2025
Annual Notice of Changes

RiverSpring MAP

(HMO D-SNP)

For more information, call us **1-800-362-2266** (TTY/TDD 711)
8 a.m. to 8 p.m. ET – 7 days a week.

www.RiverSpringHealthPlans.org

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RiverSpring MAP (HMO D-SNP) offered by RiverSpring Health Plans

RiverSpring MAP (HMO D-SNP) Annual Notice of Changes for 2025

You are currently enrolled as a member of RiverSpring MAP (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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.RiverSpringHealthplans.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your

Medicare & You 2025 handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in RiverSpring MAP (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with *RiverSpring MAP (HMO D-SNP)*.
- Look in section *3.2*, page *18* to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish, Chinese and Russian
- Please contact our Member Services number at 1-800-362-2266 for additional information. (TTY users should call 711.) Hours are 8:00 am to 8:00 pm ET, 7 days a week. This call is free.
- You can get this information for free in other formats, such as large print, braille, or audio. Call 1-800-362-2266 (TTY users should call 711.). Hours are 8:00 am to 8:00 pm ET, 7 days a week.
- **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 *RiverSpring MAP (HMO D-SNP) RiverSpring MAP (HMO D-SNP)*

- RiverSpring MAP (HMO D-SNP) is a plan with a Medicare and Medicaid contract. Enrollment in RiverSpring MAP (HMO D-SNP) depends on Contract renewal. The plan also has a written agreement with the New York Medicaid program to coordinate your Medicaid benefits

When this document says "we," "us," or "our," it means RiverSpring Health Plans. When it says "plan" or "our plan," it means RiverSpring MAP (HMO D-SNP) *RiverSpring MAP (HMO D-SNP)*.

Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *RiverSpring MAP (HMO D-SNP)* in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 or 48.70 for your Part D Premium	$0 or 72.30 for your Part D Premium
Part B Deductible	The Part B Deductible is $240 except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	The Part B Deductible is $ 240 except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0. These are 2024 cost-sharing amounts and may change for 2025. RiverSpring MAP will provide updated rates as soon as they are released.
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: $0 per visit Specialist visits: $0 per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.
Inpatient hospital stays	$0 Coinsurance or Copayment.	$0 Coinsurance or Copayment.

Cost	2024 (this year)	2025 (next year)
	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $ 545 except for covered insulin products and most adult Part D vaccines. *Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility. (Look at the separate inert, the "LIS Rider" for your deductible amount.) Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Depending on your Medicaid eligibility you pay: **For generic drugs (including brand drugs treated as generic)**: $0 copay; or $1.55 copay; or $4.50 copay; or 25% of the cost. **For all other drugs**: $0 copay; or $4.60 copay; or $11.20 copay; or 25% of the cost. You pay $35 per month supply of each covered insulin product on this tier.	Deductible: *$590* except for covered insulin products and most adult Part D vaccines. *Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility. (Look at the separate inert, the "LIS Rider" for your deductible amount.) Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Depending on your Medicaid eligibility you pay: **For generic drugs (including brand drugs treated as generic)**: $0 copay; or $1.60 copay; or $4.90 copay; or 25% of the cost. **For all other drugs**: $0 copay; or $4.80 copay; or $12.15 copay; or 25% of the cost. You pay $35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$8,850 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,900 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or 48.70 for your Part D Premium	$0 or 72.30 for your Part D Premium

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	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays 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.	$8,850 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.	*$8,900* Once you have paid *$8,900* 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

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.RiverSpringHealthplans.org. 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 2025 *Provider Directory* www.RiverSpringHealthplans.org 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 2025 *Pharmacy Directory* www.RiverSpringHealthplans.org to see which pharmacies are in our network**.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

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

Cost	2024 (this year)	2025 (next year)
Emergency Services Emergency Services refers to services: - furnished by a provider qualified to furnish emergency services; and - needed to evaluate or stabilize an emergency medical condition.	You pay a $100 copay per office visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $110 copay per office visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Urgently Needed Services Are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area.	You pay a $55 copay per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $45 copay per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Over-The-Counter (OTC) Items	$155 per month. Any unused amount is not carried over to the next period.	$218 per month. Any unused amount is not carried over to the next period.

Cost	2024 (this year)	2025 (next year)
Over-The-Counter (OTC) + Grocery Benefit	$155 per month. You are allowed to spend 50% ($77.50) of the OTC benefit amount towards food and produce. For eligible members (with certain chronic conditions) the Special Supplemental Benefits for Chronically Ill (grocery benefit) combines with the OTC benefit to cover certain grocery items as part of the monthly OTC allowance, which may only be purchased at select pharmacies and/or retailers.	$218 per month. You are allowed to spend 50% ($109) of the OTC benefit amount towards food and produce. For eligible members (with certain chronic conditions) the Special Supplemental Benefits for Chronically Ill (grocery benefit) combines with the OTC benefit to cover certain grocery items as part of the monthly OTC allowance, which may only be purchased at select pharmacies and/or retailers. The benefits mentioned are a part of special supplemental program for the chronically ill. Some examples of conditions include *Cardiovascular Disorder, Hypertension, Osteoarthritis, Endocrine Disorder and Gastrointestinal Disorder*. Eligibility for this benefit cannot be guaranteed based solely on your condition. Eligible members will be notified and provided instructions on how to access this benefit.
Mental Health Specialty Services	Prior Authorization is required	Prior Authorization is **not** required
Psychiatric Services	Prior Authorization is required	Prior Authorization is **not** required

Cost	2024 (this year)	2025 (next year)
Outpatient Diagnostic and Therapeutic Radiological Services	Diagnostic Procedures/Tests: Authorization is **not required.** Lab Services: Routine lab services: *Authorization is **not required.** *Some Lab Services might require an authorization.	Prior Authorization is required for MRI and PET scans. Lab Services: Routine lab services: *Authorization is **not required.** *Some Lab Services might require an authorization.
Other Medicare-Covered Preventive Services	Medicare covered Barium Enemas: Prior Authorization is required	Medicare covered Barium Enemas: Prior Authorization is **not** required.
Dental Services: Supplemental Preventive Dental Services	Supplemental Preventive Dental Services: Not Covered	Supplemental Preventive Dental Services: Coverage of Supplemental Preventive Dental Services is limited to selected service codes from the categories below. You pay $0 copayment for the following Supplemental Preventative Dental Services: Prior Authorization is not required • Periodic Oral Exams: 1 every 6 months • Limited Oral Evaluation: 2 every 12 months. • Comprehensive Oral Evaluation: 1 per provider in a lifetime

Cost	2024 (this year)	2025 (next year)
Dental Services: Supplemental Preventive Dental Services (continued)		• Oral Evaluation (problem focused): 3 every 12 months. • Dental X-Rays: Intraoral, complete series or panoramic x-ray 1 every 36 months. Intraoral, periapical - 3 every 6 months. Bitewings - 3 every 12 months. Sialography - 2 every week • Other Diagnostic Dental Services*: Cone beam CT capture and interpretation - 1 every 60 months. *Prior Authorization is required. • Prophylaxis (cleaning): 1 every 6 months Prior Authorization is not required. • Fluoride Treatment: 1 covered up to age of 20 Prior Authorization is not required • Other Preventive Dental Services: Tobacco counseling, control prevention oral disease – 1 every 6 months. Prior Authorization is not required.

Cost	2024 (this year)	2025 (next year)
Dental Services: Supplemental Comprehensive Dental Services	Supplemental Comprehensive Dental Services: Not Covered	• Restorative Services: Amalgam / Resin based composite filling - 1 per tooth, per surface - every 24 months. Crown services - 1 per tooth - every 60 months. Prior Authorization is required. • Endodontics: 1 per tooth, per lifetime. Prior Authorization is required. • Periodontics: Gingivectomy or gingivoplasty - 1 every 12 months, per quad. Crown lengthening - 1 per tooth per lifetime. Periodontal scaling and root planing - 1 every 24 months per site. Periodontal maintenance once every 6 months. Prior Authorization is required. • Prosthodontics: Complete /Partial denture - 1 every 96 months, per arch. Denture Adjustment - 4 every 12 months, per arch (Not covered within 6 months of placement). Prior Authorization is required.

Cost	2024 (this year)	2025 (next year)
Dental Services: Supplemental Comprehensive Dental Services (continued)		• Maxillofacial Prosthetics: 1 every 12 months. Prior Authorization is required. • Implant Services: Surgical placement of implant - 1 per tooth, in a lifetime. Abutment services - 1 per tooth, every 96 months. Debridement services - 1 per tooth, every 24 months. Prior Authorization is required. • Prosthodontics: 1 every 60 months per tooth. • Oral and Maxillofacial Surgery: Extraction of erupted or impacted tooth 1 per tooth, in a lifetime. Alveoloplasty once per site/quad in a lifetime. Other Oral and Maxillofacial Surgery by report. Prior Authorization is required. • Adjunctive General Services: Palliative emergency treatment 2 every 12 months. Deep sedation maximum of 60 minutes or 4 units. Prior Authorization is required.

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, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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

Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if, we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately add new restrictions.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by *September 30th*, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $*545*. Your deductible amount may be $0, depending on the level of "Extra Help" you receive. (Look at the separate insert, the LIS Rider, for your deductible amount.)	The deductible is $*590*. Your deductible amount may be $0, depending on the level of "Extra Help" you receive. (Look at the separate insert, the LIS Rider, for your deductible amount.)

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage 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**. The costs in this row are for a one-month (*30*-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply; or at a network pharmacy, look in Chapter 6, Section 5 of your *Evidence of Coverage*. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is. **For generic drugs (including brand drugs treated as generic)**: $0 copay; or $1.55 copay; or $4.50 copay; or 25% of the cost. **For all other drugs**: $0 copay; or $4.60 copay; or $11.20 copay; or 25% of the cost. You pay $35 per month supply of each covered insulin product on this tier. Once your total drug costs have reached $*5,030*, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is $. **For generic drugs (including brand drugs treated as generic)**: $0 copay; or $1.60 copay; or $4.90 copay; or 25% of the cost. **For all other drugs**: $0 copay; or $4.80 copay; or $12.15 copay; or 25% of the cost. You pay $35 per month supply of each covered insulin product on this tier. Once you have paid $*2,000* out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Once you reach the annual out of pocket threshold of $2,000 you enter the Catastrophic Coverage phase. This means you will have **no** cost-sharing for Medicare Part D Formulary drugs. For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-866-845-1803 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *RiverSpring MAP (HMO D-SNP)*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our RiverSpring Map (HMO D-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025*

handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

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

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

SECTION 4 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, 2025.

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

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

Because you have *New York Medicaid*, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In *New York*, the SHIP is called Office for the Aging Health Insurance Information, Counseling and assistance Program (HIICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *HIICAP* counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *HIICAP* at 1-800-701-0501. You can learn more about *HIICAP* by visiting their website (https://www.aging.ny.gov/health-insurance-information-counseling-and-assistance).

For questions about your New York Medicaid benefits, contact New York Medicaid Helpline at 1-800-541-2831 (TTY users call 711), from 8:00 am to 5:00 pm, Monday through Friday. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** *New York* has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) that helps people pay for

prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York State HIV Uninsured Care Programs. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-866-845-1803 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from *RiverSpring MAP (HMO D-SNP)*

Questions? We're here to help. Please call Member Services at 1-800-362-2266. (TTY only, call 711.) We are available for phone calls 8:00 am to 8:00 pm, 7 days a week. Calls to these numbers are free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for *RiverSpring MAP (HMO D-SNP).* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.RiverSpringHealthplans.org. 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.RiverSpringHealthplans.org*. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List).*

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2025*

Read the *Medicare & You 2025* 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.

Section 8.3 – Getting Help from Medicaid

To get information from Medicaid you can call New York Medicaid Helpline at 1-800-541-2831 from 8:00 am to 5:00 pm, Monday through Friday. TTY users should call 711.

Notice of Non-Discrimination

ElderServe Health, Inc. d/b/a RiverSpring Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ElderServe Health, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ElderServe Health, Inc. d/b/a RiverSpring Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that ElderServe Health, Inc. d/b/a RiverSpring Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Civil Rights Coordinator
80 West 225th Street
Bronx, NY, 10463
Phone: 1-347-842-3660, TTY 711
Fax: 1-888-341-5009

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-362-2266. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-362-2266. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-362-2266。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-362-2266。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-362-2266. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-362-2266. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-362-2266 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-362-2266. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-362-2266번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-362-2266. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-362-2266 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-362-2266 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-362-2266. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-362-2266. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-362-2266. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-362-2266. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-362-2266にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)

RiverSpring Health Plans

1-800-362-2266 (TTY/TDD 711)
8 a.m. to 8 p.m. ET. – 7 days a week.

www.RiverSpringHealthPlans.org