

Annual Notice of Change (ANOC)

2024



Valor Health Plan

Insurance focused on you.

For more information, contact Valor Health Plan (HMO-SNP) from 8:00 a.m. to 8:00 p.m., 7 days a week at 1-800-485-3793 TTY: 711 or visit www.valorhealthplan.com

Valor Health Plan (HMO-SNP) offered by TSG Guard, Inc.

Annual Notice of Changes for 2024

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

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

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

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including authorization requirements and costs.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

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

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

- If you don't join another plan by December 7, 2023, you will stay in *Valor Health Plan*.
- To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1-800-485-3793 for additional information. (TTY users should call 711.) Hours are October 1 – March 31, 8:00 a.m. to 8:00 p.m. with interactive voice response system for Thanksgiving and Christmas Day. April 1 – September 30, hours are 8:00 a.m. to 8:00 p.m. with interactive voice response system for Saturdays, Sundays and Federal Holidays. This call is free.
- This document may be available in an alternate format (braille, large format, etc.) Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Valor Health Plan

- Valor Health Plan (HMO-SNP) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means *TSG Guard, Inc. (Valor Health Plan)*. When it says “plan” or “our plan,” it means *Valor Health Plan*.

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Summary of Important Costs for 2024

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

Cost	2023 (this year)	2024 (next year)
<p>Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$34.70	\$40.90
<p>Deductible</p>	\$226	\$240 (except for insulin furnished through an item of durable medical equipment.)
<p>Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$8,300	\$8,850
<p>Doctor office visits</p>	Primary care visits: 20% per visit Specialist visits: 20% per visit	Primary care visits: 20% per visit Specialist visits: 20% per visit
<p>Inpatient hospital stays</p>	You pay a \$1,600 deductible for days 1-60 You pay a \$400 copay per day for days 61-90 You pay a \$800 per lifetime reserve day Cost shares are applied starting on the first day of admission and do not	You pay a \$1,632 deductible for days 1-60 You pay a \$408 copay per day for days 61-90 You pay a \$816 per lifetime reserve day Cost shares are applied starting on the first day of admission and do not

Cost	2023 (this year)	2024 (next year)
	include the date of discharge.	include the date of discharge.
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$505 (except for covered insulin products and most adult Part D vaccines) during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. 	<p>Deductible: \$545 (except for covered insulin products and most adult Part D vaccines) during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: 25% You pay up to \$35 per month supply of each covered insulin product on this tier. <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	34.70	\$40.90

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see Section 5 regarding “Extra Help” from Medicare.

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

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$8,300	\$8,850 Once you have paid \$8,850 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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

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

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

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Note that beginning July 2023, cost-sharing for insulin furnished through an item of DME is subject to a coinsurance cap of \$35 for one-month's supply of insulin. You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

Cost	2023 (this year)	2024 (next year)
<i>Colorectal Cancer Screening</i>	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay 15% of the Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a 15% coinsurance. The Part B deductible doesn't apply.
<i>Diabetes self-management training, diabetic services, and supplies</i>	20% of the cost for Medicare covered services Authorizations required for charges greater than \$1,000 or more.	20% of the cost for Medicare covered services Authorization <i>no longer</i> required for charges greater than \$1,000 or more.
<i>Emergency Care</i>	20% of the cost for Medicare covered services (Up to \$90).	20% of the cost for Medicare covered services (Up to \$100)

Cost	2023 (this year)	2024 (next year)
<p><i>Inpatient Hospital Care</i></p>	<p>You pay a \$1,600 deductible for days 1-60</p> <p>You pay a \$400 copay per day for days 61-90</p> <p>You pay a \$800 per lifetime reserve day</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p>	<p>You pay a \$1,632 deductible for days 1-60</p> <p>You pay a \$408 copay per day for days 61-90</p> <p>You pay a \$816 per lifetime reserve day</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p>
<p>Inpatient Services in a Psychiatric Hospital</p>	<p>You pay a \$1,600 deductible for days 1-60</p> <p>You pay a \$400 copay per day for days 61-90</p> <p>You pay a \$800 per lifetime reserve day</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p>	<p>You pay a \$1,632 deductible for days 1-60</p> <p>You pay a \$408 copay per day for days 61-90</p> <p>You pay a \$816 per lifetime reserve day</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p>
<p>Inpatient Stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p>	<p>You pay nothing for the first 20 days of each benefit period.</p> <p>You pay \$200 per day for days 21 – 100.</p> <p>You pay all costs for each day after day 100.</p>	<p>You pay nothing for the first 20 days of each benefit period.</p> <p>You pay \$204 per day for days 21 – 100.</p> <p>You pay all costs for each day after day 100.</p>

Cost	2023 (this year)	2024 (next year)
<p>Medicare Part B prescription drugs</p> <p><i>Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</i></p>		<p><i>20% of the cost of Medicare covered services</i></p>
<p>Outpatient Mental Health Care</p> <p>Covered services include:</p>	<p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, <i>licensed professional counselor (LPC), licensed marriage and family therapist (LMFT)</i>, nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>
<p>Skilled Nursing Facility (SNF) Care</p>	<p>You pay nothing for the first 20 days of each benefit period.</p> <p>You pay \$200 per day for days 21 – 100.</p> <p>You pay all costs for each day after day 100.</p>	<p>You pay nothing for the first 20 days of each benefit period.</p> <p>You pay \$204 per day for days 21 – 100.</p> <p>You pay all costs for each day after day 100.</p>
<p>Urgently Needed Services</p>	<p>20% of the cost for Medicare covered services (up to \$65) and up to 3 days</p>	<p>20% of the cost for Medicare covered services (up to \$55) and up to 3 days</p>

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our “Drug List”

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

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

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

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive “Extra Help” and didn’t receive this insert with this packet, please call Member Services and ask for the LIS Rider.

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

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
<p>Stage 1: Yearly Deductible Stage</p> <p>During this stage, you pay the full cost of your brand name drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.</p>	<p>The deductible is \$505.</p>	<p>The deductible is \$545.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>You pay 25% of the total cost.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>You pay 25% of the total cost.</p>
<p>Stage 2: Initial Coverage Stage (continued)</p> <p>The costs in this row are for a one-month 31-day supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	<p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in *Valor Health Plan*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our *Valor Health Plan*.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- **To change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *Valor Health Plan*.
- **To change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *Valor Health Plan*.
- **To change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.

- – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

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

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

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

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

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

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In *Ohio*, the SHIP is called ***Ohio Senior Health Insurance Information Program (OSHIIP)***.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. ***Ohio Senior Health Insurance Information Program*** counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *OSHIIP* at 1-800-686-1578. You can learn more about *OSHIIP* by visiting their website (<https://insurance.ohio.gov/about-us/divisions/oshiip>).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual

deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the *Ohio AIDS Drug Assistance Program*, Ohio Department of Health, 246 N. High Street, Columbus, Ohio 43215. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-777-4775.

SECTION 6 Questions?

Section 6.1 – Getting Help from *Valor Health Plan*

Questions? We're here to help. Please call Member Services at 1-800-485-3793. (TTY only, call 711). We are available for phone calls *October 1 – March 31, 8:00 a.m. to 8:00 p.m. CST with interactive voice response system for Thanksgiving and Christmas Day. April 1 – September 30, hours are 8:00 a.m. to 8:00 p.m. CST with interactive voice response system for Saturdays, Sundays and Federal Holidays.* Calls to these numbers are free.

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage for Valor Health Plan*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.valorhealthplan.com You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



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