Health Partners Medicare Special (HMO SNP) offered by Health Partners Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of Health Partners Medicare Special. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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 1.1 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.
- 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 specialists 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 & Pharmacy 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 Health Partners Medicare Special.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 2.2, page 13 to learn more about your choices.

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

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Health Partners Medicare Special.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Relations number at 1-866-901-8000 for additional information. (TTY users should call 1-877-454-8477.) Hours are 24 hours a day, seven days a week.
- You can also request this information in alternate formats (such as braille, large print or audio) by calling Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477).
- **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 Health Partners Medicare Special

- Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal. The plan also has a written agreement with the Pennsylvania Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means Health Partners Medicare. When it says "plan" or "our plan," it means Health Partners Medicare Special.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Health Partners Medicare Special 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.HPPMedicare.com. You may also call Member Relations to ask us to mail you an *Evidence of Coverage.* If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Important note: Cost-sharing shown for Medicare Part A and Part B medical services in this ANOC are based on your Full Benefit Dual Eligible status. Should you lose Medicaid coverage and remain on the Special plan while seeking to restore this coverage, Medicaid will not pay your cost-sharing and you will be responsible for these amounts. Your cost-sharing for most benefits in this situation will be no more than 20% coinsurance. Immediately below we list how other cost-sharing amounts shown in this ANOC would be altered during this period.

Medical cost-sharing without Medicaid coverage

Plan deductible: $233 a year

Inpatient hospital stays:

For each inpatient hospital admission, you pay:

- $1,556 deductible;
- $0 copay for days 1–60;
- $389 copay each day for days 61–90;
- $778 copay each day for days 91+ (up to 60 lifetime reserve days).

Part D note: Through our participation in Medicare's Value-Based Insurance Design program, members getting "Extra Help" (levels 1, 2, 3 or 4) will have no cost-sharing for covered Part D prescription drugs in 2022. Prescription drug cost-sharing shown in this ANOC reflects this cost elimination. Please contact the plan for information about how your cost-sharing would change if you lost all eligibility for "Extra Help" and remained on the plan.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $40.70
Deductible	$0 a year	$0 a year
Doctor office visits	Primary care visits: 0% coinsurance per visit. Specialist visits: 0% coinsurance per visit.	Primary care visits: 0% coinsurance per visit. Specialist visits: 0% coinsurance per visit.
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.	You pay a $0 deductible; $0 copay each day for days 1-60; $0 copay each day for days 61- 90; $0 copay each day for days 91+ (up to 60 lifetime reserve days).	You pay a $0 deductible; $0 copay each day for days 1-60; $0 copay each day for days 61-90; $0 copay each day for days 91+ (up to 60 lifetime reserve days).

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 or $445 Copay/Coinsurance during the Initial Coverage Stage: • **Generic Drugs**: $0, $1.30, $3.70 copay or no more than 25% coinsurance • **All other drugs**: $0, $4.00, $9.20 copay or no more than 25% coinsurance	Deductible: $0 Copay/Coinsurance during the Initial Coverage Stage: • **Generic Drugs**: $0 copay • **All other drugs**: $0 copay
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,450 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,450 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0, depending on your level of "Extra Help"	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $40.70

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 this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450	$3,450 Once you have paid $3,450 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2022. An updated *Provider & Pharmacy Directory* is located on our website at www.HPPMedicare.com. You may also call Member Relations for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **We strongly suggest that you review our current *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still 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 *Provider & Pharmacy Directory* is located on our website at www.HPPMedicare.com. You may also call Member Relations for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2022 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are 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, *Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at www.HPPMedicare.com.You may also call Member Relations to ask us to mail you an *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)
Food and Produce	Food and Produce are not covered.	You pay a $0 copay for eligible produce and other food items as an extension of your OTC benefit. $300 quarterly allowance applies to combined OTC and food purchases. Unused amounts do not roll over from one calendar quarter to the next. Covered for members with eligible chronic illnesses. Please see your EOC for details.

Cost	2021 (this year)	2022 (next year)
Over-the-Counter Items	You pay a $0 copay for eligible over-the-counter items, up to $300 each calendar quarter. Unused amounts roll over.	You pay a $0 copay for eligible over-the-counter items, up to $300 each calendar quarter. Unused amounts do not roll over from quarter to quarter.
Physician/Practitioner Services	Prior authorization is required for telehealth services and for mental health specialty and psychiatric services (except initial consultation).	Prior authorization may be required for mental health specialty and psychiatric services other than initial consultation, routine outpatient therapy and medication management visits.
Podiatry Services (Routine)	You pay a $20 copay per visit once every 3 months.	You pay a $0 copay per visit once every 3 months.
Telehealth	Prior authorization is required for telehealth services.	Prior authorization is not required for the telehealth process. However, services that require prior authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.
Telemonitoring Services	Covered for members who have congestive heart failure (CHF) or uncontrolled diabetes.	Covered for members who have congestive heart failure (CHF), uncontrolled diabetes or hypertension.

Cost	2021 (this year)	2022 (next year)
Vision Care: Eyewear (Routine)	You pay a $0 copay for one of the following yearly: - one pair of eyeglasses (lenses and up to $150 for frame) - one pair of eyeglass lenses - one eyeglass frame (up to $150) - contact lenses (up to $200)	You pay a $0 copay for one of the following, up to $300 yearly: - one pair of eyeglasses (lenses and frame) - contact lenses
Wellness and Health Care Planning	Wellness and Health Care Planning is not covered.	Members will be assigned a care coordinator who will outreach to provide education and support around a range of health issues, including preventive care, identifying and overcoming social barriers to accessing care, and advance care planning.

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.
    - 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 Relations.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Relations 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.

As a current member, you may receive up to a temporary 30-day supply of a drug that is affected by negative formulary changes in the new contract year within the first 90 days of renewal. After your first 30-day supply, we will not cover these drugs unless approved through the non-formulary exception process or through prior authorization. If you receive coverage for a temporary medication fill, we will notify you if a formulary exception determination or prior authorization is needed for continued coverage of your medication.

Formulary exceptions are granted for a one-year (365-day) period. If a formulary exception is approved in 2021, it will be good into 2022. A new request will need to be submitted if you want Health Partners Medicare Special to continue to cover an excepted drug after this one-year period has expired.

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

Cost	2021 (this year)	2022 (next year)
Part D Prescription Drug Cost Reduction	Part D Prescription Drug Cost Reduction is not covered.	You pay no deductible and $0 copay for covered Part D drugs through Part D Prescription Drug Cost Reduction. To receive the Part D Drug Cost Reduction, you must be eligible for Low Income Subsidy level 1, 2, 3 or 4.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in.

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 in your *Summary of Benefits*.

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

Stage	2021 (this year)	2022 (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.** 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic Drugs**: You pay $0, $1.30 or $3.70 per prescription, or no more than 25% coinsurance per prescription. **All other drugs**: You pay $0, $4.00 or $9.20 per prescription or no more than 25% per prescription. Once your total drug 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**: You pay $0 per prescription. **All other drugs**: You pay $0 per prescription. Once your total drug 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 Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Health Partners Medicare Special

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 Health Partners Medicare Special plan.

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

To learn more about Original Medicare and the different types of Medicare plans, 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.**

As a reminder, Health Partners Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Health Partners Medicare Special.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Health Partners Medicare Special.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Relations 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.

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

SECTION 3 Changing Plans

If you want to change to a different plan or 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.

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 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

PA MEDI 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. PA MEDI 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 PA MEDI at 1-800-783-7067. You can learn more about PA MEDI by visiting their website (www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx).

For questions about your Pennsylvania Medicare Education and Decision Insight benefits, contact Pennsylvania Medicare Education and Decision Insight at 1-800-692-7462, TTY 1-800-451-5886 Monday-Friday, 8:30 a.m. - 5:30 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Pennsylvania Medicare Education and Decision Insight coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

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

- "**Extra Help**" **from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

- The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE) 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 (the name and phone numbers for this organization are in Section 4 of this booklet).
- **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 State Pharmaceuticals Benefit Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-922-9384.

SECTION 6 Questions?

Section 6.1 – Getting Help from Health Partners Medicare Special

Questions? We're here to help. Please call Member Relations at 1-866-901-8000. (TTY only, call 1-877-454-8477.) We are available for phone calls 24 hours a day, 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 Health Partners Medicare Special. 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.HPPMedicare.com. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.HPPMedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Pennsylvania Department of Human Services at 1-800-692-7462. TTY users should call 1-800-451-5886.