PriorityHealth

2022
Annual Notice of Changes

Michigan Public School Employees' Retirement System

offered by Priority Health

January 1, 2022 - December 31, 2022

OMB Approval 0938-1051 (Expires: February 29, 2024)

H2320_NCMS110011402222W_M 06162021

You are currently enrolled as a member of
PriorityMedicare℠ (Employer HMO-POS)
Next year, there will be changes to your plan's costs and benefits.
This booklet details these changes.

Additional resources
This information is available in a different format, including Braille and large print.

Please contact our Customer Service at 888.389.6648, option #3, for additional information. (TTY users should call 711). We're available 8 a.m. to 8 p.m., seven 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 your plan
Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.

When this booklet says "we," "us," or "our," it means Priority Health Medicare. When it says "plan" or "our plan," it means your Priority Health plan.

ASK: Which changes apply to you

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

- Review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit *go.medicare.gov/drugprices*, and click the "dashboards" link in the middle of the second note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and hospitals will be in our network next year.

- Look in Section 1.3 and 1.4 for information about our *Provider/Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

CHOOSE: Decide whether you want to change your plan

- If you want to keep **Priority**Medicare (Employer HMO-POS), you don't need to do anything. You will stay in **Priority**Medicare (Employer HMO-POS).
- If you decide other coverage will better meet your needs, contact the Office of Retirement Services at 800.381.5111 to see what your plan options are. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for **Priority**Medicare (Employer HMO-POS) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your coverage is provided through a contract with the Michigan Public School Employees' Retirement System. Contact the Office of Retirement Services for information about your plan premium. See Section 1.1 for details.	Contact the Office of Retirement Services at 1.800.381.5111	Contact the Office of Retirement Services at 1.800.381.5111
Deductible	HMO (in-network) $300 POS (out-of-network) $500	HMO (in-network) $450 POS (out-of-network) $575
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.)	HMO (in-network) $2,100 POS (out-of-network) $3,000	HMO (in-network) $2,100 POS (out-of-network) $3,000
Doctor office visits	HMO (in-network) Primary care visits: $0-$10 per visit. Specialist visits: $0-$35 per visit. POS (out-of-network) 30% per visit with a PCP or specialist, after deductible.	HMO (in-network) Primary care visits: $0-$10 per visit. Specialist visits: $0-$35 per visit. POS (out-of-network) 30% per visit with a PCP or specialist, after deductible.

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	HMO (in-network) 10% per stay, after deductible. POS (out-of-network) 30% per stay, after deductible.	HMO (in-network) 10% per stay, after deductible. POS (out-of-network) 30% per stay, after deductible.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: Preferred Retail • Drug Tier 1: $9 • Drug Tier 2: $9 • Drug Tier 3: $40 • Drug Tier 4: $70 • Drug Tier 5: 20% of the cost up to a $100 maximum Standard Retail • Drug Tier 1: $15 • Drug Tier 2: $15 • Drug Tier 3: $45 • Drug Tier 4: $75 • Drug Tier 5: 20% of the cost up to a $100 maximum	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: Preferred Retail • Drug Tier 1: $9 • Drug Tier 2: $9 • Drug Tier 3: $40 • Drug Tier 4: $70 • Drug Tier 5: 20% of the cost up to a $100 maximum Standard Retail • Drug Tier 1: $15 • Drug Tier 2: $15 • Drug Tier 3: $45 • Drug Tier 4: $75 • Drug Tier 5: 20% of the cost up to a $100 maximum

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

- Your coverage is provided through a contract with the Michigan Public School Employees' Retirement System. Please contact the Office of Retirement Services at 1.800.381.5111, Monday through Friday, 8:30 a.m. to 5 p.m. for information about your plan premium.
- You must continue to pay your Medicare Part B premium.
- You may be 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. The Michigan Public School Employees' Retirement System pays this penalty on your behalf.
- 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.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (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 (if applicable) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	HMO (in-network) $2,100	HMO (in-network) $2,100 Once you have paid $2,100 out-of-pocket for in-network covered services, you will pay nothing for your covered services from in-network providers for the rest of the plan year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount ***(continued)***	POS (out-of-network) $3,000	POS (out-of-network) Once you have paid $3,000 out-of-pocket for out-of-network covered services, you will pay nothing for your covered services from out-of-network providers for the rest of the plan year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at *priorityhealth.com/mpsers*. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at *priorityhealth.com/mpsers*. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Ambulance services	Prior authorization is required for non-emergent ambulance services.	Prior authorization is <u>not</u> required for non-emergent ambulance services.

Cost	2021 (this year)	2022 (next year)
Diabetes self-management training, diabetic services and supplies	Prior authorization is required for diabetic shoes and/or shoe inserts.	Prior authorization is not required for diabetic shoes and/or shoe inserts.
Emergency care	HMO (in-network) & POS (out-of-network) $90 for each Medicare-covered emergency room visit.	HMO (in-network) & POS (out of network) $120 for each Medicare-covered emergency room visit.
Hearing services	HMO (in-network) You receive the following with a hearing aid purchase from a TruHearing provider: $0 for one routine hearing exam every two years. 48 batteries per hearing aid. 45-day trial period.	HMO (in-network) You receive the following with a hearing aid purchase from a TruHearing provider: $0 for routine hearing exams every year. 80 batteries per hearing aid. 60-day risk-free trial period.
Outpatient diagnostic tests and therapeutic services and supplies	HMO (in-network) $10 per day, per provider, for Medicare-covered lab services. POS (out-of-network) 30% per day, per provider, for Medicare-covered lab services.	HMO (in-network) $0 per day, per provider, for Medicare-covered anticoagulant lab services. $10 per day, per provider, for all other Medicare-covered lab services. POS (out-of-network) $0 per day, per provider, for Medicare-covered anticoagulant lab services. 30% per day, per provider, for all other Medicare-covered lab services.

Cost	2021 (this year)	2022 (next year)
Outpatient hospital observation	HMO (in-network) & POS (out-of-network) $90 for each Medicare-covered observation visit, including all services received.	HMO (in-network) & POS (out-of-network) $120 for each Medicare-covered observation visit, including all services received.
Outpatient hospital services	Prior authorization is required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy. Prior authorization is not required for blepharoplasty.	Prior authorization is not required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy. Prior authorization is required for blepharoplasty.
Outpatient surgery, *including services provided at hospital outpatient facilities and ambulatory surgical centers*	Prior authorization is required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy. Prior authorization is not required for blepharoplasty.	Prior authorization is not required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy. Prior authorization is required for blepharoplasty.
Physician/Practitioner services, including doctor's office visits	HMO (in-network) $35 for each palliative care physician office visit.	HMO (in-network) $0 for each palliative care physician office visit.
Services to treat kidney disease	HMO (in-network) $0 for each Medicare-covered renal dialysis service with an in-network provider or when you are outside of the plan's service area. POS (out-of-network) $0 for each Medicare-covered renal dialysis service with an out-of-network provider when you are in the plan's service area	HMO (in-network) 10% for each Medicare-covered renal dialysis service with an in-network provider or when you are outside of the plan's service area. POS (out-of-network) 10% for each Medicare-covered renal dialysis service with an out-of-network provider when you are in the plan's service area

Section 1.6 – 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 in this envelope.

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

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time** temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you had a formulary exception in 2021, you would have received a letter from us showing when this exception ended. Generally, we only make an exception for one contract year. If you are still taking the drug, you may need to request an exception for contract year 2022. See Chapter 5, Section 5.2 of the *Evidence of Coverage* for how to make an exception request.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

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 may not apply to you.** We have included 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 Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage.*

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage ***(30 day retail)*** 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 for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 - preferred generic drugs:** *Standard cost sharing:* $15 *Preferred cost sharing:* $9 **Tier 2 - generic drugs:** *Standard cost sharing:* $15 *Preferred cost sharing:* $9 **Tier 3 - preferred brand drugs:** *Standard cost sharing:* $45 *Preferred cost sharing:* $40 **Tier 4 - non-preferred drugs:** *Standard cost sharing:* $75 *Preferred cost sharing:* $70 **Tier 5 - specialty drugs:** *Standard cost sharing:* 20% of the cost up to a $100 maximum *Preferred cost sharing:* 20% of the cost up to a $100 maximum	Your cost for a one-month supply at a network pharmacy: **Tier 1 - preferred generic drugs:** *Standard cost sharing:* $15 *Preferred cost sharing:* $9 **Tier 2 - generic drugs:** *Standard cost sharing:* $15 *Preferred cost sharing:* $9 **Tier 3 - preferred brand drugs:** *Standard cost sharing:* $45 *Preferred cost sharing:* $40 **Tier 4 - non-preferred drugs:** *Standard cost sharing:* $75 *Preferred cost sharing:* $70 **Tier 5 - specialty drugs:** *Standard cost sharing:* 20% of the cost up to a $100 maximum *Preferred cost sharing:* 20% of the cost up to a $100 maximum

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage ***(90 day mail-order)*** The costs in this row are for a three-month (90-day) supply when you fill your prescription through mail-order. For information about the costs for a long-term supply or for 30-day or 60-day mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. Our pharmacy network includes mail-order pharmacies that offer standard cost sharing and preferred cost sharing. Preferred cost sharing for mail-order is limited to our preferred mail-order pharmacy, Express Scripts, but you may choose any network mail-order pharmacy to receive your covered prescription drugs. Your cost sharing may be less at Express Scripts.	Your cost for a three-month supply at a mail-order pharmacy: **Tier 1 - preferred generic drugs:** *Standard cost sharing:* $0 *Preferred cost sharing:* $0 **Tier 2 - generic drugs:** *Standard cost sharing:* $18 *Preferred cost sharing:* $18 **Tier 3 - preferred brand drugs:** *Standard cost sharing:* $80 *Preferred cost sharing:* $80 **Tier 4 - non-preferred drugs:** *Standard cost sharing:* $140 *Preferred cost sharing:* $140 **Tier 5 – specialty drugs:** Not available _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a three-month supply at a mail-order pharmacy: **Tier 1 - preferred generic drugs:** *Standard cost sharing:* $45 *Preferred cost sharing:* $0 **Tier 2 - generic drugs:** *Standard cost sharing:* $45 *Preferred cost sharing:* $18 **Tier 3 - preferred brand drugs:** *Standard cost sharing:* $135 *Preferred cost sharing:* $80 **Tier 4 - non-preferred drugs:** *Standard cost sharing:* $225 *Preferred cost sharing:* $140 **Tier 5 – specialty drugs:** Not available _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

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

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Physician/Practitioner services, including doctor's office visits	All members with back and neck pain, with the exception of those requiring urgent surgical evaluation, must have an evaluation with a Spine Center of Excellence approved clinic prior to referral to an orthopedic specialist or neurosurgeon.	All members with back and neck pain do not need to have an evaluation with a Spine Center of Excellence approved clinic prior to referral to an orthopedic specialist or neurosurgeon.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in **Priority**Medicare (Employer HMO-POS)

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, you will automatically be enrolled in our **Priority**Medicare (Employer HMO-POS).

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 for 2022 follow these steps:

Step 1: Learn about and compare your choices

- Contact the Office of Retirement Services at 1.800.381.5111 to discuss your options.

- *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 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to *www.medicare.gov/plan-compare*. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- If you choose to change plans, contact the Office of Retirement Services. They will notify Priority Health Medicare on your behalf.
- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from **Priority**Medicare (Employer HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from **Priority**Medicare (Employer HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send the Office of Retirement Services a written request to disenroll. Contact the Office of Retirement Services at 800.381.5111.
    - – *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 4 Deadline for Changing Plans

If you want to change to a different plan for next year, contact the Office of Retirement Services at 1.800.381.5111 for more information.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

MMAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. MMAP 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 MMAP at 800.803.7174. You can learn more about MMAP by visiting their website (*www.mmapinc.org*).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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. Many people are eligible and don't even know it. 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 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
    - Change Healthcare at 1-866-783-7047, between 9 am to 6 pm, Monday through Friday. TTY users should call 1-877-644-3244. Priority Health works with MyAdvocate Change Healthcare to help members identify and apply for programs that they may qualify for. For additional information please go to *MyAdvocateHelps.com*.
- **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 Michigan HIV/AIDS Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 888.826.6565.

SECTION 7 Questions?

Section 7.1 – Getting Help from **Priority**Medicare (Employer HMO-POS)

Questions? We're here to help. Please call Customer Service at 888.389.6648, option 3. (TTY only, call 711.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for **Priority**Medicare (Employer HMO-POS). 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 included in this envelope.

Visit our Website

You can also visit our website at *priorityhealth.com/mpsers*. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy 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

You can visit the Medicare website (*www.medicare.gov*). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to *www.medicare.gov/plan-compare*.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* 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 get it at the Medicare website (*www.medicare.gov*) 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.