PHP (HMO SNP) offered by AIDS Healthcare Foundation

Annual Notice of Changes for 2022

You are currently enrolled as a member of PHP (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.2 and 1.5 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.

CALIFORNIA

H5852_1140 2022 091021_M
OMB Approval 0938-1051 (Expires February 29, 2024)

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including specialist you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

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

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

- If you don't join another plan by December 7, 2021, you will be enrolled in PHP.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

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

- If you don't join by **December 7, 2021**, you will be enrolled in PHP.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Discrimination Is Against the Law

PHP (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services.

If you believe that PHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, P.O. Box 46160, Los Angeles, CA 90046, (800) 263-0067, TTY 711, Fax (888) 235-8552, email php@positivehealthcare.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-263-0067 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-263-0067（TTY：711）

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-263-0067 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-263-0067 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-263-0067 (TTY: 711) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-263-0067 (TTY (հեռատիպ)՝ 711):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-263-0067 (TTY: 711) تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-263-0067 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-263-0067（TTY: 711）まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-263-0067 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-263-0067 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-800-263-0067 (TTY: 711)។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-263-0067 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-263-0067 (TTY: 711) पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-263-0067 (TTY: 711).

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at (800) 263-0067 for additional information. (TTY users should call 711). Hours are 8:00 a.m. to 8:00 p.m., seven days a week.
- This information is available in other formats such as large print and in audio tapes.
- **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 PHP

- PHP is an HMO plan with a Medicare contract. Enrollment in PHP depends on contract renewal.
- When this booklet says "we," "us," or "our," it means AIDS Healthcare Foundation. When it says "plan" or "our plan," it means PHP.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for PHP in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.php-ca.org/for-members/publications. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$5,000	$5,000
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	• $100 copay per day for days 1 through 6 • $0 copay per day for days 7 through 90 • $0 copay per day for "lifetime reserve days" 91 through 150	• $100 copay per day for days 1 through 6 • $0 copay per day for days 7 through 90 • $0 copay per day for "lifetime reserve days" 91 through 150
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $445 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 15% • Drug Tier 2: 15% • Drug Tier 3: 25% • Drug Tier 4: 25% • Drug Tier 5: 0%	Deductible: $480 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 15% • Drug Tier 2: 15% • Drug Tier 3: 25% • Drug Tier 4: 25% • Drug Tier 5: 0%

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 — Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must continue to pay your Medicare Part B premium.)	$0	$0

- 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 Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach the maximum out-of-pocket amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount	$5,000	$5,000
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Once you have paid $5,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 — Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.php-ca.org/provider-find. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

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

Section 1.4 — Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our Web site at www.php-ca.org/provider-find. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy*

Directory. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 — Changes to Benefits and Costs for Medical Services

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

Opioid treatment program services

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

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

Cost	2021 (this year)	2022 (next year)
Ambulatory Surgery Center	You pay nothing for outpatient surgery and ambulatory surgery center services. Referral and authorization required.	You pay nothing for outpatient surgery and ambulatory surgery center services done at an ambulatory surgery center. Referral and authorization required. If outpatient surgery and/or surgery services are done at a hospital facility, you will be subject to an outpatient hospital copay. See "Outpatient Hospital" below.
Dental Services	You pay nothing for limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). Referral and authorization required.	You pay nothing for limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). Referral and authorization required.

Cost	2021 (this year)	2022 (next year)
Dental Services (continued)	You pay nothing for preventive dental services: • Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 1 every year) • Fluoride treatment (for up to 2 every year) • Oral exams (unlimited) You pay nothing for comprehensive dental services such as the following: • Non-routine services • Diagnostic services • Restorative services • Endodontics/ periodontics/ extractions • Prosthodontics, other oral/maxillofacial surgery, other services **Comprehensive dental services are limited to $700 every year.** No referral or authorization required for preventive or comprehensive dental services.	You pay nothing for preventive dental services: • Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 1 every year) • Fluoride treatment (for up to 2 every year) • Oral exams (unlimited) You pay nothing for comprehensive dental services such as the following: • Non-routine services • Diagnostic services • Restorative services • Endodontics/ periodontics/ extractions • Prosthodontics, other oral/maxillofacial surgery, other services **Comprehensive dental services are limited to $750 every year.** No referral or authorization required for preventive or comprehensive dental services.

Cost	2021 (this year)	2022 (next year)
Diagnostic Services/ Labs/Imaging	You pay nothing for the following services: • Diagnostic radiology services, e.g., MRI, CT, PET scans • Lab services • Diagnostic tests and procedures • Outpatient x-rays Referral required. Some tests and services require authorization.	You pay nothing for the following services: • Diagnostic radiology services, e.g., MRI, CT, PET scans • Lab services • Diagnostic tests and procedures • Outpatient x-rays • Colonoscopy, sigmoidoscopy, endoscopy Referral required. Some tests and services require authorization. If diagnostic, lab or imaging services are done at a hospital facility, you will be subject to an outpatient hospital copay. See "Outpatient Hospital" below.
Hearing Services	You pay nothing for the following services every year: • One routine hearing exam • One fitting-evaluation for a hearing aid • Up to two hearing aids **$400 plan coverage limit for up to 2 hearing aids every year.** Authorization required.	You pay nothing for the following services every year: • One routine hearing exam • One fitting-evaluation for a hearing aid • Up to two hearing aids **$1,000 plan coverage limit for up to 2 hearing aids every year.** Authorization required

Cost	2021 (this year)	2022 (next year)
Meal Benefit	You pay nothing for up to two (2) meals per day for up to 28 days (56-meal limit per year). Meal benefit is available to members after discharge from an acute hospital or skilled nursing facility. Authorization required.	You pay nothing for up to two (2) meals per day for up to 28 days (56-meal limit per year). Meal benefit is available to members post-inpatient discharge from an acute hospital or skilled nursing facility and members who have a chronic condition or other medical condition that prevents leaving the home to grocery shop. Meals may be provided in multiple increments through the year up to the 56-meal limit for the year. Authorization required.
Outpatient Hospital	You pay nothing for outpatient hospital services. Some services require referral and authorization.	You pay $100 copay per outpatient hospital service, i.e., outpatient surgery and surgery services and diagnostic radiology services, tests and procedures done at a hospital facility. Some services require referral and authorization.

Cost	2021 (this year)	2022 (next year)
Vision Care	You pay nothing for Medicare-covered vision care services. Referral and authorization required for the following: • Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration • For members who at high risk for glaucoma, one glaucoma screening each year • For members with diabetes, one diabetic retinopathy screening each year • One (1) pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens You pay nothing for supplemental vision care benefits. No referral or authorization required for the following: • One (1) routine eye exam every year	You pay nothing for Medicare-covered vision care services. Referral and authorization required for the following: • Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration • For members who at high risk for glaucoma, one glaucoma screening each year • For members with diabetes, one diabetic retinopathy screening each year • One (1) pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens You pay nothing for supplemental vision care benefits. No referral or authorization required for the following: • One (1) routine eye exam every year

Cost	2021 (this year)	2022 (next year)
Vision Care (continued)	• One (1) pair of eyeglasses (lenses and frames or lenses) or contact lenses every year **$150 plan coverage limit for eyewear every year.**	• One (1) pair of eyeglasses (lenses and frames or lenses) or contact lenses every year **$200 plan coverage limit for eyewear every year.**

Section 1.6 — Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

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

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

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

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in

therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are currently taking a drug that was approved by the plan through the formulary exception process, you will need to make a new formulary exception request for the next plan year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for your Part D prescription drugs does 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. Because you receive "Extra Help," if you haven't received this insert by September 30, 2021, please call Member Services and ask for the "LIS Rider."

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.php-ca.org/for-members/publications You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your generic, preferred brand, non-preferred brand and specialty drugs until you have reached the yearly deductible.	The deductible is $445 During this stage, you pay no cost-sharing for drugs on Tier 5 (Select Care Drugs) and the full cost of drugs on Tier 1 (Generic Drugs), Tier 2 (Preferred Brand Drugs), Tier 3 (Non-Preferred Brand Drugs) and Tier 4 (Specialty Drugs) until you have reached the yearly deductible.	The deductible is $480 During this stage, you pay no cost-sharing for drugs on Tier 5 (Select Care Drugs) and the full cost of drugs on Tier 1 (Generic Drugs), Tier 2 (Preferred Brand Drugs), Tier 3 (Non-Preferred Brand Drugs) and Tier 4 (Specialty Drugs) until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

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

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage 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 that provides standard cost-sharing. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your *Evidence of Coverage*. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic Drugs (Tier 1):** You pay 15% of the total cost. **Preferred Brand Drugs (Tier 2):** You pay 15% of the total cost. **Non-Preferred Brand Drugs (Tier 3):** You pay 25% of the total cost. **Specialty Drugs (Tier 4):** You pay 25% of the total cost. **Select Care Drugs (Tier 5):** You pay 0% of the total cost. Once your total drugs costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic Drugs (Tier 1):** You pay 15% of the total cost. **Preferred Brand Drugs (Tier 2):** You pay 15% of the total cost. **Non-Preferred Brand Drugs (Tier 3):** You pay 25% of the total cost. **Specialty Drugs (Tier 4):** You pay 25% of the total cost. **Select Care Drugs (Tier 5):** You pay 0% of the total cost. Once your total drugs costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 — If You Want to Stay in PHP

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 PHP.

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 for 2022, follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from PHP.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from PHP.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP 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 HICAP at (800) 434-0222. TTY users should call 711. You can learn more about HICAP by visiting their Web site (www.aging.ca.gov/hicap).

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. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **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 California Department of Public Health, Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP call center at (844) 421-7050, Monday through Friday, 8:00 a.m. to 5:00 p.m.

SECTION 6 Questions?

Section 6.1 — Getting Help from PHP

Questions? We're here to help. Please call Member Services at (800) 263-0067. (TTY only, call 711.) We are available for phone calls 8:00 a.m. to 8:00 p.m., seven days a week. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for PHP. 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 www.php-ca.org/for-members/publications. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Web site

You can also visit our website at www.php-ca.org. 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 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 Web site

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

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.