2022
Annual Notice of Changes

Senior Whole Health (HMO D-SNP) and Senior Whole Health NHC (HMO D-SNP)

Massachusetts H2224-001, 003

Serving the following counties: Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk and Worcester

Effective January 1 through December 31, 2022

Senior Whole Health®
BY MOLINA HEALTHCARE

Senior Whole Health NHC (HMO D-SNP) *and* Senior Whole Health (HMO D-SNP)

Offered by Molina Healthcare, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Senior Whole Health NHC (HMO D-SNP) or Senior Whole Health (HMO D-SNP). 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 Section 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 3.2 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 Senior Whole Health (HMO D-SNP) or Senior Whole Health NHC (HMO D-SNP).
- 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 3, page 15 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 Senior Whole Health (HMO D-SNP) or Senior Whole Health NHC (HMO D-SNP).
- 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 Services number at 1-888-794-7268 (TTY 711) from 8 a.m. to 8 p.m., 7 days a week for additional information.

- This document is available for free in Spanish.
- Esta información está disponible gratuitamente en otros idiomas y en formatos alternativos. Por favor comuníquese con el número de Servicios al Miembro al 1-888-794-7268 (TTY 711). El horario de atención es de 8 a.m. a 8 p.m., los siete (7) días de la semana.
- This information is available in other formats, such as braille, large print, and audio.
- **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 Senior Whole Health (HMO D-SNP) & Senior Whole Health NHC (HMO D-SNP)

- Product offered by Senior Whole Health of Massachusetts, LLC, a wholly owned subsidiary of Molina Healthcare, Inc.
- Senior Whole Health (HMO D-SNP) and Senior Whole Health NHC (HMO D-SNP) are Coordinated Care plans with a Medicare Advantage contract and a contract with the Commonwealth of Massachusetts/ EOHHS MassHealth Medicaid program. Enrollment depends on annual contract renewal.
- When this booklet says "we," "us," or "our," it means Senior Whole Health, LLC. When it says "plan" or "our plan," it means Senior Whole Health (HMO D-SNP) or Senior Whole Health NHC (HMO D-SNP).
- This is not a complete description of benefits. Call 1-888-794-7268 (TTY 711) for more information.
- Out-of-network/non-contracted providers are under no obligation to treat Senior Whole Health members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
- Senior Whole Health/Senior Whole Health NHC (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.
- Molina Healthcare, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Senior Whole Health (HMO D-SNP) and Senior Whole Health NHC (HMO D-SNP) 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.SWHMA.com You may also call Member Services 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.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium	**$0**	**$0**
Doctor office visits	Primary care visits: **$0 per visit** Specialist visits: **$0 per visit**	Primary care visits: **$0 per visit** Specialist visits: **$0 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**.**	**$0 per stay**	**$0 per stay**

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage See Section 1.6 for details	Deductible: **$0** Copayment during the Initial Coverage Stage: **Generic and preferred multi-source drugs:** You pay **$0** per prescription **All other drugs:** You pay **$0** per prescription.	Deductible: **$0** Copayment during the Initial Coverage Stage: **Generic and preferred multi-source drugs:** You pay **$0** per prescription **All other drugs:** You pay **$0** per prescription.
Maximum out-of-pocket amount See Section 1.2 for details.	**$0** 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.	**$0** 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.

Annual Notice of Changes for 2022

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**	**$0**

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." Typically, once you reach this 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	**$0** 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.	**$0** 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 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.SWHMA.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/ Pharmacy 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 *Provider/Pharmacy Directory* is located on our website at www.SWHMA.com. You may also call Member Services for updated pharmacy 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 and Medicaid 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), in your *2022 Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at www.SWHMA.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Item	2021 (this year)	2022 (next year)
Medicare Part B step therapy	Does not apply	*Part B step therapy may be required when receiving Part B prescription drugs.*
Opioid treatment program services	Opioid use disorder (OUD) treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Prior authorization is not required.	Members of our plan with opioid use disorder (OUD) can receive expanded 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 & group therapy • Toxicology testing • Intake activities • Periodic assessments *Prior authorization may be required.*
Other health care professional services • **Mental health specialty services** • **Psychiatric services** • **Additional telehealth services**	Prior authorization is not required.	*Prior authorization may be required.*
Outpatient diagnostic tests and therapeutic services and supplies	Prior authorization **may be required.**	Prior authorization is not required for outpatient x-ray services.
Outpatient hospital services: observation	**Prior authorization is required.**	Prior authorization is not required.

Item	2021 (this year)	2022 (next year)
Over-the counter-items	Maximum reimbursement every 3 months is $110.	Maximum allowance every 3 months is $160.
Personal Emergency Response System (PERS) This benefit is an in-home medical alarm system that can get you help in an emergency.	Prior authorization is not required.	Member must meet qualifying criteria. Your Case Manager will decide if you qualify for this benefit. *Prior authorization may be required.*
Physical fitness benefit	$40/month for health club membership	No reimbursement for health club membership. Members have access to: • Home fitness kit • Activity tracker • Contracted fitness facilities
Remote access technology • **Nursing hotline**	Not available	Prior authorization is not required.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	Limited service	Eight (8) more visits are offered in addition to Medicare's visits. Prior authorization is not required for these additional sessions.

Item	2021 (this year)	2022 (next year)
Special supplemental benefits for the chronically ill • **Transportation for non-medical needs**	• Beneficiaries who qualify are eligible for non-medical transportation (e.g., to church or grocery store), provided by the plan's medical transportation vendor, to plan-approved locations.	• Beneficiaries who qualify are eligible for non-medical transportation (e.g., to church or grocery store), provided by the plan's medical transportation vendor, rideshare services or taxi to plan-approved locations.
• **Groceries and produce**	• Maximum 24 one-way trips per year, to a single destination, up to 25 miles in one direction • No groceries or produce benefit	• Maximum 75 one-way trips per year, to a single destination, up to 25 miles in one direction • Beneficiaries with a chronic illness are also eligible for a Healthy You debit card. ○ Provides allowances that may be used towards fresh produce and groceries ○ $100 quarterly/ maximum $400 annually Coverage provided for those who have a medical condition including but not limited to all listed Chronic Conditions in the *Evidence of Coverage (EOC).* *Participation in a care management program is required*
Vision benefits • **Eye exams**	**Prior authorization is required.**	Prior authorization is not required.
• **Eyewear**	Prior authorization is not required.	*Prior authorization may be required.*

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 8 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 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 a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

Current formulary exceptions will be covered until the date on the approval letter sent to you. Authorizations span calendar years and you will receive a letter from us 45 days before your current authorization expires reminding you of the expiration.

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"), t**he information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and 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 stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

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

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 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 or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic and preferred multi-source drugs:** You pay **$0** per prescription. **All other drugs:** You pay **$0** per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic and preferred multi-source drugs:** You pay **$0** per prescription. **All other drugs:** You pay **$0** per prescription.

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* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Item	2021 (this year)	2022 (next year)
Administrative changes On January 1, 2021, Senior Whole Health of Massachusetts was acquired by Molina Healthcare, Inc.	S W H Senior Whole Health A MAGELLAN COMPANY	S W H Senior Whole Health BY MOLINA HEALTHCARE
• Owner and administrator of your health plan	Senior Whole Health and Senior Whole Health NHC *a Magellan Company* 1075 Main Street, Suite 400 Waltham, MA 02451	Senior Whole Health (HMO D-SNP) and Senior Whole Health NHC (HMO D-SNP) *by Molina Healthcare* 1075 Main Street, Suite 400 Waltham, MA 02451
• Claims address	Senior Whole Health Claims Department P.O. Box 956 Elk Grove Village, IL 60009-0956	Senior Whole Health (HMO D-SNP) Claims Department 7050 Union Park Center Suite 200 Midvale, UT 84047
• Member direct reimbursement address	Senior Whole Health Attn: Claims Operations – Member Reimbursement 1075 Main Street, Suite 400 Waltham, MA 02451	Senior Whole Health (HMO D-SNP) Attn: Medicare Member Services P.O. Box 22640 Long Beach, CA 90809
• Behavioral health services	Magellan Complete Care Behavioral Health	Molina Healthcare Behavioral Health
• Pharmacy services	Express Scripts	CVS/caremark

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Senior Whole Health (HMO D-SNP)

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 Senior Whole Health for 2022.

Section 3.2 – 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 *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 Senior Whole Health (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Senior Whole Health (HMO D-SNP).
- 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.

  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 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to 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 9, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts, the SHIP is called Serving Health Information Needs of Everyone (SHINE).

SHINE 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. SHINE 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 SHINE at 1-800-243-4636. To be connected to a local SHINE counselor and schedule an appointment call MassOptions at 1-800-243-4636. MassRelay 711 or 1-800-439-0183 (voice) TTY/ASCII 1-800-439-2370.

For questions about your MassHealth benefits, contact MassHealth at 1-800-841-2900 (TTY 1-800-497-4648) Monday through Friday from 8 a.m. to 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get MassHealth coverage.

You may also contact My Ombudsman for help with your MassHealth (Medicaid) benefits. My Ombudsman is a group that helps individuals, including their families and caregivers, address concerns or questions that may impact their experience with their health plan or the ability to access health plan benefits and services. My Ombudsman works with the member, MassHealth, and the health plan to help resolve concerns and ensure you receive your benefits and rights within your plan. They can help you file a grievance or appeal with our plan. My Ombudsman is neutral. My Ombudsman can be reached at 1-855-781-9898 (TTY 711) Monday through Friday from 9 a.m. to 4 p.m.

To get help in person, visit their office at:

11 Dartmouth Street
Suite 301 Malden, MA 02148

Walk-in hours are Monday from 1 p.m. to 4 p.m. and Thursday from 9 a.m. to 12 p.m. For more information, visit www.myombudsman.org.

SECTION 6 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 a.m. and 7 p.m., 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. Massachusetts has a program called Prescription Advantage 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 5 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 HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Community Research Initiative of New England/HDAP at 1-800-228-2714.

SECTION 7 Questions?

Section 7.1 – Getting Help from Senior Whole Health (HMO D-SNP)

Questions? We're here to help. Please call Member Services at 1-888-794-7268 (TTY 711). We are available for phone calls from 8 a.m. to 8 p.m., 7 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 Senior Whole Health (HMO D-SNP) or Senior Whole Health NHC (HMO D-SNP). 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.SWHMA.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 7.2 – 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 7.3 – Getting Help from Medicaid

To get information from MassHealth (Medicaid) you can call MassHealth at 1-800-841-2900, Monday through Friday 8:00 a.m. – 8:00 p.m. TTY users should call 1-800-497-4648.

Getting Important Plan Materials

Senior Whole Health
BY MOLINA HEALTHCARE

How to Get Important Plan Documents

You are important to us! We make it easy for you to get the information you need. You can go online anytime, anywhere, from any device to:

- Read important plan documents
- Find a network provider or pharmacy
- Look up your prescription drugs

Your 2022 plan documents, like your Evidence of Coverage, Formulary, and Provider/Pharmacy Directory, will be available online by **October 15, 2021**.

Get to know your plan documents

- **Evidence of Coverage (EOC):** A guide to what's covered under your plan. It has details about your plan benefits and coverage, member rights, and more.
- **Formulary (Drug List):** A list of covered drugs under your plan.
- **Provider/Pharmacy Directory:** A list of network doctors, specialists, and pharmacies with phone numbers and addresses.

For more information: Learn more about your Senior Whole Health plan. Visit **www.SWHMA.com.**

How to see or request your plan documents:

View or download a copy of your documents online. Use any device – computer, tablet, or mobile phone. Visit **www.SWHMA.com**.

Visit our self-service member portal: You can view your plan documents and find a network provider or pharmacy. Beginning January 1, 2022, please visit **MyMolina.com**. Click "Create an Account" and follow the step-by-step instructions to sign up.

Call us toll-free: Let us know if you don't have computer access or if you prefer to have a printed copy of an EOC, Formulary, or Provider/Pharmacy Directory mailed to you. If you have questions about your benefits or need help finding a network provider or pharmacy, call us from Monday - Friday (from October 1-March 31, 7 days a week), 8 a.m. to 8 p.m., local time.

Member Services (888) 794-7268, TTY: 711

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