

2027
Annual Notice of Changes

PriorityMedicare® Dual Premier (HMO D-SNP)
Offered by Priority Health Medicare

January 1, 2027 - December 31, 2027

OMB Approval 0938-1051 (Expires: July 31, 2029)
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PriorityMedicare Dual Premier® (HMO-DSNP) offered by Priority Health Medicare

Annual Notice of Change for 2027

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to your benefits, coverage, and costs. This Annual Notice of Change tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at **prioritythealth.com/dual27**. You can also call Customer Care at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook.*

Additional resources

- **You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 833.939.0983 (TTY: 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1– Sept. 30, we're available Mon.– Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–Noon ET. The call is free.**
    - Our plan can also give you your important plan materials in languages other than English and in formats such as large print, braille, or audio. To get your important plan materials in one of these alternative formats, you can submit a request using any of the following methods:
        * Contact our Customer Care team by calling 833.939.0983 (TTY: 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1– Sept. 30, we're available Mon.– Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–Noon ET.
        * Create and log in to your member account at *member.prioritythealth.com* to send us a secure message.
        * Send a written request to:
          Priority Health
          MS: 1175
          1231 East Beltline Ave. NE Grand Rapids, MI 49525

OMB Approval 0938-1444 (Expires: 5/31/2029)

- Upon receiving your request, unless you indicate this is a one-time need, we will continue to send future mailings and communications in the preferred language and/or format. If at any time you would like to update or change your preferred preferences, you can use any of the above contact methods.

For questions about or problems with the MI Coordinated Health program or our plan, contact the MI Community, Home, and Health Ombudsman (MI CHHO) for free help. MI CHHO is an independent program and isn't connected with this plan. Call 1-888-746-6456 or visit the MI CHHO website at meji.org/michho/mhlo. To schedule an appointment with a person-centered options counselor, please call MI Options at 1-800-803-7174 8 a.m. to 8 p.m., Monday through Friday.

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A. Disclaimers

PriorityMedicare Dual Premier (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. Enrollment depends on contract renewal.

[1]Help with certain chronic conditions is part of a special supplemental benefit for chronically ill members with one of the following conditions: diabetes, chronic obstructive pulmonary disease (COPD), arrhythmias, depression, heart failure, prostate/breast/other cancers, and bipolar disorder. This is not a complete list of qualifying conditions. Even if you have a qualifying condition, you will not necessarily qualify to receive the benefit because coverage of the item or service depends on if you are chronically ill as defined by CMS and meet all applicable eligibility requirements. To see if you qualify, contact our Customer Care team by calling 833.939.0983 (TTY 711)

B. Reviewing your Medicare and Michigan Medicaid (Medicaid) coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section D** for more information on changes to your benefits for next year.

PriorityMedicare Dual Premier is part of the MI Coordinated Health (MICH) program. MICH is a highly integrated dual eligible special needs plan (HIDE SNP) that provides benefits of both Medicare and Medicaid to enrollees.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You'll still be in the Medicare and Michigan Medicaid programs as long as you're eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section F2 refer to Chapter 10, Section A of the Member Handbook.**
- Michigan Medicaid options and services in **Section F2 refer to Chapter 1, Section B2 of the Member Handbook.**

B1. Information about PriorityMedicare Dual Premier

- **Priority**Medicare Dual Premier is a health plan that contracts with both Medicare and Medicaid to provide benefits of both programs to members. Enrollment depends on contract renewal.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means **Priority**Medicare Dual Premier.

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they'll work for you next year.
  - Refer to **Section D1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy, or quantity limits?
  - Review changes to make sure our drug coverage will work for you next year.
  - Refer to **Section D2** for information about changes to our drug coverage.
  - Your drug costs may have risen since last year.
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.

- **Check if your providers and pharmacies will be in our network next year.**
    - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
    - Refer to **Section C** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
    - How much will you spend out-of-pocket for the services and drugs you use regularly?
    - How do the total costs compare to other coverage options?

Think about whether you're happy with our plan.

If you decide to stay with PriorityMedicare Dual Premier:	**If you decide to change plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in **Priority**Medicare Dual Premier.	If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section F2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our network providers and pharmacies

Amounts you pay for your drugs depends on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they're filled at one of our network pharmacies.

Our provider and pharmacy networks have changed for 2027.

Please review the 2027 *Provider and Pharmacy Directory* to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at **prioritythealth.com/dual27**. You

may also call Customer Care at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory.*

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Customer Care at the number at the bottom of the page for help.

D. Changes to benefits and costs for next year

D1. Changes to benefits and costs for medical services

We're changing our coverage for certain medical services and what you pay for these covered medical services next year. The table below describes these changes.

	2026 (this year)	2027 (next year)
Durable Medical Equipment (DME)	**In-Network** Continuous Glucose Monitors (CGM's) are not covered when obtained through a network retail or mail-order pharmacy.	**In-Network** $0 for Continuous Glucose Monitors (CGM's) when obtained through a network retail or mail-order pharmacy. Covered products are limited to Dexcom and Freestyle Libre.

	2026 (this year)	2027 (next year)
Medicare Vision Benefits	$0 for one routine exam per year. $200 allowance for non-Medicare/Medicaid covered eye wear.	Non-Medicare covered routine vision exam and eyewear allowance are not covered. Coverage obtained through Medicaid benefit.
Personal Emergency Response System (PERS)	$0 copay for Personal Emergency response System (PERs).	Not covered. Coverage may be obtained for qualifying members through Medicaid benefit under a Home and Community-Based Services (HCBS) waiver.
Physician/Provider services, including doctor's office visits Telehealth (virtual visits)	Telehealth (virtual) visit – Urgently needed services isn't covered.	You pay $0 for telehealth (virtual) urgently needed services per visit.

	2026 (this year)	2027 (next year)
PriorityFlex (Over the Counter (OTC) benefit)	Depending on where you live in our service area – $96 (Barry County) allowance per month to use towards OTC items and home and bathroom safety devices and modifications. $70 (all other counties) allowance per month to use towards OTC items and home and bathroom safety devices and modifications. Allowance does not rollover.	$65 per month for Barry, Branch, Macomb, and Wayne counties. $66 per month for Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties. Can be used for over the counter items, home and bathroom safety devices and modifications. Allowance does not rollover.

D2. Changes to drug coverage

Changes to our *Drug List*

Our *List of Covered Drugs* is also called the *Formulary* or *Drug List*. A copy of our *Drug List* is posted online at **priorityhealth.com/dual27**.

You can get the complete Drug List by calling Customer Care at the number at the bottom of the page or visiting our website at **priorityhealth.com/dual27**.

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover and changes to 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 find out if there are 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 and/or the state that will affect you during the calendar 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 a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
    - You can call Customer Care at the numbers at the bottom of the page, or contact your care coordinator to ask for a *List of Covered Drugs* that treat the same condition.
    - This list can help your provider find a covered drug that might work for you.
- Work with your doctor (or other prescriber) and ask us to make an exception to cover the drug.
    - You can ask for an exception before next year, and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement).
    - To learn what you must do to ask for an exception, refer to **Chapter 9** of your *Member Handbook* or call Customer Care at the numbers at the bottom of the page.
    - If you need help asking for an exception, contact Customer Care or your care coordinator. Refer to **Chapters 2 and 3** of your *Member Handbook* to learn more about how to contact your care coordinator.
- Ask us to cover a temporary supply of the drug.
    - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
    - This temporary supply is for up to 30-days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
    - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If you received approval for a formulary exception in 2026, please refer to your approval letter to see when that approval will end. You may need to ask for a new exception for 2027.

Changes to drug costs

Because you're eligible for Michigan Medicaid, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Care and ask for the "LIS Rider."

There are three payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on your level of Extra Help and which stage you're in when you get a prescription filled or refilled. These are the three stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2027. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches $2,400. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you'll pay for drugs.

Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

D3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our *Drug List* to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our *Drug List*.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 5 drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you.

For information about the costs for a long-term supply; or for mail-order prescriptions go to **Chapter 6, Section D** of your *Member Handbook*.

	2026 (this year)	**2027 (next year)**
Drugs in Tier 1 (preferred generic drugs) Cost for a one-month supply of a drug in Tier 1 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0.	Your copay for a one-month (30-day) supply is $0.
Drugs in Tier 2 (generic drugs) Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0.	Your copay for a one-month (30-day) supply is $0.

	2026 (this year)	2027 (next year)
Drugs in Tier 3 (preferred brand drugs) Cost for a one-month supply of a drug in Tier 3 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 - $12.65 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).	Your copay for a one-month (30-day) supply is $0 - $14.40 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).
Drugs in Tier 4 (non-preferred drugs) Cost for a one-month supply of a drug in Tier 4 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is $0 - $12.65 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).	Your copay for a one-month (30-day) supply is $0 - $14.40 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).
Drugs in Tier 5 (specialty drugs) Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy **Drugs in this tier are limited to a 30-day supply per fill.**	Your copay for a one-month (30-day) supply is $0 - $12.65 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).	Your copay for a one-month (30-day) supply is $0 - $14.40 (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help).

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,400**. At that point the Catastrophic Coverage Stage begins. The plan covers all of your Part D drugs until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information about how much you pay for drugs.

D4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit **$2,400** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered Part D drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

For more information about your costs in the Catastrophic Coverage stage, refer to **Chapter 6 Section F in the Member Handbook.**

E. Administrative changes

	2026 (this year)	2027 (next year)
"Coverage during "Deeming Period"	When enrolled within this plan, you are allowed to remain enrolled for up to three (3) months after the loss of Medicaid eligibility. This period of time is referred to as "deeming," which gives you a chance to get your redetermination paperwork sorted out with your caseworker. If you lose your Michigan Medicaid eligibility but can be expected to regain it within 3 months, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits and Michigan Medicaid covered benefits during the "deeming" period. Your coverage remains the same during the "deeming" period.	When enrolled within this plan, you are allowed to remain enrolled for up to three (3) months after the loss of Medicaid eligibility. This period of time is referred to as "deeming," which gives you a chance to get your redetermination paperwork sorted out with your caseworker. If you lose your Michigan Medicaid eligibility but can be expected to regain it within 3 months, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits during the "deeming" period. We will no longer provide Michigan Medicaid covered benefits once you lose your Michigan Medicaid eligibility. Your coverage changes during the "deeming" period. You may have cost-share for medical services and prescription drugs that Michigan Medicaid would have covered. For more information, refer to Chapter 4 of your Member Handbook or call Customer Care at the number at the bottom of the page for help.

	2026 (this year)	2027 (next year)
"Special supplemental benefits for the chronically ill" (SSBCI) – Eligibility determination process**"**	To see if you qualify go to priorityhealth.com/dsnp26 and complete a survey or contact Customer Care. You are required to complete a survey, self-attesting you have been diagnosed with one or more of the qualifying chronic conditions, be at high risk for hospitalization or other adverse health outcomes and require intensive care coordination.	To qualify for SSBCI benefits your treating provider will be asked to complete a SSBCI Provider Attestation form. The information submitted is used to help determine whether: You have one or more qualifying chronic conditions that are life-threatening or significantly limit your overall health or function; You are at high risk of hospitalization or other adverse health outcomes; You require intensive care coordination; and The SSBCI benefit has a reasonable expectation of improving or maintaining your health or overall function.

F. Choosing a plan

F1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2027.

F2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you're enrolled in **Priority**Medicare Dual Premier, you have some choices to end your membership in our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for Michigan Medicaid or Extra Help changed, **or**
- you recently moved into or are currently getting care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section F2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call 877.264.7223. If you need help or more information: • Call MI Options at 1-800-803-7174. For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program . **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. You can also contact the plan you wish to enroll in directly.

2. You can change to: **Original Medicare with a separate Medicare drug plan** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call MI Options at 1-800-803-7174 For more information or to find a local MI Options office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program . **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason** **To apply for Medicaid, complete an application online at** www.michigan.gov/mibridges. **NOTE**: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call MI Options at 1-800-803-7174 (TTY 711) 8 a.m. to 8 p.m., Monday through Friday https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call MI Options at 1-800-803-7174 For more information or to find a local office in your area, please visit https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 877.264.7223. If you need help or more information: • Call MI Options at 1-800-803-7174 **OR** Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.

Your Michigan Medicaid services

For questions about how to get your Michigan Medicaid services after you leave our plan, contact the Beneficiary Help Line: 1-800-642-3195 or beneficiarysupport@michigan.gov. For more information log on to www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support. Ask how joining another plan or returning to Original Medicare affects how you get your Michigan Medicaid coverage.

G. Getting help

G1. Our plan

We're here to help if you have any questions. Call Customer Care at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2027. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook* for 2027 will be available by October 15. An up-to-date copy of the *Member Handbook* is available on our website at **priorityhealth.com/dual27**. You may also call Customer Care at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2027.

Our website

You can visit our website at **priorityhealth.com/dual27**. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List* (*List of Covered Drugs*).

G2. MI Options

You can also call the state health insurance program (SHIP). In Michigan the SHIP is called MI Options. MI Options can help you understand your plan choices and answer questions about switching plans. MI Options isn't connected with us or with any insurance company or health plan. MI Options has trained counselors in every county and services are free. MI Options phone number is 1-800-803-7174 (TTY 711) For more information or to find a local MI Options office in your area, please visit www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/long-term-services-and-supports

G3. The MI Community, Home, and Health Ombudsman

The MI Community, Home, and Health Ombudsman (MI CHHO) serves as an advocate and problem-solver for people enrolled in MICH program. MI CHHO isn't connected with any insurance company or health plan and all of its services are free and it keeps all information confidential. Call the MI CHHO if you have trouble or delay with your plan providing medical care, services, equipment, other benefits, or with the quality of care. MI CHHO can also help you learn about the MICH program and options for care in the community, including your rights. You can call MI CHHO if your plan has denied medical care, services, equipment, or other benefits - including help with appeals.

Contact us at our toll-free hotline at:1-888-746-6456

G4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")

Medicare & You 2027

You can read the *Medicare & You 2027* 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. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G5. Michigan Medicaid

Michigan Medicaid is a health care program that provides comprehensive health care services to low income adults and children. Services covered by Medicaid are offered through what's called fee-for-service or through Medicaid Managed Care Organizations

- Fee-for-service is the term for Medicaid paid services that aren't provided through a health plan. This means that Medicaid pays for the service. People under fee-for-service will use the www.michigan.gov/mdhhs/assistance-programs/healthcare/adults/quicklinks/the-mihealth-card card to receive services.
- Additional information regarding Michigan Medicaid can be found by accessing the following website www.michigan.gov/mdhhs/assistance-programs/healthcare

- People may join a health plan. The health plan pays for most of the services. For people to choose to join a health plan, Michigan Enrolls will send a letter with more information. After enrollment with a health plan, both the MIhealth card and the health plan card are needed to access services. For additional information regarding joining a health plan, please visit the following website www.michigan.gov/mdhhs/assistance-programs/healthcare

Costs

People with Medicaid and Medicare that are enrolled in a HIDE SNP, such as our plan, won't have premiums, co-pays, cost-sharing, coinsurance, or deductibles for in-network services, except in some instances for Medicare Part D drugs. Individuals with Pre-Eligibility Medical Expenses (PEME) and Patient Pay Amounts (PPAs) are still required to pay these expenses when enrolled in a HIDE SNP. If you disenroll from our HIDE SNP, you may have to pay a small amount called a co-pay. People age 21 and older may have a co-pay for the services listed in the Beneficiary Co-Payment Requirements. To see a list of co-pay amounts in this chart, please visit www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=18CE85BF53B120E81739BD1F781CE2B8.

G6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, you don't need to do anything to continue participating in 2027. This payment option might help you manage your expenses, but it doesn't save you money or lower your total out-of-pocket drug costs.

"Extra Help" from Medicare and help from your state's pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.Medicare.gov.



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