PriorityHealth

2023

Annual Notice of Changes

PriorityMedicare Vital[SM] (PPO)

offered by Priority Health

January 1, 2023–December 31, 2023

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You are currently enrolled as a member of **Priority**Medicare Vital. 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 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 Vital
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 **Priority**Medicare Vital.

Please see page 3 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 your unique *Evidence of Coverage*, which will be available starting 10/1/22 on our website at *priorityhealth.com/vital23*. (You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

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

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at *www.medicare.gov/plan-compare* website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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

- If you don't join another plan by December 7, 2022, you will stay in **Priority**Medicare Vital.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with **Priority**Medicare Vital.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for **Priority**Medicare Vital in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Deductible	In-network & out-of-network (combined) $0	In-network & out-of-network (combined) $0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	In-network & out-of-network (combined) $4,700	In-network & out-of-network (combined) $4,900
Doctor office visits	In-network Primary care visits: $0 per visit. Specialist visits: 0%-20% per visit. Out-of-network $0 per visit with a PCP. 0%-20% per visit with a specialist.	In-network Primary care visits: $0 per visit. Specialist visits: $0-$50 per visit. Out-of-network $0 per visit with a PCP. $0-$50 per visit with a specialist.
Inpatient hospital stays	In-network $435 per day, days 1-4. Out-of-network $435 per day, days 1-4.	In-network $350 per day, days 1-5. Out-of-network $350 per day, days 1-5.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $350 on tiers 3-5 Copay/Coinsurance during the Initial Coverage Stage: <u>Preferred Retail</u> • Drug Tier 1: $1 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 4: 45% • Drug Tier 5: 26% <u>Standard Retail</u> • Drug Tier 1: $6 • Drug Tier 2: $15 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26% <u>Insulin</u> You pay the amount of the copayment or coinsurance for the drug tier your drug is in. <u>Part D Vaccines</u> You pay the amount of the copayment or coinsurance for the drug tier the vaccine is in.	Deductible: $350 on tiers 3-5 Copay/Coinsurance during the Initial Coverage Stage: <u>Preferred Retail</u> • Drug Tier 1: $1 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 4: 45% • Drug Tier 5: 26% <u>Standard Retail</u> • Drug Tier 1: $6 • Drug Tier 2: $15 • Drug Tier 3: $47 • Drug Tier 4: 50% • Drug Tier 5: 26% <u>Insulin</u> You pay no more than $35 for a one-month supply of covered insulin (defined by Medicare) regardless of the drug tier your drug is in, whether at a preferred or standard retail pharmacy. <u>Part D Vaccines</u> You pay $0 for certain vaccines (defined by Medicare) regardless of the drug tier the vaccine is in, whether at a preferred or standard retail pharmacy. For updates on covered insulin and vaccines go to *priorityhealth.com/ira*.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)		
Region 1 Counties: Allegan, Barry, Kent, Lenawee, Ottawa	$0	$0
Region 2 Counties: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0	$0
Region 3 Counties: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A	N/A
Region 4 Counties: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	N/A	N/A
Region 5 Counties: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$0

Cost	2022 (this year)	2023 (next year)
Enhanced dental and vision package *(optional supplemental benefit available for an extra premium)* See Chapter 4, Section 2.2 *(Extra "optional supplemental" benefits you can buy)* of the Evidence of Coverage for details.	$29.00	$29.00
Medicare Part B premium reduction	You will receive a $30 reduction to your Medicare Part B premium each month. This will be reflected in the amount deducted from your Social Security payment each month or the amount you are billed quarterly from CMS.	You will continue to receive a $30 reduction to your Medicare Part B premium each month. This will be reflected in the amount deducted from your Social Security payment each month or the amount you are billed quarterly from CMS.

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

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your in-network maximum out-of-pocket amount.	$4,700	$4,900 Once you have paid $4,900 out-of-pocket for covered services, you will pay nothing for your covered services from in-network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your combined maximum out-of-pocket amount for medical services.	$4,700	$4,900 Once you have paid $4,900 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at *priorityhealth.com/vital23*. You may also call Customer Service for updated provider information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Enhanced dental and vision package *(optional supplemental benefit available for an extra premium)* See Chapter 4, Section 2.2 *(Extra "optional supplemental" benefits you can buy)* of the Evidence of Coverage for details.	Dentures are <u>not</u> covered 50% for simple extractions – once per tooth per lifetime 50% for crown repairs – once per tooth every 12 months 50% for fillings – oncer per tooth every 24 months $0 copayment for anesthesia when used in conjunction with these services	50% coverage for dentures – once every 60 months. Simple extractions, crown repairs, fillings and anesthesia when used in conjunction with these services will now be covered as part of your Medicare Advantage plan and will no longer be included as part of the Enhanced dental and vision package. Please see "Dental services" below for more information.
Abridge Abridge is a smartphone based application that securely records medical conversations during patient appointments.* Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/ family as they wish. *Medical professionals must verbally consent to being recorded.	<u>Not</u> covered.	$0 for Abridge services.

Cost	2022 (this year)	2023 (next year)
Ambulance services	In- and out-of-service area: 20% for each one-way Medicare-covered ambulance transport. 20% for each non-Medicare covered ambulance stabilization when there is no transport.	In- and out-of-service area: $265 for each one-way Medicare-covered ambulance transport. $265 for each non-Medicare covered ambulance stabilization when there is no transport.
Cardiac rehabilitation services	In- and out-of-network 20% for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service.	In- and out-of-network $20 for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation services.
Chiropractic services	In- and out-of-network 20% for each Medicare-covered visit. 20% for each non-Medicare covered routine visit, up to 12 visits each year. 20% for non-Medicare covered x-ray services performed once per year by a chiropractor (you would pay this in addition to your visit).	In- and out-of-network $20 for each Medicare-covered visit. $20 for each non-Medicare covered routine visit, up to 12 visits each year. $40 for non-Medicare covered x-ray services performed once per year by a chiropractor (you would pay this in addition to your visit).

Cost	2022 (this year)	2023 (next year)
Dental services	Simple extractions, crown repairs, fillings and anesthesia when used in conjunction with these services are not covered No maximum plan benefit coverage amount each year	$0 copayment for simple extractions – once per tooth per lifetime. $0 copayment for crown repairs – once per tooth every 12 months. $0 copayment for fillings – oncer per tooth every 24 months. $0 copayment for anesthesia when used in conjunction with these services. $1,500 maximum plan benefit coverage amount each year for simple extractions, crown repairs, fillings, brush biopsy and anesthesia when used in conjunction with these services.
Emergency care	In- and out-of-network 20% for each Medicare-covered emergency room visit, up to $90.	In- and out-of-network $110 for each Medicare-covered emergency room visit.
Hearing services	In- and out-of-network $0 for each Medicare-covered diagnostic hearing exam with a primary care provider. 20% for each Medicare-covered diagnostic hearing exam with a specialist.	In- and out-of-network $0 for each Medicare-covered diagnostic hearing exam with a primary care provider. $50 for each Medicare-covered diagnostic hearing exam with a specialist.

Cost	2022 (this year)	2023 (next year)
Hospice care	Out-of-network 20% for the initial Medicare-covered hospice consultation.	Out-of-network $0 for the initial Medicare-covered hospice consultation.
Inpatient hospital care	In- and out-of-network For each Medicare-covered hospital admission/stay you pay: $435 per day, days 1-4. $0 for additional hospital days.	In- and out-of-network For each Medicare-covered hospital admission/stay you pay: $350 per day, days 1-5. $0 for additional hospital days.
Inpatient services in a psychiatric hospital	In- and out-of-network For each Medicare-covered hospital admission/stay you pay: $435 per day, days 1-4. $0 for additional hospital days.	In- and out-of-network For each Medicare-covered hospital admission/stay you pay: $350 per day, days 1-5. $0 for additional hospital days.
Out-of-area travel benefit	Under our out-of-state travel benefit you will pay the same for services received from a Medicare-participating provider (i.e. doctors or hospitals) when traveling outside the state of Michigan, for up to 12 months, as you would if you were seeing in-network providers. Please contact the plan for assistance in locating a provider when using the out-of-state travel benefit.	The upper peninsula of Michigan is now included as part of our out-of-area (formerly out-of-state) travel benefit. This means you will pay in-network cost sharing when you see any Medicare participating provider in the upper peninsula of Michigan. This benefit will apply when traveling outside of the lower peninsula of Michigan for up to 12 months.

Cost	2022 (this year)	2023 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	In- and out-of-network 20% per day, per provider, for diagnostic procedures and tests. 20% per day, per provider, for Medicare-covered x-ray services. 20% per day, per provider, for Medicare-covered, radiation therapy services.	In- and out-of-network $0 per day, per provider, for diagnostic procedures and tests. $40 per day, per provider, for Medicare-covered x-ray services. $40 per day, per provider, for Medicare-covered, radiation therapy services.
Outpatient hospital observation	In- and out-of-network 20% for each Medicare-covered observation visit, including all services received.	In- and out-of-network $110 for each Medicare-covered observation visit, including all services received.
Outpatient hospital services	In- and out-of-network $0 for each rural health clinic visit. 20% for each Medicare-covered outpatient hospital facility visit. Prior authorization **is** required for radiosurgery (such as but not limited to, neutron beam radiotherapy (NBRT), proton beam radiotherapy (PBRT), stereotactic radiosurgery (SRS), and stereotactic body radiation therapy (SBRT). Prior authorization is **not** required for radiation oncology procedure intensity-modulated radiation therapy (IMRT).	In- and out-of-network $0 for each rural health clinic visit. $300 for each Medicare-covered outpatient hospital facility visit. Prior authorization **is** required for radiation oncology procedures (such as but not limited to, intensity-modulated radiation therapy (IMRT), neutron beam radiotherapy (NBRT), proton beam radiotherapy (PBRT), stereotactic radiosurgery (SRS), and stereotactic body radiation therapy (SBRT).

Cost	2022 (this year)	2023 (next year)
Outpatient mental health care	In- and out-of-network 20% for each Medicare-covered individual visit. 20% for each Medicare-covered group visit.	In- and out-of-network $20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.
Outpatient rehabilitation services	In- and out-of-network 20% per day for Medicare-covered physical therapy services. 20% per day for Medicare-covered occupational therapy services. 20% per day for Medicare-covered speech language therapy services.	In- and out-of-network $40 per day for Medicare-covered physical therapy services. $40 per day for Medicare-covered occupational therapy services. $40 per day for Medicare-covered speech language therapy services.
Outpatient substance abuse services	In- and out-of-network 20% for each Medicare-covered individual visit. 20% for each Medicare-covered group visit.	In- and out-of-network $20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.

Cost	2022 (this year)	2023 (next year)
Outpatient surgery, *including services provided at hospital outpatient facilities and ambulatory surgical centers*	In- and out-of-network 20% for each Medicare-covered ambulatory surgical center visit. 20% for each Medicare-covered outpatient hospital facility visit. Prior authorization **is** required for radiosurgery (such as but not limited to, neutron beam radiotherapy (NBRT), proton beam radiotherapy (PBRT), stereotactic radiosurgery (SRS), and stereotactic body radiation therapy (SBRT). Prior authorization is **not** required for radiation oncology procedure intensity-modulated radiation therapy (IMRT).	In- and out-of-network $300 for each Medicare-covered ambulatory surgical center visit. $300 for each Medicare-covered outpatient hospital facility visit. Prior authorization **is** required for radiation oncology procedures (such as but not limited to, intensity-modulated radiation therapy (IMRT), neutron beam radiotherapy (NBRT), proton beam radiotherapy (PBRT), stereotactic radiosurgery (SRS), and stereotactic body radiation therapy (SBRT).
Over-the-counter (OTC) items In 2023 this benefit will be called OTC Plus which includes over the counter items and for members who are eligible for Supplemental Benefits for the Chronically Ill, this allowance can also used towards healthy food and produce.	$40 allowance per quarter for OTC items.	$20 allowance per month to use on OTC items. If eligible, this allowance can be used on healthy food and produce.
Partial hospitalization services	In- and out-of-network 20% per day for Medicare-covered partial hospitalization services.	In- and out-of-network $55 per day for Medicare-covered partial hospitalization services.

Cost	2022 (this year)	2023 (next year)
Physician/Practitioner services, including doctor's office visits	In- and out-of-network $0 for each Medicare-covered visit with a PCP. 20% for each Medicare-covered visit with a specialist.	In- and out-of-network $0 for each Medicare-covered visit with a PCP. $50 for each Medicare-covered visit with a specialist.
Podiatry services	In- and out-of-network 20% for nail debridement & callous removal, for members with specific medical conditions. 20% for each Medicare-covered visit.	In- and out-of-network $0 for nail debridement & callous removal, for members with specific medical conditions. $50 for each Medicare-covered visit.
Produce ***Special Supplemental Benefits for the Chronically Ill***	$10 monthly produce allowance for members with certain chronic conditions who meet eligibility criteria.	See "Over-the-counter (OTC) items" in this section (*Section 1.3 Changes to Benefits and Costs for Medical Services*) for details.
Prosthetic devices and related supplies	In- and out-of-network 20% for Medicare-covered prosthetic devices and supplies.	In- and out-of-network $0 for devices implanted as part of a surgery in an ambulatory surgery center or outpatient hospital facility. 20% for all other Medicare-covered prosthetic devices and supplies.
Pulmonary rehabilitation services	In- and out-of-network 20% for each Medicare-covered pulmonary rehabilitation service.	In- and out-of-network $20 for each Medicare-covered pulmonary rehabilitation service.

Cost	2022 (this year)	2023 (next year)
Skilled nursing facility (SNF) care	In- and out-of-network For Medicare-covered services for each benefit period[+] you pay: $0 per day for days 1-20. $188 per day for days 21-100.	In- and out-of-network For Medicare-covered services for each benefit period[+] you pay: $0 per day for days 1-20. $196 per day for days 21-100.
Supervised exercise therapy (SET)	In- and out-of-network 20% for each Medicare-covered SET visit.	In- and out-of-network $20 for each Medicare-covered SET visit.
Urgently needed services	In- and out-of-network 20% for each Medicare-covered urgent care provider visit, up to $65.	In- and out-of-network $60 for each Medicare-covered urgent care provider visit.
Vision care	In- and out-of-network $0 for annual glaucoma screenings. $0 for Medicare-covered eyewear after cataract surgery. $0 for annual diabetic retinopathy screening. 20% for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye. **Non-Medicare covered eyewear:** $100 allowance for non-Medicare covered eyewear.	In- and out-of-network $0 for annual glaucoma screenings. $0 for Medicare-covered eyewear after cataract surgery. $0 for annual diabetic retinopathy screening. $50 for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye. **Non-Medicare covered eyewear:** $125 allowance for non-Medicare covered eyewear.

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. You can get the complete Drug List by calling Customer Service or visiting our website (*priorityhealth.com/vital23*).

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.**

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

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We will send 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 haven't received this insert, please call Customer Service and ask for the "LIS Rider."

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

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your tier 3-5 drugs until you have reached the yearly deductible.	The deductible is $350 on tiers 3-5. During this stage, you pay the same cost sharing that you do in initial coverage for drugs on tier 1-2 and the full cost of drugs on tier 3-5 until you have reached the yearly deductible.	The deductible is $350 on tiers 3-5. During this stage, you pay the same cost sharing that you do in initial coverage for drugs on tier 1-2 and the full cost of drugs on tier 3-5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply at a network pharmacy: **Tier 1 - preferred generic drugs:** *Preferred cost sharing:* $1 *Standard cost sharing:* $6 **Tier 2 - generic drugs:** *Preferred cost sharing:* $10 *Standard cost sharing:* $15	Your cost for a one-month supply at a network pharmacy: **Tier 1 - preferred generic drugs:** *Preferred cost sharing:* $1 *Standard cost sharing:* $6 **Tier 2 - generic drugs:** *Preferred cost sharing:* $10 *Standard cost sharing:* $15

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage ***(30 day retail) (continued)*** You pay no more than $35 for a one-month supply of covered insulin (defined by Medicare), whether you fill your prescription at a preferred or standard retail pharmacy. You pay $0 for certain vaccines (defined by Medicare) regardless of the drug tier the vaccine is in, whether at a preferred or standard retail pharmacy. For updates on covered insulin and vaccines included please go to *priorityhealth.com/ira*. 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.	**Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $42 *Standard cost sharing:* $47 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **Tier 5 - specialty drugs:** *Preferred cost sharing:* 26% *Standard cost sharing:* 26%	**Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $42 *Standard cost sharing:* $47 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **Tier 5 - specialty drugs:** *Preferred cost sharing:* 26% *Standard cost sharing:* 26%

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage ***(90 day retail)*** The costs in this row are for a three-month (90-day) supply when you fill your prescription at a network pharmacy. For information about the costs, look in Chapter 6, Section 5 of your *Evidence of Coverage*. You pay no more than $105 for a three-month supply of covered insulin (defined by Medicare) whether you fill your prescription at a preferred or standard retail pharmacy. For updates on covered insulin please go to *priorityhealth.com/ira*.	Your cost for a three-month supply at a network pharmacy: **Tier 1 – preferred generic drugs:** *Preferred cost sharing:* $3 *Standard cost sharing:* $18 **Tier 2 – generic drugs:** *Preferred cost sharing:* $30 *Standard cost sharing:* $45 **Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $126 *Standard cost sharing:* $141 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **Tier 5 – specialty drugs:** Not available	Your cost for a three-month supply at a network pharmacy: **Tier 1 - preferred generic drugs:** *Preferred cost sharing:* $0 *Standard cost sharing:* $18 **Tier 2 - generic drugs:** *Preferred cost sharing:* $30 *Standard cost sharing:* $45 **Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $126 *Standard cost sharing:* $141 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **Tier 5 – specialty drugs:** Not available

Stage	2022 (this year)	2023 (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, look in Chapter 6, Section 5 of your *Evidence of Coverage*. You pay no more than $105 for a three-month supply of covered insulin (defined by Medicare) whether you fill your prescription through preferred or standard mail-order. For updates on covered insulin please go to *priorityhealth.com/ira*. 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:** *Preferred cost sharing:* $0 *Standard cost sharing:* $18 **Tier 2 – generic drugs:** *Preferred cost sharing:* $0 *Standard cost sharing:* $45 **Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $105 *Standard cost sharing:* $141 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **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).	Your cost for a three-month supply at a mail-order pharmacy: **Tier 1 - preferred generic drugs:** *Preferred cost sharing:* $0 *Standard cost sharing:* $18 **Tier 2 - generic drugs:** *Preferred cost sharing:* $0 *Standard cost sharing:* $45 **Tier 3 - preferred brand drugs:** *Preferred cost sharing:* $105 *Standard cost sharing:* $141 **Tier 4 - non-preferred drugs:** *Preferred cost sharing:* 45% *Standard cost sharing:* 50% **Tier 5 – specialty drugs:** Not available _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in **Priority**Medicare Vital

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 **Priority**Medicare Vital.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (*www.medicare.gov/plan-compare),* read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 4), or call Medicare (see Section 6.2).

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 Vital.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from **Priority**Medicare Vital.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll or visit our website to disenroll online. Contact Customer Service if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

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

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

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

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

SECTION 4 Programs That Offer Free Counseling about Medicare

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

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 or dial 211. You can learn more about MMAP by visiting their website (*mmapinc.org*).

SECTION 5 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. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).
- 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.*
- An additional source for members to see if they qualify for extra help from Medicare may be found by calling Priority Health at 1-888-389-6648.

- **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 6 Questions?

Section 6.1 – Getting Help from **Priority**Medicare Vital

Questions? We're here to help. Please call Customer Service at 888.389.6648. (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 *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for **Priority**Medicare Vital. 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/vital23*. 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/vital23*. 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 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (*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.

PriorityMedicare Vital's pharmacy network includes limited lower-cost, preferred pharmacies in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 888.389.6648, TTY users should call 711, or consult the online pharmacy directory at *priorityhealth.com/vital23*.

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