Community Health Plan of Washington (CHPW) Medicare Advantage Dual Plan (HMO) offered by Community Health Plan of Washington

Annual Notice of Changes for 2023

You are currently enrolled as a member of *CHPW MA Dual Plan*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at medicare.chpw.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

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

☐ 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 Medicare Plan Finder at medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in *CHPW MA Dual Plan*.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with *CHPW MA Dual Plan*.
- Look in section *2.2* page *13* to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Service number at 1-800-942-0247 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week.
- You can ask for this information in alternative formats such as Braille and large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *CHPW MA Dual Plan*

- Community Health Plan of Washington is an HMO Plan with a Medicare contract and a contract with the Washington State Medicaid Program. Enrollment in Community HealthPlan of Washington depends on contract renewal.

When this document says "we," "us," or "our," it means *Community Health Plan of Washington*. When it says "plan" or "our plan," it means *CHPW MA Dual Plan*.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for *CHPW MA Dual Plan* in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$40.40	$41.00
Doctor office visits	Primary care visits: $0 copayment or 20% per visit Specialist visits: $0 copayment or 20% per visit	Primary care visits: No change Specialist visits: No change

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	For Medicare-covered hospital stays: With full Medicaid cost share assistance, you pay a $0 copayment. Without Medicaid cost share assistance, you are subject to the Original Medicare cost sharing amounts for 2022.	For Medicare-covered hospital stays: With full Medicaid cost share assistance, you pay a $0 copayment. Without Medicaid cost share assistance, you are subject to the Original Medicare cost sharing amounts for 2023, which will be set by CMS in the fall of 2022. These are 2022 cost sharing amounts and may change for 2023. Please contact Customer Service for updated amounts. $1,556 deductible for days 1 to 60; $389 copayment each day for days 61 to 90; $778 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0-$480 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0-$9.85	Deductible: $0-$505 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0

Cost	2022 (this year)	2023 (next year)
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.)	$7,550 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,300 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$40.40	$41.00

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. **Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.**	$7,550	$8,300 Once you have paid $8,300 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 and Pharmacy Networks

Updated directories are also located on our website at medicare.chpw.org/member-center/member-resources/provider-directory. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are no changes to our network of providers for next year.

There are no changes to our network of pharmacies for next year.

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Dental Services (Supplemental)	You pay nothing for supplemental preventive and comprehensive services up to $4,500 combined total benefit limit per year. You pay 100% of any costs over the plan benefit limit.	You pay nothing for supplemental preventive and comprehensive services up to $5,000 combined total benefit limit per year. You pay 100% of any costs over the plan benefit limit.
Emergency Care	$0 copayment or 20% coinsurance (up to $90) for each Medicare-covered emergency room visit.	$0 copayment or 20% coinsurance (up to $95) for each Medicare-covered emergency room visit.
Family on Demand	Not Covered	Pairs members with adults, providing relief and respite to caregivers by assisting with independent activities of daily living $0 copay for up to 60 hours of assistance per year

Cost	2022 (this year)	2023 (next year)
Grocery Card	Not Covered	You pay nothing for a prepaid grocery card up to the $50 per month limit.
Health and Wellbeing	Covered services include routine chiropractic visits combined with acupuncture and naturopathic visits up to the plan maximum. Plan maximum of 12 visits per calendar year for routine chiropractic, acupuncture and naturopathic visits combined.	Benefit includes acupuncture, naturopathy, routine chiropractic, massage therapy, and various CHPW-recommended Well Being programs, with up to a total of 25 services/programs combined per year.
Hearing Services (Supplemental)	You pay nothing for one routine hearing exam per year and one hearing aid fitting/evaluation per year. You pay nothing for supplemental hearing aids and supplies, up to the $1,700 benefit limit every calendar year. You pay 100% of any costs over the plan benefit limit.	You pay nothing for one routine hearing exam per year and one hearing aid fitting/evaluation per year. You pay nothing for supplemental hearing aids and supplies, up to the $2,250 benefit limit every calendar year. You pay 100% of any costs over the plan benefit limit.

Cost	2022 (this year)	2023 (next year)
Meals Benefit (Supplemental)	After your inpatient stay in either the hospital or a skilled nursing facility, you are eligible to receive 2 meals per day for 14 days at no extra cost to you. Meal program limited to 6 times per calendar year.	After your inpatient stay in either the hospital or a skilled nursing facility, each COVID-19 positive diagnosis, or each Care Management meal referral for homebound members engaged in a Care Management program, you are eligible to receive 2 meals per day for 14 days at no extra cost to you. Meal program limited to 6 times per calendar year
Over-the-Counter (OTC) Card	You pay nothing for up to $350 allowance per each 3-month (or “quarter”) benefit limit.	You pay nothing for over-the counter (OTC) products, up to the $125 per month limit.
Vision Care (supplemental)	Through the VSP Choice Network: • You pay nothing for one Well Vision exam every year. • You pay nothing for supplemental hardware up to the $400 plan benefit limit every two years. Outside the VSP Choice Network: • You pay nothing up to the plan benefit limit. You pay for any costs over the plan benefit limit.	Through the VSP Choice Network: • You pay nothing for one Well Vision exam every year. • You pay nothing for supplemental hardware up to the $500 plan benefit limit every year. Outside the VSP Choice Network: • You pay nothing up to the plan benefit limit. You pay for any costs over the plan benefit limit.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. The Drug List includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Customer Service or visiting our website (*medicare.chpw.org*).

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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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

Starting in 2023, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Changes to Prescription Drug Costs

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is $0 to $480, depending on the level of "Extra Help" you receive.	Your deductible amount is $0 to $505, depending on the level of "Extra Help" you receive.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: You pay $0 - $9.85 per prescription. Once your total drug costs have reached $4,430, 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: You pay $0 per prescription Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Changes to your VBID Part D Benefit

Because CHPW is approved to offer VBID Model Part D benefits, *CHPW MA Dual Plan* offers $0 Part D Cost-Share for prescription drugs.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in *CHPW MA Dual Plan*

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 *CHPW MA Dual 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 2023 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Community Health Plan of Washington offers other Medicare health 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 *CHPW MA Dual Plan*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *CHPW MA Dual Plan*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so. You can call Customer Service at 1-800-942-0247 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

- *– 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, 2023.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

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

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA 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 SHIBA at 1-800-562-6900.You can learn more about SHIBA by visiting their website (insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba).

For questions about your Washington State Medicaid benefits, contact Washington State Health Care Authority, 1-800-562-3022, TTY 1-800-848-5429, available 7:30am to 5:00pm, Monday through Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Washington State Medicaid 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Washington has a program called Washington State Health Insurance Pool (WSHIP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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 Washington State Early Intervention Program (EIP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call EIP at 1-877-376-9316 or email Ask.EIP@doh.wa.gov.

SECTION 6 Questions?

Section 6.1 – Getting Help from *CHPW MA Dual Plan*

Questions? We're here to help. Please call Customer Service at 1-800-942-0247. (TTY only, call 711.) We are available for phone calls 8:00am to 8:00pm. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for *CHPW MA Dual Plan.* 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 medicare.chpw.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at medicare.chpw.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 Website

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

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Washington State Health Care Authority at 1-800-562-3022. TTY users should call 1-800-848-5429.