medicaid home care and long-term care services and covers Medicare services for those who live in the service area and have both Medicare Part A and Part B and have Medicaid.
- 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 Total is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits and:

- Must be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to health and safety, based upon criteria provided by New York State Department of Health
- Must be determined eligible for long-term care services by the plan or an entity designated by the Department of Health using the current New York State Uniform Assessment System eligibility tool
- Must be eligible for nursing home level of care
- Must meet the Minimum Needs Requirements by requiring at least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or individuals with a Dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL
- Must require care management and be expected to need at least one of the following Community-Based Long-Term Care Services and Supports (CBLTSS) for more than 120 days from the effective date of enrollment:

- a. nursing services in the home;
 - b. therapies in the home;
 - c. home health aide services;
 - d. personal care services in the home;
 - e. adult day health care;
 - f. private duty nursing; or
 - g. Consumer-Directed Personal Assistance Services;
- Must be 18 years of age or older;
 - Must reside in the plan's service area.

Under VNS Health Total, you can get your Medicare and Medicaid services in one health plan. Your Care Team will help manage your health care needs.

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), 24 hours a day, 7 days a week. (TTY: 1-877-486-2048).

*Grocery and utility benefits are part of special supplemental benefits for the chronically ill and not all members qualify. Chronic illnesses include diabetes, dementia, heart failure, lung disorders, stroke, and other conditions. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

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C. 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. רופט 1-866-783-1444 (TTY: 711).	Yiddish



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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 নান্দুল্যে 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

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

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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.



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D. Frequently asked questions

The following table lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What's a Medicaid Advantage Plus (MAP/HMO) + Dual Eligible Special Needs Plan (D-SNP) plan?	Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has a Care Team to help you manage all of your providers and services. They all work together to provide the care you need. Our MAP plan is called VNS Health Total.



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Frequently Asked Questions (FAQ)	Answers
Will I get the same Medicare and Medicaid benefits in VNS Health Total that I get now?	If you're coming to VNS Health Total from Original Medicare or another Medicare plan, you may get benefits or services differently. You'll get almost all your covered Medicare and Medicaid benefits directly from VNS Health Total. When you enroll in VNS Health Total, you and your Care Team will work together to develop an Individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that VNS Health Total 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 Total to cover your drug if medically necessary.
Can I use the same health care providers I use now? (continued on the next page)	That's often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) work with VNS Health Total and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." You must use the providers in VNS Health Total's network. • If you need urgent or emergency care, or behavioral health crisis services or out-of-area dialysis services, you can use providers outside of VNS Health Total's network. To find out if your providers are in the plan's network, call your Care Team at the numbers listed at the bottom of this page or read the VNS Health Total's <i>Provider and Pharmacy Directory</i>. You can also visit our website at vnshealthplans.org/providers for the most current listing.



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Frequently Asked Questions (FAQ)	Answers
Can I use the same health care providers I use now? (continued)	If VNS Health Total is new for you, we'll work with you to develop an Individualized Plan of Care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2027, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. “Continuous Behavioral Health Episode of Care” means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2027, by the same provider for the treatment of the same or related behavioral health condition.
What's 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 make sure you get what you need. Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager (refer to Section G. Benefits covered outside of VNS Health Total).



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Frequently Asked Questions (FAQ)	Answers
What are Managed Long-term Services and Supports (MLTSS)?	Managed Long-term Services and Supports (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.
What happens if I need a service but no one in VNS Health Total's network can provide it?	Most services will be provided by our network providers. If you need a service that can't be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, VNS Health Total will cover services provided by an out-of-network provider.
Where's VNS Health Total available?	The service area for this plan includes: Albany, Bronx, Erie, Kings (Brooklyn), Monroe, Nassau, New York (Manhattan), Queens, Rensselaer, Richmond (Staten Island), Schenectady, Suffolk, and Westchester Counties in New York State. You must live in one of these areas to join the plan.



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Frequently Asked Questions (FAQ)	Answers
What's prior authorization?	Prior authorization means that you must get approval from VNS Health Total before VNS Health Total will cover a specific service, item, drug, or out-of-network provider. VNS Health Total may not cover the service, item or drug if you don't get prior approval. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first. VNS Health Total can provide you with a list of services or procedures that require you to get prior authorization from VNS Health Total before the service is provided. Refer to Chapter 3 of the <i>Evidence of Coverage</i> to learn more about prior authorization. Refer to the Benefits Chart in Chapter 4 of the <i>Evidence of Coverage</i> to learn which services require prior authorization. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call your Care Team at the number listed at the bottom of this page for help.



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Frequently Asked Questions (FAQ)	Answers
What's a referral?	A referral means that your primary care provider (PCP) must give you written approval before you can use specialists or other providers in the plan's network. This can be done electronically, however if you don't get approval, VNS Health Total may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. VNS Health Total can provide you with a list of services that require you to get a referral from your PCP before the service is provided. For more information on when a referral is needed, call your Care Team at the numbers listed at the bottom of this page or refer to Chapter 3 of the <i>Evidence of Coverage</i>.
Do I pay a monthly amount (also called a premium) under VNS Health Total?	No. Because you have Medical Assistance (Medicaid), you won't pay any monthly premiums to VNS Health Total for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party.
Do I pay a deductible as a member of VNS Health Total?	No. You don't pay deductibles in VNS Health Total.
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of VNS Health Total?	There's no cost sharing (copays or deductibles) for medical services in VNS Health Total, so your annual out-of-pocket costs will be \$0.



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E. Overview of services

The following table is a quick overview of what services you may need and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital care	\$0	Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your health care provider must tell the plan of your hospital admission. Up to 365 days per year (366 days for leap year) May require prior authorization.
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	\$0	Plan covers medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. May require prior authorization.
	Ambulatory surgical center (ASC) services	\$0	May require prior authorization.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to use an outpatient health care provider	Doctor visits (including visits to Primary Care Providers and specialists)	\$0	No prior authorization required for doctor visits.
	Visits to treat an injury or illness	\$0	
You want to use a health care provider	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	\$0	
	Wellness visits, such as a physical	\$0	
	“Welcome to Medicare” preventive visit (one time only)	\$0	



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care	Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs)	\$0	You may use any emergency room or CPEP if you reasonably believe you need emergency care. You don't need prior authorization and you don't have to be in-network. Emergency room services AREN'T covered outside of the U.S. and its territories except under limited circumstances. Contact the plan for details.
	Urgent care	\$0	Urgent care isn't emergency care. You don't need prior authorization and you don't have to be in-network. Urgent care ISN'T covered outside the U.S. and its territories except under limited circumstances. Contact the plan for details.
You need medical tests (Continued on the next page)	Lab tests, such as blood work	\$0	May require prior authorization.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests (Continued)	X-rays or other pictures, such as CAT scans	\$0	May require prior authorization.
	Screenings, such as genetic tests to check for cancer	\$0	May require prior authorization.
You need hearing/auditory services (Continued on the next page)	Hearing screenings (including routine hearing exams)	\$0	Exam to diagnose and treat hearing and balance issues Routine hearing exam (for up to 1 every year)



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/auditory services (Continued)	Hearing aids (as well as fittings and associated accessories and supplies)	\$0	Hearing aid fitting/evaluation (for up to 2 every three years) Fitting/evaluation is limited to one per ear (one right, one left) every three years. The plan covers hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Plan coverage limit is \$2,000 for hearing aids limited to \$1,000 per ear (one right, one left) every 3 years. No prior authorization required.
You need dental care	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	\$0	\$3,500 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. There is no annual service category deductible for Medicare-covered benefits. Additional coverage available under Medicaid based on medical necessity. May require prior authorization. For more information, please see section M.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (Continued on the next page)	Vision services (including annual eye exams)	\$0	1 routine eye exam per year. A routine eye exam 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	Eyeglasses or contact lenses limited to one pair every year unless medically necessary. The cost of standard lenses and frames is limited to \$350 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.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (Continued)	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	\$0	Plan covers yearly glaucoma screening.
Annual health related social needs screening and navigation to services	You can connect to organizations in your community that provide services to help with housing, transportation, and care management at no-cost to you, through a regional Social Care Network (SCN).	\$0	If you're interested, please call your Care Team and we'll connect you to a SCN in your area. The Social Care Navigator will verify your eligibility, tell you more about these services, and help you get connected to them.
You have a mental health condition (Continued on the next page)	Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment Centers (ATC), Inpatient addiction rehabilitation, Inpatient	\$0	Plan covers up to 190 days of inpatient hospital care in a lifetime. Inpatient hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. May require prior authorization.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Medically Supervised Detox, or critical access hospital)		
	Adult Outpatient Mental Health (OMH) care • Continuing Day Treatment (CDT) • Partial hospitalization Adult outpatient rehabilitative mental health care • Assertive Community Treatment (ACT) • Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Personalized Recovery Oriented Services (PROS)	\$0	



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements. These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services: • Psychosocial Rehabilitation (PSR) • Community Psychiatric Supports and Treatment (CPST) • Empowerment services – peer supports • Family Support and Training (FST)	\$0	
	Adult mental health crisis services	\$0	



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	• Comprehensive Psychiatric Emergency Program (CPEP) • Mobile Crisis and Telephonic Crisis Services • Crisis Residential Programs • Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care) • (Note: This isn't a complete list of the plan's expanded outpatient mental health services.		Outpatient Mental Health (OMH) services may be provided by any licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Call your Care Team at the numbers listed at the bottom of this page or read the <i>Evidence of Coverage</i> for more information.)		
You're having a mental health or substance use crisis	Mobile Crisis services (assessment by telephone or mobile crisis team response); short-term residential crisis stabilization (for mental health crises)	\$0	Any approved mobile crisis or licensed crisis residence provider in New York State.
You have a mental health condition or a substance use disorder (Continued on the next page)	CORE Services (which are person-centered, recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence). (Note: For more information about CORE Services and to	\$0	CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition or a substance use disorder (Continued)	determine whether you're eligible for them, call your Care Team at the numbers listed at the bottom of this page or read the <i>Evidence of Coverage</i> .)		
You have a substance use disorder (Continued on the next page)	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment) (Note: This isn't a complete list of the plan's expanded substance use disorder services. Call your Care Team at the numbers listed at the bottom of this page or read the <i>Evidence of</i>	\$0	Plan covers Outpatient Substance Abuse Care: Assessment from a network provider in a 12-month period (you may self-refer) for outpatient substance abuse services.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder (Continued)	Coverage for more information.)		
You need a place to live with people available to help you	Skilled nursing care	\$0 copay for days 1-100	Plan covers additional days beyond Medicare 100-day limit. May require prior authorization.
	Nursing home	\$0	
	Custodial care (long-term care in a Nursing Facility)	\$0	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	\$0	Plan covers Medicare-covered: Physical Therapy visits, Speech Language Therapy visits, and Occupational Therapy visits. Plan covers Medicaid-covered, medically necessary visits that are ordered by a doctor or other licensed professional for: Physical Therapy visits, Speech Language Therapy visits, and Occupational Therapy visits. Requires prior authorization
You need help getting to health services	Emergency transportation	\$0	Ambulance services must be medically necessary. You do not need prior authorization for ambulance services, and you do not have to be in-network.
You need drugs to treat your illness or condition (Continued on the next page)	Medicare Part B drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment)	\$0	Read the <i>Evidence of Coverage</i> for more information on these drugs. There may be limitations on the types of drugs covered. Refer to VNS Health Total's <i>Formulary</i> at



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D drugs Generic and Brand name drugs		vnshealthplans.org/formulary for more information. VNS Health Total may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from VNS Health Total for certain drugs. You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that can't be met by most pharmacies in your network. These drugs are listed on the plan's website, List of Covered Drugs (<i>Formulary/Drug List</i>), and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			The plan offers two ways to get long-term supplies of drugs: through mail order or at a retail pharmacy.
	Over-the-counter (OTC) drugs	\$0	There may be limitations on the types of drugs covered. Please see the List of Covered Drugs (<i>Formulary/Drug List</i>) for more information. Please refer to the table labeled COVERED OVER-THE-COUNTER (OTC) DRUGS in the front pages of the <i>Formulary</i>. Please see the OTC and Grocery Catalog for a list of supplemental items, drugs and services covered by the plan.
You need foot care (Continued on the next page)	Podiatry services (including routine exams)	\$0	Plan covers: • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions • Routine foot care (up to 6 visit(s) every year) Requires prior authorization for Podiatry services



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need foot care (Continued)			No prior authorization required for Routine Foot care
	Orthotic services	\$0	Requires prior authorization.
You need durable medical equipment (DME) or supplies	Wheelchairs, nebulizers, crutches, roll about knee walkers, walkers, and oxygen equipment and supplies, for example (Note: This isn't a complete list of covered DME or supplies. Call your Care Team at the numbers listed at the bottom of this page or read the <i>Evidence of Coverage</i> for more information.)	\$0	May require prior authorization.
You need interpreter services	Spoken language interpreter	\$0	
	Sign language interpreter	\$0	



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (Continued on the next page)	Acupuncture	\$0	Original Medicare covers up to 12 visits in 90 days for Medicare beneficiaries meeting the criteria for lower back pain. May require prior authorization.
	Plan Care coordination	\$0	Our Plan Care Coordination is designed to help adults with many long-term health conditions and life situations. We look at each person's needs carefully, involve different health experts, and respect everyone's culture. This helps ensure our members get the health care and support services that they need.
	Chiropractic services	\$0	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Requires prior authorization.
	Diabetic supplies	\$0	



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (Continued)	Early and Periodic Screening Diagnosis and Treatment (EPSDT) (including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services)	\$0	EPSDT is for members under 21 years of age.
	Family planning	\$0	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service. Not covered by the plan; your Care Manager can assist with obtaining access and coordinating these services.
	Hospice care	\$0	
	Mammograms	\$0	
	Managed Long-term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical	\$0	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility and allows them to get necessary care in a residential or community setting.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (Continued)	therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); and social adult day care)		MLTSS is available to all members; specific service authorization, including amount, is indicated in the member's individualized approved Plan of Care. Non-medical transportation is covered directly by Medicaid Fee-for-Service.
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting)	\$0	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.
	Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional	\$0	Requires prior authorization.



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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (Continued)	nurse, as certified by a physician in accordance with a member's written plan of care)		
	Prosthetic services	\$0	Plan covers New York State Medicaid-covered prosthetics, orthotics and orthopedic footwear. No diabetic prerequisite for orthotics. Requires prior authorization.
	Services to help manage your disease	\$0	

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read VNS Health Total's *Evidence of Coverage*. If you have questions, you can also call the VNS Health Total Care Team at the numbers listed at the bottom of this page.



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F. Additional services VNS Health Total covers

This isn't a complete list. Call your Care Team at the numbers listed at the bottom of this page or read the *Evidence of Coverage* to find out about other covered services.

Additional Services VNS Health Total covers	Your costs
Acupuncture Plan covers up to 55 visits every year. No prior authorization required.	\$0



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Additional Services VNS Health Total covers	Your costs
Additional Telehealth Services Covers the following services: Urgently Needed Services; Home Health Services; Primary Care Physician Services; Occupational Therapy Services; Physician Specialist Services; Individual Sessions for Mental Health Specialty Services; Group Sessions for Mental Health Specialty Services; Individual Sessions for Psychiatric Services; Group Sessions for Psychiatric Services; Physical Therapy and Speech-Language Pathology Services; Opioid Treatment Program Services; Outpatient Hospital Services; Observation Services; Ambulatory Surgical Center (ASC) Services; Individual Sessions for Outpatient Substance Abuse; Group Sessions for Outpatient Substance Abuse; Kidney Disease Education Services; and Diabetes Self-Management Training	\$0



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Additional Services VNS Health Total covers	Your costs
Home Health (HH) and Health Home Plus (HH+) Care Management Services	\$0
Certified Community Behavioral Health Clinics (CCBHC)	\$0
Enhanced Disease Management A benefit that can provide you more support to take care of your health. Eligible members can participate to receive enhanced disease management. 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 May require prior authorization.	\$0
Gym Membership You are covered for a health club membership through SilverSneakers®. This includes group exercise classes at participating health club facilities and online. This fitness membership program is designed for Medicare beneficiaries. For more information about this benefit, visit the website at silversneakers.com .	\$0



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Additional Services VNS Health Total covers	Your costs
Help with Certain Chronic Conditions You may be eligible for the Palliative Care Program if you have a serious illness. Palliative Care is provided by a team of doctors, nurses and other specially trained people and continues alongside your regular medical care as added support. You will receive the following support through Care Management Services: • Comprehensive care assessment • Care planning and goals of care discussions • Access to social services and community resources • Coordination with your Primary Care Physician	\$0
Meals (Post-Discharge) 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 discharges per year. No prior authorization required. See your <i>Evidence of Coverage</i> for more information.	\$0
Nutrition The plan covers a nutritionist to assess your dietary needs and make recommendations to help ensure that your diet is consistent with your personal needs.	\$0



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Additional Services VNS Health Total covers	Your costs
Over-the-Counter, Grocery and Flex Get up to \$318 each month on your Healthy Extras Card for eligible OTC items, groceries*, utility bills*, and certain dental, hearing, or vision expenses. At the start of every month, your allowance is added to your card. Any unused balance expires at the end of the month. See the Healthy Extras Card Summary on page 52 for details. <i>*Grocery and utility benefits are part of special supplemental benefits for the chronically ill and not all members qualify. Chronic illnesses include diabetes, dementia, heart failure, lung disorders, stroke, and other conditions. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.</i>	\$0
Personal Emergency Response System (PERS) The plan covers PERS, which is a system that enables an individual to call for help in an emergency by pushing a button. Once the “help” button is activated, a signal is sent to a response center and appropriate actions are taken to assist the individual. There is no copayment for PERS. May require prior authorization.	\$0



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G. Benefits covered outside of VNS Health Total

This isn't a complete list. Call your Care Team at the numbers listed at the bottom of this page to find out about other services not covered by VNS Health Total but available through Medicaid fee-for-service.

Other services covered directly by Medicaid fee-for-service	Your costs
CSS (Community Support Services)	\$0
Health Home (HH) and Health Home Plus (HH+) Care Management services	\$0
Certified Community Behavioral Health Clinics (CCBHC)	\$0
Children's Crisis Residence Services Youth ages 18-20	\$0
Non-emergency Medical Transportation	\$0

H. Services that VNS Health Total, Medicare, and Medicaid don't cover

The following services aren't covered by our plan. This isn't a complete list. Call your Care Team at the numbers listed at the bottom of the page to find out about other excluded services.

Services that VNS Health Total, Medicare, and Medicaid don't cover
Cosmetic surgery if not medically necessary
Directly Observed Therapy for Tuberculosis Disease
HIV COBRA Case Management

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Services that VNS Health Total, Medicare, and Medicaid don't cover

Personal and Comfort items

Services considered not medically necessary according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.

Services of a provider that isn't part of the plan, unless the plan sends you to that provider, except family planning.



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I. Your rights and responsibilities as a member of the plan

As a member of VNS Health Total, you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you can't be refused medically necessary treatment. You can use these rights without losing your health care services. We'll tell you about your rights at least once a year. For more information on your rights, read the *Evidence of Coverage*.

Your rights include, but aren't limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
 - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex, age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation
 - Ask for and get information in other formats (for example, large print, braille, audio) free of charge
 - Be free from any form of physical restraint or seclusion
 - Not be billed by network providers
 - Have your questions and concerns answered completely and courteously
 - Apply your rights freely without any negative effect on the way VNS Health Total or your provider treats you



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- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
 - VNS Health Total
 - Description of the services we cover
 - How to get services
 - How much services will cost you
 - Names of health care providers and Care Managers
 - Your rights and responsibilities
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
 - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call 1-866-783-1444 (TTY: 711) if you want to change your PCP.
 - Use a women's health care provider without a referral
 - Get your covered services and drugs quickly
 - Know about all treatment options, no matter what they cost or whether they're covered
 - Refuse treatment as far as the law allows, even if your health care provider advises against it
 - Stop taking medicine, even if your health care provider advises against it
 - Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. VNS Health Total will pay for the cost of your second opinion visit.
 - Make your health care wishes known in an advance directive



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- **You have the right to timely access to care that doesn't have any communication or physical access barriers.** This includes the right to:
 - Get timely medical care
 - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act.
 - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call 1-866-783-1444 (TTY: 711) if you need help with this service
 - Have your *Evidence of Coverage* and any printed materials from VNS Health Total translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
 - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation
- **You have the right to emergency and urgent care when you need it.** This means you have the right to:
 - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
 - Use an out-of-network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
 - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
 - Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.
 - Have privacy during treatment



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- **You have the right to make complaints about your covered services or care.** This includes the right to:
 - Access an easy process to voice your concerns, and to expect follow up by VNS Health Total.
 - File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers
 - Ask for a State Appeal (State Fair Hearing)
 - Get a detailed reason why services were denied

Your responsibilities include, but aren't limited to, the following:

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
 - Treat your health care providers with dignity and respect
 - Keep appointments, be on time, and call in advance if you're going to be late or have to cancel
- **You have the responsibility to give information about you and your health.** You should:
 - Tell your health care provider your health complaints clearly and provide as much information as possible
 - Tell your health care provider about yourself and your health history
 - Tell your health care provider that you are a VNS Health Total member
 - Talk to your PCP, Care Manager, or other appropriate person about seeking the services of a specialist before you go to a hospital (except in cases of emergency)
 - Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment



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- Notify your Total Care Team if there are any changes in your personal information, such as your address or phone number
- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
 - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
 - Partner with your Care Team and work out treatment plans and goals together
 - Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health
- **You have the responsibility to obtain your services from VNS Health Total.** You should:
 - Get all your health care from VNS Health Total, except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless VNS Health Total provides a prior authorization for out-of-network care
 - Not allow anyone else to use your VNS Health Total Member ID Card to obtain health care services
 - Notify VNS Health Total when you believe that someone has purposely misused VNS Health Total's benefits or services

For more information about your rights, you can read the VNS Health Total's *Evidence of Coverage*. If you have questions, you can also call your Care Team at the numbers listed at the bottom of this page.



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J. How to file a complaint or appeal a denied service

If you have a complaint or think VNS Health Total should cover something we denied, call us at 1-866-783-1444 (TTY: 711). You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Evidence of Coverage*. You can also call your Care Team at the numbers listed at the bottom of this page.

You can contact the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process.

Independent Consumer Advocacy Network (ICAN)
Phone: 1-844-614-8800 Mon. - Fri. 8:00 AM - 6:00 PM. (TTY: 711).

Mail: Independent Consumer Advocacy Network (ICAN)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017

You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

Phone: 1-866-712-7197
E-mail: mltccomplaints@health.ny.gov
Mail: New York State Department of Health
Bureau of Consumer Services
99 Washington Ave/ One Commerce Plaza 16th Fl
Albany, NY 12210

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K. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

- Call your Care Team. Phone numbers are at the bottom of this page.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). (TTY: 1-877-486-2048). You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, call the New York State Medicaid Program Fraud Hotline 1-877-87 FRAUD.



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L. 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.



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

M. 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	Copayment	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	Once per year



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N. Healthy Extras Card Summary

Your Healthy Extras Card gives you up to \$318 each month for eligible:

- OTC health items
- Grocery items*
- Home-delivered meals and produce
- Utility bills* (electric, gas, internet and phone)
- Dental, hearing, and vision expenses beyond your plan coverage



Each month, your allowance is added to your card. Any unused balance expires at the end of the month. See the OTC and Grocery catalog for a list of approved items and participating stores, pharmacies, grocery stores, and bodegas. You can also visit mybenefitscenter.com.

Here are a few examples of how your allowance may help cover dental, hearing, or vision costs:

- Your glasses break after you've used your vision benefit.
- You reach your dental benefit limit before treatment is complete.
- You need a replacement hearing aid before your plan will cover a new one.

Important to know:

- Your allowance can't be used for items or services that are not eligible.
- If you enroll after January 1, 2027, your monthly benefit amount will be based on when your coverage becomes effective.
- Call us if you have questions about whether an item or service is eligible.



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

Healthy Extras Card Summary (Continued)

Grocery and utility benefits are part of special supplemental benefits for the chronically ill and not all members qualify. Chronic illnesses include diabetes, dementia, heart failure, lung disorders, stroke, and other conditions. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

Member Rewards Program

And there's more! You are automatically enrolled in our Member Rewards Program.

Earn rewards when you complete eligible health activities.

We verify completed activities through claims submitted by your providers. Rewards are loaded onto your **Healthy Extras Card** three times a year.

Your rewards will be available for use once your allowance is fully used each month.

Check your welcome kit to learn more about the rewards program.



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

O. Member Resources

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

Evidence of Coverage (Downloadable PDF)	vnshealthplans.org/total-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.



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

P. 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 with your Care Team at 1-866-783-1444 (TTY: 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage*, especially for those services for which you routinely see a doctor. Visit vnshealthplans.org/total-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

- ☐ 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*).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ **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.



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



If you have general questions or questions about our plan, services, service area, billing for Member ID Cards, call your Care Team:

1-866-783-1444 (TTY: 711). Calls to this number are free.

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

We have free language interpreter services available for non-English speakers.

If you need immediate behavioral health care:

Call Carelon at 1-866-317-7773 (TTY: 711). Calls to this number are free.

Routine behavioral health support: Monday – Friday, 8 am – 8 pm.

Behavioral health crisis and emergency support: Available 24 hours a day, 7 days a week.

Carelon has free language interpreter services available for non-English speakers.