Priority Health

2025
Annual Notice of Changes

PriorityMedicare[SM] Vintage (HMO-POS)
offered by Priority Health

January 1, 2025–December 31, 2025

OMB Approval 0938-1051 (Expires: August 31, 2026)
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You are currently enrolled as a member of **Priority**Medicare Vintage. 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 ***irs.gov/Affordable-Care-Act/Individuals-and-Families*** for more information.

About PriorityMedicare Vintage
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 Vintage.

PriorityMedicare Vintage (HMO-POS) offered by Priority Health Medicare

Annual Notice of Changes for 2025

You are currently enrolled as a member of **Priority**Medicare ONE (HMO-POS). 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/vintage25. You may also call Member Services 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

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

2. COMPARE: Learn about other plan choices

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

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

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

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2024, you will stay in **Priority**Medicare Vintage (HMO-POS).
   - 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 ONE (HMO-POS).
   - 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 888.389.6648 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.
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About PriorityMedicare Vintage (HMO-POS)

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

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Summary of Important Costs for 2025

The table below compares the 2024 costs for **Priority**Medicare ONE (HMO-POS) and 2025 costs for **Priority**Medicare Vintage (HMO-POS) 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	**In-Network** $0 **Out-of-Network** $1,000 except for acupuncture and insulin furnished through an item of durable medical equipment.	**In-Network** $0 **Out-of-Network** $1,500 except for acupuncture and insulin furnished through an item of durable medical equipment.
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.)	$4,300	$5,300

Cost	2024 (this year)	2025 (next year)
Doctor office visits	**In-Network** Primary care visits: $0 copay per visit Specialist visits: $0 to $35 copay per visit **Out-of-Network** 50% of the total costs for visits with a PCP or specialist, after deductible	**In-Network** Primary care visits: $0 copay per visit Specialist visits: $0 to $35 copay per visit **Out-of-Network** 50% of the total costs for visits with a PCP or specialist, after deductible
Inpatient hospital stays	**In-Network** $285 copay per day, days 1-7 $0 for additional hospital days **Out-of-Network** 50% of the total costs, per stay, after deductible	**In-Network** $320 copay per day, days 1-7. $0 for additional hospital days **Out-of-Network** 50% of the total costs, per stay, after deductible
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay at a preferred network pharmacy or $6 copay at a standard network pharmacy • Drug Tier 2: $10 copay at a preferred network pharmacy or $20 copay at a standard network pharmacy	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copay at a preferred network pharmacy or $10 copay at a standard network pharmacy • Drug Tier 2: $15 copay at a preferred network pharmacy or $20 copay at a standard network pharmacy

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 3: $42 copay at a preferred network pharmacy or $47 copay at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.	• Drug Tier 3: 25% of the total cost at a preferred network pharmacy or 25% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.
	• Drug Tier 4: 45% of the total cost at a preferred network pharmacy or 50% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.	• Drug Tier 4: 40% of the total cost at a preferred network pharmacy or 45% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.
	• Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.	• Drug Tier 5: 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier.
	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

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

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

If you do nothing by December 7, 2024, we will automatically enroll you in our PriorityMedicare Vintage (HMO-POS). This means starting January 1, 2025, you will be getting your medical and prescription drug coverage through **Priority**Medicare Vintage (HMO-POS). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

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.)	$0	$0
Monthly premium for optional supplemental benefits	$42	$49

- 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 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 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.	$4,300	$5,300 Once you have paid $5,300 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

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at priorityhealth.com/vintage25. 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/vintage25 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 Member Services so we may assist.

Section 2.4 – 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	2024 (this year)	2025 (next year)
Ambulance Services	**In- or Out-of-Network** You pay $285 copay for each one-way Medicare-covered ground ambulance service. You pay $285 copay for each one-way Medicare-covered air ambulance service. You pay $285 for each non-Medicare covered stabilization when there is no transport.	**In- or Out-of- Network** You pay $270 copay for each one-way Medicare-covered ground ambulance service. You pay $270 copay for each one-way Medicare-covered air ambulance service. You pay $270 copay for each non-Medicare covered stabilization when there is no transport.
Chiropractic Services	**In-Network** You pay $20 copay for one non-Medicare covered x-ray service per plan year by a chiropractor.	**In-Network** You pay $35 copay for one non-Medicare covered x-ray service per plan year by a chiropractor.
Dental Services	**In-Network** You pay $0 to $285 copay for each Medicare-covered visit.	**In-Network** You pay $0 to $350 copay for each Medicare-covered visit.
Fitness Benefit	**In-Network** You pay $0 copay for SilverSneakers®.	**In-Network** Fitness benefit is not covered.

Cost	2024 (this year)	2025 (next year)
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.
Inpatient Hospital Care	**In-Network** For Medicare-covered inpatient hospital stays, you pay $285 copay per day, days 1-7. $0 for additional hospital days. For inpatient hospital stays, you pay $285 copay per day for days 1-7; $0 copay per day for days 8-60.	**In-Network** For Medicare-covered inpatient hospital stays, you pay $320 copay per day, days 1-7. $0 for additional hospital days. For inpatient hospital stays, you pay $320 copay per day for days 1-7; $0 copay per day for days 8-60.
Inpatient Services in a Psychiatric Hospital	**In-Network** For Medicare-covered inpatient mental health stays, you pay $285 copay per day, days 1-7. $0 for additional hospital days. For inpatient mental health stays, you pay $285 copay per day for days 1-7; $0 copay per day for days 8-60.	**In-Network** For Medicare-covered inpatient mental health stays, you pay $275 copay per day, days 1-6. $0 for additional hospital days. For inpatient mental health stays, you pay $275 copay per day for days 1-6; $0 copay per day for days 7-60.
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)
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	**In-Network** For Medicare-covered outpatient diagnostic procedures and tests, you pay $0 copay. For Medicare-covered outpatient lab services, you pay $0 copay. For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), you pay $175 copay. For Medicare-covered outpatient therapeutic radiology services (such as radiation treatment for cancer), you pay $35 copay. For Medicare-covered outpatient X-rays, you pay $20 copay.	**In-Network** For Medicare-covered outpatient diagnostic procedures and tests, you pay $5 copay. For Medicare-covered outpatient lab services, you pay $0 to $5 copay. For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), you pay $180 copay. For Medicare-covered outpatient therapeutic radiology services (such as radiation treatment for cancer), you pay $25 copay. For Medicare-covered outpatient X-rays, you pay $35 copay.
Outpatient Rehabilitation Services	**In-Network** You pay $20 copay for each Medicare-covered occupational therapy visit. You pay $20 copay for each Medicare-covered physical therapy or speech therapy visit.	**In-Network** You pay $25 copay for each Medicare-covered occupational therapy visit. You pay $25 copay for each Medicare-covered physical therapy or speech therapy visit.

Cost	2024 (this year)	2025 (next year)
Outpatient Surgery	Includes services provided at hospital outpatient facilities and ambulatory surgical centers.	
	In-Network For Medicare-covered services at an outpatient hospital facility, you pay $0 to $285 copay. For Medicare-covered services at an ambulatory surgical center, you pay $285 copay.	**In-Network** For Medicare-covered services at an outpatient hospital facility, you pay $0 to $350 copay. For Medicare-covered services at an ambulatory surgical center, you pay $350 copay.
Over-the-Counter (OTC) Items	**In-Network** $26 maximum plan coverage amount every month for OTC items.	**In-Network** OTC items benefit is not covered.
Podiatry Services	**In-Network** You pay $0 to $35 copay for each routine foot care visit (6 visits every year).	**In-Network** Routine foot care benefit is not covered.
Remote Access Technologies	**In-Network** You pay $0 copay for Abridge.	**In-Network** Abridge is not covered.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	**In-Network** Healthy food and produce is covered for members with SSBCI.	**In-Network** Healthy food and produce is not covered.

Cost	2024 (this year)	2025 (next year)
Supervised Exercise Therapy (SET)	**In-Network** You pay $20 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).	**In-Network** You pay $15 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).
Support for Caregivers of Enrollees	**In-Network** Not covered.	**In-Network** You pay $0 copay for unlimited caregiver support provided by Carallel. See your Evidence of Coverage (EOC) for more information.
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 copay for each visit for Medicare-covered urgently needed care services.	**In- or Out-of-Network** You pay $50 copay for each visit for Medicare-covered urgently needed care services.

Cost	2024 (this year)	2025 (next year)
Vision Care	**In-Network** $175 maximum coverage amount every year for all non-Medicare-covered eyewear.	**In-Network** $100 maximum coverage amount every year for all non-Medicare-covered eyewear.
Worldwide Emergency / Urgently Needed Care Services	**In- or Out-of-Network** You pay $35 copay for each urgently needed care visit outside of the United States and its territories. You pay $285 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.	**In- or Out-of-Network** You pay $50 copay for each urgently needed care visit outside of the United States and its territories. You pay $270 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.

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/vintage25).

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

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

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

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

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 3 – preferred brand drugs, your cost sharing in the Initial Coverage Stage is changing from a copayment to a coinsurance. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: 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.**	Your cost for a one-month supply is: **Tier 1 – Preferred Generic Drugs:** *Standard cost sharing:* You pay $6 per prescription. *Preferred cost sharing:* You pay $0 per prescription.	Your cost for a one-month supply is: **Tier 1 – Preferred Generic Drugs:** *Standard cost sharing:* You pay $10 per prescription. *Preferred cost sharing:* You pay $4 per prescription.

Stage	2024 (this year)	2025 (next year)
For 2024 you paid a $42 or $47 copayment for drugs on Tier 3 – preferred brand drugs. For 2025 you will pay a 25% coinsurance for drugs on this tier.	**Tier 2 – Generic Drugs:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $10 per prescription.	**Tier 2 – Generic Drugs:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $15 per prescription.
	Tier 3 – Preferred Brand Drugs: *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 3 – Preferred Brand Drugs:** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 25% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier.
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. Most adult Part D vaccines are covered at no cost to you.	**Tier 4 – Non-Preferred Drugs:** *Standard cost sharing:* You pay 50% of the total cost per prescription. *Preferred cost sharing:* You pay 45% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 4 – Non-Preferred Drugs:** *Standard cost sharing:* You pay 45% of the total cost per prescription. *Preferred cost sharing:* You pay 40% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2024 (this year)	2025 (next year)
	Tier 5 – Specialty Drugs: *Standard cost sharing:* You pay 33% of the total cost per prescription. *Preferred cost sharing:* You pay 33% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 – Specialty Drugs:** *Standard cost sharing:* You pay 33% of the total cost per prescription. *Preferred cost sharing:* You pay 33% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

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

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 Vintage (HMO-POS)

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

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. If you do not enroll in a

Medicare drug plan, please see Section 2.1 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 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 Vintage (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from **Priority**Medicare Vintage (HMO-POS).
- 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.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 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

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).

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.** 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.
- **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 Vintage (HMO-POS)

Questions? We're here to help. Please call Member Services at 888.389.6648. (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 Vintage (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at priorityhealth.com/vintage25. 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/vintage25. 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.

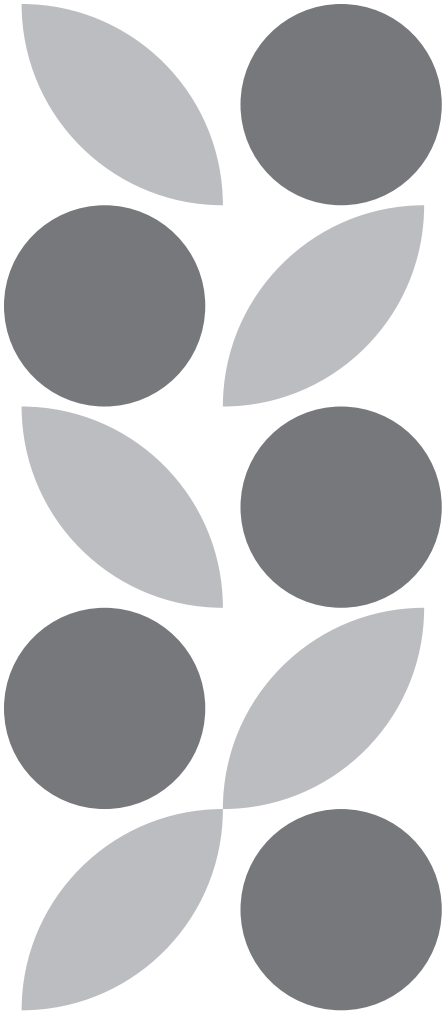
Visit the Medicare Website

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.

PriorityMedicare Vintage'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 844.403.0444, TTY users should call 711, or consult the online pharmacy directory at priorityhealth.com/vintage25.



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