PriorityHealth

# 2022

## Annual Notice of Changes

# **Priority**Medicare D-SNP[SM] (HMO)

offered by Priority Health

January 1, 2022 – December 31, 2022

OMB Approval 0938-1051 (Expires: February 29, 2024)
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You are currently enrolled as a member of **Priority**Medicare D-SNP. Next year, there will be changes to your plan's 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 833.939.0983 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 PriorityMedicare D-SNP**
Priority Health has a D-SNP (HMO) plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in **Priority**Medicare D-SNP (HMO) 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 **Priority**Medicare D-SNP.

You are currently enrolled as a member of **Priority**Medicare D-SNP. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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## 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.

- It's important to 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.
- Your drug costs may have risen since last year. 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 other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- 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 much will you spend on your premium and deductibles?

- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at *www.medicare.gov/plan-compare* website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ 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 want to keep **Priority**Medicare D-SNP, you don't need to do anything. You will stay in **Priority**Medicare D-SNP.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 4, page 15 to learn more about your choices.

**4. ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in **Priority**Medicare D-SNP.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

## Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for **Priority**Medicare D-SNP in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at *priorityhealth.com/dsnp*. You can review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under The Michigan Medicaid program, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Monthly plan premium** | $0 | $0 |
| **Deductible** | HMO (in-network)<br>$0 | HMO (in-network)<br>$0 |
| **Doctor office visits** | HMO (in-network)<br>Primary care visits:<br>$0 per visit<br><br>Specialist visits:<br>$0 per visit | HMO (in-network)<br>Primary care visits:<br>$0 per visit<br><br>Specialist visits:<br>$0 per visit |
| **Inpatient hospital stays**<br>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)<br>$0 | HMO (in-network)<br>$0 |

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Part D prescription drug coverage**<br>(See Section 1.6 for details.) | If you receive Extra Help, you pay one of the following amounts:<br>Deductible: $0 or $92<br><br>Generic drugs (including brand drugs treated as generic):<br>• $0 copay or<br>• $1.30 copay or<br>• $3.70 copay or<br>• 15% of the total cost of the drug<br><br>For all other covered drugs:<br>• $0 copay or<br>• $4.00 copay or<br>• $9.20 copay or<br>• 15% of the total cost of the drug<br><br>If you do not qualify for Extra Help from Medicare, you will pay the following for your prescription drug costs:<br>Deductible: $445<br><br>Coinsurance during the Initial Coverage Stage:<br>For all covered drugs: You pay 25% of the total cost | If you receive Extra Help, you pay one of the following amounts:<br>Deductible: $0 or $99 on tiers 2-5<br><br>Tier 1 preferred generic drugs: $0<br><br>Generic drugs (including brand drugs treated as generic):<br>• $0 copay or<br>• $1.35 copay or<br>• $3.95 copay or<br>• 15% of the total cost of the drug<br><br>For all other covered drugs:<br>• $0 copay or<br>• $4.00 copay or<br>• $9.85 copay or<br>• 15% of the total cost of the drug<br><br>If you do not qualify for Extra Help from Medicare, you will pay the following for your prescription drug costs:<br>Deductible: $480 on tiers 2-5<br><br>Copay/Coinsurance during the Initial Coverage Stage:<br>• Tier 1: $0<br>• Tier 2: $13<br>• Tier 3: $47<br>• Tier 4: 50%<br>• Tier 5: 25% |

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>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)<br>$7,550<br><br>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. | HMO (in-network)<br>$7,550<br><br>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. |

# *Annual Notice of Changes* for 2022
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# SECTION 1 Changes to Benefits and Costs for Next Year

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must continue to pay your Medicare Part B premium unless it is paid for you by the Michigan Medicaid program.)<br><br>Service Area:<br>Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, St. Clair, St. Joseph, Sanilac, Shiawassee, Tuscola, Van Buren, Washtenaw, Wayne, Wexford | $0 | $0 |

## 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) |
|---|---|---|
| **In-network maximum out-of-pocket amount**<br>**Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are receiving full Medicaid benefits, 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.<br><br>If you lose your Medicaid eligibility and fall into the grace period, your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $7,550 | $7,550<br><br>Once you have paid $7,550 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 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/dsnp*. 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.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at *priorityhealth.com/dsnp*. 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

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

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, *Benefits Chart (what is covered)*, in your *2022 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at *priorityhealth.com/dsnp*. You may also call Customer Service to ask us to mail you an *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 not required for non-emergent ambulance services. |
| **Dental services** | **Non-Medicare covered**<br>$0 for two preventive exams, two cleanings (regular or periodontal maintenance).<br><br>Fluoride treatments are not covered.<br><br>$0 for 1 brush biopsy and 1 set of bitewing x-rays per year.<br><br>Comprehensive dental services are not covered. | **Non-Medicare covered**<br>$0 for two preventive exams, two cleanings (regular or periodontal maintenance).<br><br>$0 for 1 fluoride treatment per year.<br><br>$0 for 1 brush biopsy, 1 set of bitewing x-rays per year and all other radiographs (full-mouth series, periapical or panoramic x-rays) every 2 years.<br><br>$0 for comprehensive services including; fillings and crown repair, simple extractions (non-surgical), bridges and dentures (once every 5 years), relines and repairs to bridges and dentures (once every 36 months, per appliance), and other basic services including certain films and tests.<br><br>$2,000 annual maximum for comprehensive dental services. |
| **Diabetic 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. |

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Hearing services** | You receive the following with a hearing aid purchase from a TruHearing provider:<br><br>3 follow-up provider visits within the first year of a hearing aid purchase.<br><br>48 batteries per hearing aid.<br><br>45-day trial period. | You receive the following with a hearing aid purchase from a TruHearing provider:<br><br>All provider visits within the first year of purchase.<br><br>80 batteries per hearing aid.<br><br>60-day trial period. |
| **Meal benefit** | Not covered. | $0 for 28 home-delivered meals, provided through Mom's Meals, up to four times per year following inpatient hospital, psychiatric hospital or Skilled Nursing Facility (SNF) discharge. |
| **Outpatient hospital services** | Prior authorization is required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy.<br><br>Prior authorization is not required for blepharoplasty. | Prior authorization is not required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy.<br><br>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.<br><br>Prior authorization is not required for blepharoplasty. | Prior authorization is not required for radiofrequency catheter ablation for cardiac arrhythmia and thyroidectomy.<br><br>Prior authorization is required for blepharoplasty. |
| **Over-the-counter (OTC) + Healthy Savings Program** | $145 allowance per quarter. | $150 allowance per quarter. |

| Cost | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Personal Emergency Response System (PERS)** | Not covered. | $0 for Personal Emergency Response System (PERS) device and services. |
| **Transportation services** | Not covered. | $0 for up to 30 one-way trips every year to or from health-related locations.<br><br>Trips are limited to 30 miles per one-way trip. |

## 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 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 in your *Summary of Benefits* or 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**<br>During this stage, **you pay the full cost** of your tier 2-5 drugs until you have reached the yearly deductible. | If you receive Extra Help, your deductible amount is either $0 or $92 depending on the level of Extra Help you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)<br><br>If you do not qualify for Extra Help from Medicare to help pay your prescription drug costs, your deductible is $445. | If you receive Extra Help, your deductible amount is either $0 or $99 on tiers 2-5, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)<br><br>If you do not qualify for Extra Help from Medicare to help pay your prescription drug costs, your deductible is $480 on tiers 2-5.<br><br>During this stage, you pay $0 cost sharing for drugs on tier 1 and the full cost of drugs on tier 2-5 until you have reached the yearly deductible. |

### 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)*** 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 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 filled at a network pharmacy: If you receive Extra Help, you pay one of the following amounts: Generic drugs (including brand drugs treated as generic): • $0 copay or • $1.30 copay or • $3.70 copay or • 15% of the total cost of the drug For all other covered drugs: • $0 copay or • $4.00 copay or • $9.20 copay or • 15% of the total cost of the drug If you do not qualify for Extra Help from Medicare, you will pay the following for your prescription drug costs: For all covered drugs: You pay 25% of the total cost | Your cost for a one-month supply filled at a network pharmacy: **Tier 1 – preferred generic drugs:** $0 If you receive Extra Help, you pay one of the following amounts: Generic drugs (including brand drugs treated as generic): • $0 copay or • $1.35 copay or • $3.95 copay or • 15% of the total cost of the drug For all other covered drugs: • $0 copay or • $4.00 copay or • $9.85 copay or • 15% of the total cost of the drug If you do not qualify for Extra Help from Medicare, you will pay the following for your prescription drug costs: • **Tier 2 – generic drugs:** $13 • **Tier 3 – preferred brand drugs:** $47 • **Tier 4 – non-preferred drugs:** 50% • **Tier 5 – specialty drugs:** 25% |

| Stage | 2021 (this year) | 2022 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage** ***(30 day retail) (continued)*** | Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). | If you receive Extra Help, once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).<br><br>If you do not qualify for Extra Help from Medicare, 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 Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or 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 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 stay enrolled in our **Priority**Medicare D-SNP plan for 2022.

### 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

- 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, 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.**

As a reminder, Priority Health Medicare offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from **Priority**Medicare D-SNP.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from **Priority**Medicare D-SNP.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - *– 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 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

### 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 the Michigan Medicaid program, 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.

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

## SECTION 5 Programs That Offer Free Counseling about Medicare and the Michigan Medicaid Program

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*).

For questions about your Michigan Medicaid program benefits, contact Michigan Department of Health and Human Services at 517.241.3740 (TTY 711), Monday-Friday, 8 a.m. to 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Michigan Medicaid program coverage.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have the Michigan Medicaid program, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or 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 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 a.m. to 6 p.m., 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 D-SNP

Questions? We're here to help. Please call Customer Service at 833.939.0983. (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 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 *priorityhealth.com/dsnp*. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

### Visit our Website

You can also visit our website at *priorityhealth.com/dsnp*. 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.

## Section 7.3 – Getting Help from the Michigan Medicaid program

To get information from Medicaid you can call Michigan Department of Health and Human Services at 517.241.3740, Monday-Friday, 8 a.m. to 5 p.m. TTY users should call 711.

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