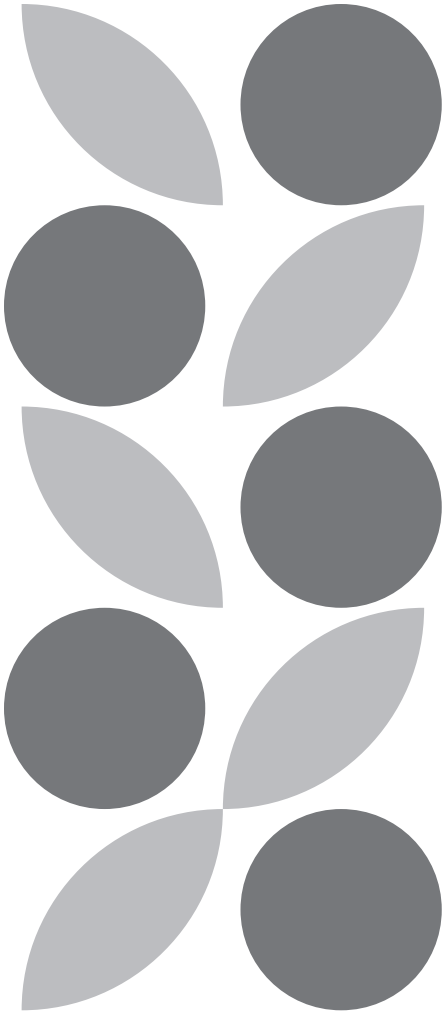


Priority Health

2025
Annual Notice of Changes

PriorityMedicare[SM] D-SNP (HMO)
offered by Priority Health

January 1, 2025–December 31, 2025
*For former **Priority**Medicare[SM] D-SNP Advantage members*

OMB Approval 0938-1051 (Expires: August 31, 2026)
H8379_110011402513_M

You are currently enrolled as a member of **Priority**Medicare D-SNP. 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 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 ***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 PriorityMedicare 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.

PriorityMedicare D-SNP (HMO) offered by Priority Health Medicare

Annual Notice of Changes for 2025

You are currently enrolled as a member of **Priority**Medicare D-SNP Advantage (HMO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at priorityhealth.com/dsnp25. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

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

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

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

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

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

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

3. **CHOOSE:** Decide whether you want to change your plan
    - If you don't join another plan by December 7, 2024, you will stay in **Priority**Medicare D-SNP (HMO).
    - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with **Priority**Medicare D-SNP (HMO).
    - Look in section 3, page 17 to learn more about your choices.
    - If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

This document is available for free in Spanish.

- Please contact our Member Services number at 833.939.0983 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This information is available in Braille and large print.
- **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 (HMO)

- 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 document says "we," "us," or "our," it means Priority Health Medicare. When it says "plan" or "our plan," it means **Priority**Medicare D-SNP (HMO).

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs for **Priority**Medicare D-SNP Advantage (HMO) and 2025 costs for **Priority**Medicare D-SNP (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Deductible	$420, except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	$420, except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.
Inpatient hospital stays	$1,800 copay per stay for days 1-90 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	$1,800 copay per stay for days 1-90 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	If you receive Extra Help you pay the following amounts: Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay If you do not qualify for Extra Help from Medicare, you will pay the following amounts: Deductible: $545 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25% of the total drug cost You pay $35 per month supply of each covered insulin product. Catastrophic Coverage: During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	If you receive Extra Help you pay the following amounts: Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay If you do not qualify for Extra Help from Medicare, you will pay the following amounts: Deductible: $590 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25% of the total drug cost You pay $35 per month supply of each covered insulin product. Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered services. (See Section 2.2 for details.) **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,500	$9,350

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in PriorityMedicare D-SNP (HMO) in 2025

On January 1, 2025, Priority Health Medicare will be closing the plan you are on and moving you to **Priority**Medicare D-SNP (HMO). There is nothing you need to do. The information in this document tells you about the differences between your current benefits in **Priority**Medicare D-SNP Advantage (HMO) and the benefits you will have on January 1, 2025, as a member of **Priority**Medicare D-SNP (HMO).

If you do nothing in 2024, we will automatically enroll you in our PriorityMedicare D-SNP (HMO). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through **Priority**Medicare D-SNP (HMO). If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2025.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

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

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,500	$9,350 Once you have paid $9,350 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Updated directories are located on our website at priorityhealth.com/dsnp25. You may also call Member Services for updated provider and/or pharmacy information or ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* priorityhealth.com/dsnp25 to see which pharmacies are in our network**.

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

Section 2.4 – 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 making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Dental Services	**In-Network** Restorative services, 4 periodontic visits, surgical & simple extractions, bridges, dentures, anesthesia, oral & maxillofacial surgery, and a brush biopsy are covered. $4,000 maximum plan coverage amount every year for diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit.	**In-Network** Restorative services, surgical and simple extractions, bridges, dentures, and anesthesia are not covered. 2 Periodontic services, brush biopsy oral & maxillofacial surgery are covered. $1,500 maximum plan coverage amount every year for diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit.
Emergency Care	**In- or Out-of-Network** You pay $100 copay for each visit for Medicare-covered emergency care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	**In- or Out-of-Network** You pay $110 copay for each visit for Medicare-covered emergency care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2024 (this year)	2025 (next year)
Fitness Benefit	**In-Network** You pay $0 copay for the fitness benefit. Benefit includes memory fitness and physical fitness.	**In-Network** You pay $0 copay for One Pass® fitness network which includes access to over 20,000 digital fitness classes and on-demand workouts, and at-home fitness kits (1 kit per plan year).
Hearing Services	**In-Network** You pay $0 copay for TruHearing 'advanced aids' hearing aids (2 hearing aids every year).	**In-Network** You pay $0 copay for TruHearing 'advanced aids' hearing aids (2 hearing aids every **2 years**).
Home and Bathroom Safety Devices and Modifications	**In-Network** Home and bathroom safety devices and modifications benefit is not covered.	**In-Network** Home and bathroom safety devices can be purchased using your monthly PriorityFlex benefit.
In-Home Support Services (PriorityCare)	**In-Network** You pay $0 copay for in-home support services.	**In-Network** In-home support services benefit is not covered.
Meal Benefit	**In-Network** You pay $0 copay per meal. Benefit may be used immediately following surgery or inpatient hospitalization.	**In-Network** Meal benefit is not covered.

Cost	2024 (this year)	2025 (next year)
PriorityFlex	**In-Network** $106 every month (no rollover) to use towards select utilities (water, sewer, trash, septic, gas, electric, phone, and internet), pest control services, healthy food and produce, and Over-the-Counter (OTC) items. *Member must be eligible for Extra Help/Low-Income Subsidy (LIS)	**In-Network** $70 every month (no rollover) to use towards select utilities (water, sewer, trash, septic, gas, electric, phone, and internet), pest control services, healthy food and produce, meals and Over-the-Counter (OTC) items. OTC items and healthy food can be purchased in-store at retailers like Walgreens, Walmart and more. OTC items, meal delivery, and pest control services can be found on priorityhealth.com/OTC, by calling 833.415.4380, or by downloading the Priority Health OTC app. For more information, please refer to your Evidence of Coverage (EOC). *Member must be eligible for Extra Help/Low-Income Subsidy (LIS)
Remote Access Technologies	**In-Network** $0 copay for Abridge.	**In-Network** Abridge is not covered.
Skilled Nursing Facility (SNF) Care	**In-Network** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20. $203 copay per day for days 21-100.	**In-Network** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20. $214 copay per day for days 21-100.

Cost	2024 (this year)	2025 (next year)
	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Transportation Services (routine)	**In-Network** You pay $0 copay for routine transportation services (30 one-way trips every year to health-related locations, up to 40 miles each way) using rideshare services, van, and medical transport.	**In-Network** You pay $0 copay for routine transportation services (30 one-way trips every year to health-related locations, up to 100 miles each way) using rideshare services, van, medical transport, and mileage reimbursement for plan-approved, health-related rides.
Urgently Needed Care Services	**In- or Out-of-Network** You pay 35% of the total cost for each visit for Medicare-covered urgently needed care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	**In- or Out-of-Network** You pay 35% of the total cost, up to a $45 maximum for each visit for Medicare-covered urgently needed care services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Section 2.5 – 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 in this envelope. The Drug List includes many—but not all—of the drugs that we will cover next year.

If you don't see your drug on this list, it might still be covered. You can get the complete Drug List by calling Member Services (see the back cover) or visiting our website (priorityhealth.com/dsnp25).

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

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

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

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

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

Changes to Prescription Drug Benefits and Costs

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

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

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	If you receive Extra Help, your deductible amount is $0, and this payment stage does not apply to you.	If you receive Extra Help, your deductible amount is $0, and this payment stage does not apply to you.
	If you do not receive Extra Help from Medicare to help pay your prescription drug costs, your deductible amount is $545.	If you do not receive Extra Help from Medicare to help pay your prescription drug costs, your deductible amount is $590.
	During this stage, you pay the full cost of your drugs until you have reached the yearly deductible.	During this stage, you pay the full cost of your drugs until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply at a network pharmacy is: **Tier 1 – All Covered Drugs**: If you receive Extra Help, you pay $0 per prescription. If you do not qualify for Extra Help from Medicare, you pay 25% of the total cost. You pay $35 per month supply of each covered insulin product. _____ If you receive Extra Help, once you have paid $8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). If you do not receive Extra Help from Medicare, once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy is: **Tier 1 – All Covered Drugs**: If you receive Extra Help, you pay $0 per prescription. If you do not qualify for Extra Help from Medicare, you pay 25% of the total cost. You pay $35 per month supply of each covered insulin product. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

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

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

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

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in PriorityMedicare D-SNP (HMO)

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 D-SNP (HMO).

Section 4.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

You can join a different Medicare health plan,

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from **Priority**Medicare D-SNP (HMO).
- 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 (HMO).
- 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 Member Services if you need more information on how to do so.
  - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

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

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

Because you have Michigan Department of Health and Human Services, you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

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

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

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

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In 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. Michigan Medicare/Medicaid Assistance Program (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 Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174 or dial 211. You can learn more about Michigan Medicare/Medicaid Assistance Program (MMAP) by visiting their website (mmapinc.org).

For questions about your Michigan Department of Health and Human Services benefits, contact Michigan Department of Health and Human Services at 517.241.3740 (TTY: 844.578.6563).

Hearing impaired callers may contact the Michigan Relay Center at 711 and ask for the number above.) 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 Department of Health and Human Services coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** Michigan has a program called Michigan Drug Assistance Program (MIDAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, 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 Michigan HIV/AIDS Drug Assistance Program (MIDAP) at 888.826.6565. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

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

SECTION 8 Questions?

Section 8.1 – Getting Help from PriorityMedicare D-SNP (HMO)

Questions? We're here to help. Please call Member Services at 833.939.0983. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for PriorityMedicare D-SNP (HMO). 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/dsnp25. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at priorityhealth.com/dsnp25. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

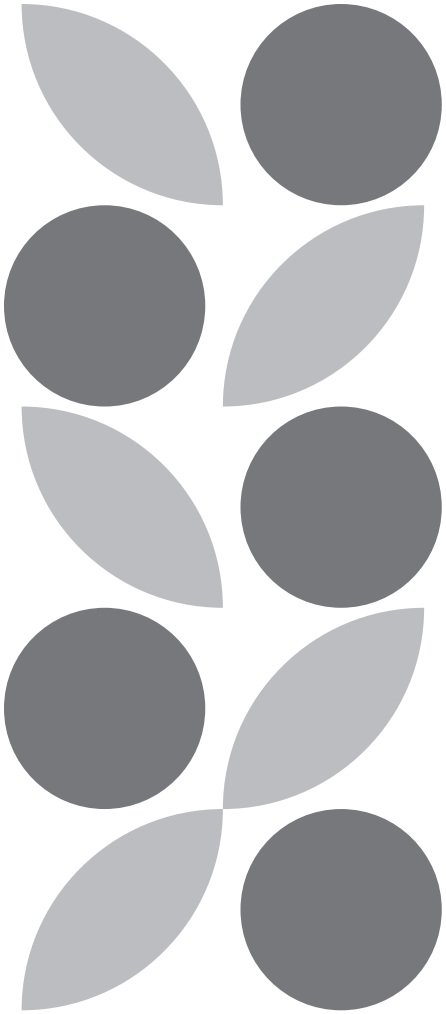
Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid, you can call Michigan Department of Health and Human Services at 517.241.3740. TTY users should call 844.578.6563

Hearing impaired callers may contact the Michigan Relay Center at 711 and ask for the number above.



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