2022
Annual Notice of Changes

Molina Medicare Choice Care (HMO)

Utah H5628_007

Serving the following counties: Box Elder, Cache, Davis, Salt Lake, Summit, Tooele, Utah, and Weber

Effective January 1 through December 31, 2022.

MOLINA® HEALTHCARE

Molina Medicare Choice Care (HMO) offered by Molina Healthcare of Utah, Inc.

Annual Notice of Changes for 2022

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

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 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.

OMB Approval 0938-1051 (Expires: February 29, 2024)

- 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 Molina Medicare Choice Care (HMO).
   - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.
4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
   - If you don't join another plan by **December 7, 2021**, you will be enrolled in Molina Medicare Choice Care.
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at (877) 644-0344 for additional information. (TTY users should call 711.) Hours are 7 days a week, 8:00 a.m. to 8:00 p.m., local time.
- You can also ask for this information in other formats, such as audio, braille, or 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Molina Medicare Choice Care (HMO)

- Molina Medicare Choice Care HMO is a Health Plan with a Medicare Contract. Enrollment in Molina Medicare Choice Care depends on contract renewal.
- Molina Healthcare 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.
- When this booklet says "we," "us," or "our," it means Molina Healthcare of Utah, Inc.. When it says "plan" or "our plan," it means Molina Medicare Choice Care (HMO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Molina Medicare Choice Care (HMO) 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.MolinaHealthcare.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$5,400	$5,400
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $40 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $40 copay 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.	The amounts for each benefit period are: $295 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay for unlimited additional days	The amounts for each benefit period are: $295 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 $0 copay per day for 60 lifetime reserve days

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $8 copay • Drug Tier 3: $45 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% of the cost • Drug Tier 6: $0 copay	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $8 copay • Drug Tier 3: $45 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% of the cost • Drug Tier 6: $0 copay

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SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Part B premium reduction	Not Applicable	$49

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see section 6 regarding "Extra Help" from Medicare.

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 Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount 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.	$5,400	$5,400 Once you have paid $5,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.MolinaHealthcare.com/Medicare. 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.MolinaHealthcare.com/Medicare. 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 which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at www.MolinaHealthcare.com/Medicare. You may also call Member Services 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)
Inpatient hospital care	You pay a $295 copay per day for days 1 through 6. You pay a $0 copay per day for days 7 and beyond for inpatient hospital care for an unlimited number of days.	You pay a $295 copay per day for days 1 through 6. You pay a $0 copay per day for days 7 through 90 and for each lifetime reserve day you use.
Urgently needed services	You pay a $40 copay for per visit.	You pay a $25 copay per visit.
Worldwide emergency/urgent coverage (Supplemental)	You pay $90 copay for these services. $10,000 allowance every calendar year.	You pay $0 copay for these services. $10,000 allowance every calendar year.

Cost	2021 (this year)	2022 (next year)
Podiatry services (Medicare-covered)	You pay a $40 copay per visit Some routine services require prior authorization. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.	You pay a $0 copay per visit There may be changes to some routine services that require prior authorization. As long as you are seeing a Provider in our network, that Network Provider will obtain any prior authorization required. If you use an out-of-network provider, you will need to obtain Prior Authorization. Please contact Member Services for assistance. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.
Transportation - Non-emergency (Supplemental)	Not covered	$125 allowance every quarter (3 months) for use to access your choice of OTC or Transportation services. Allowance expires at the end of each quarter and does not roll over to the next quarter. Simply use your MyChoice Debit Card to pay the Provider at the time services are rendered.
Over-the-counter (OTC) items (Supplemental)	$45 every quarter (3 months) to spend on plan-approved OTC items.	$125 allowance every quarter (3 months) for use to access your choice of OTC or Transportation services. Allowance expires at the end of each quarter and does not roll over to the next quarter. Simply use your MyChoice Debit Card to pay the Provider at the time services are rendered.

Cost	2021 (this year)	2022 (next year)
Meal benefit (Supplemental)	Not covered	Under this benefit, the plan's case manager will identify which members qualify. A standard meal cycle is a 2-week menu with a total of 28 meals delivered to the member, based on member's need. Maximum of 4 weeks a year, total of 56 meals.
Post discharge in-home medication reconciliation (Supplemental)	You pay a $0 copay for these services.	Not covered
In-home support services (Supplemental)	Not covered	Those that qualify can receive up to 192 hours per calendar year. There is a $0 copay for these services. Please refer to your Evidence of Coverage for specific criteria and requirements for coverage.
Part B Step Therapy (Requires you to try a specific drug to see if that can help you before another drug is approved.)	Not covered	Part B Step Therapy may apply to Part B drugs.
Dental services (Supplemental)	$1,300 maximum allowance each calendar year for all supplemental comprehensive dental services, including dentures.	$1,300 allowance every year for use to access routine dental services. You will also receive a discount card to be able to access reduced rates at certain providers just by showing your card. You no longer need to use the plan's vendor to access these services. Simply use your MyChoice Debit Card to pay the Provider.

Cost	2021 (this year)	2022 (next year)
Vision care (Supplemental)	You pay a $40 copay for up to one routine eye exam and refraction exam every calendar year. $150 every 2 calendar years for eyewear. Benefits must be provided by the plan's contracted vendor Some routine services require prior authorization. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.	$150 allowance every year for eyewear and routine vision services. You will also receive a discount card to be able to access reduced rates at certain providers just by showing your card. You no longer need to use the plan's vendor to access these services. Simply use your MyChoice Debit Card to pay the Provider. There may be changes to some routine services that require prior authorization. As long as you are seeing a Provider in our network, that Network Provider will obtain any prior authorization required. If you use an out-of-network provider, you will need to obtain Prior Authorization. Please contact Member Services for assistance. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.
Hearing services (Supplemental)	You are allowed one fitting/evaluation for hearing aids every 2 calendar years. Maximum benefit allowance of $600 for hearing aids every 2 calendar years for both ears combined.	You are allowed one fitting/evaluation for hearing aids every calendar year. Maximum benefit of up to 2 pre-selected hearing aids from a plan-approved provider each calendar year.

Cost	2021 (this year)	2022 (next year)
Prior Authorizations	Prior authorization may not be required for the following benefits: -Additional telehealth services -Mental health specialty services -Outpatient substance abuse services -Psychiatric services Some routine services require prior authorization. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.	Prior authorization may be required for the following benefits: -Additional telehealth services -Mental health specialty services -Outpatient substance abuse services -Psychiatric services There may be changes to some routine services that require prior authorization. As long as you are seeing a provider in our network, that network provider will obtain any prior authorization required. If you use an out-of-network provider, you will need to obtain prior authorization. Please contact Member Services for assistance. Prior authorization is not required to obtain emergent/urgently needed services or out of area renal dialysis.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Not covered	Those that qualify will receive a $150 allowance every quarter (3 months) for use to access one or more of the following supplemental benefits: - Mental Health & Wellness Applications - Pest Control - Service Animal Supplies - Non-Medicare covered Genetic Test kits Upon approval, your MyChoice Debit card will be loaded with your allowance to access your benefit. Allowance expires at the end of each quarter and

Cost	2021 (this year)	2022 (next year)
		does not roll over to the next quarter.
Food and produce	Not covered	$30 allowance every month for healthy food and produce. Upon approval, your MyChoice Debit card will be loaded with your allowance to access your benefit.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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"), **the 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. Because you receive "Extra Help" and haven't received this insert by September 30, 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 at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.MolinaHealthcare.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	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	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:

Stage	2021 (this year)	2022 (next year)
During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**.	***Preferred Generic - Tier 1:*** You pay $2 copay per prescription. ***Generic - Tier 2:*** You pay $8 copay per prescription. ***Preferred Brand - Tier 3:*** You pay $45 copay per prescription. ***Non-Preferred Drug - Tier 4:*** You pay $100 copay per prescription. ***Specialty Tier - Tier 5:*** You pay 33% of the cost. ***Select Care Drugs - Tier 6:*** You pay $0 copay per prescription.	***Preferred Generic - Tier 1:*** You pay $2 copay per prescription. ***Generic - Tier 2:*** You pay $8 copay per prescription. ***Preferred Brand - Tier 3:*** You pay $45 copay per prescription. ***Non-Preferred Drug - Tier 4:*** You pay $100 copay per prescription. ***Specialty Tier - Tier 5:*** You pay 33% of the cost. ***Select Care Drugs - Tier 6:*** You pay $0 copay per prescription.
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (31-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*.	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	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 other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Molina Medicare Choice Care (HMO)

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 Molina Medicare Choice Care.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

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

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

Step 2: Change your coverage

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

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

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

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

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

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Utah, the SHIP is called Division of Aging and Adult Services.

Division of Aging and Adult Services 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. Division of Aging and Adult Services 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 Division of Aging and Adult Services at County Contacts:
Box Elder: (435) 713-1467
Cache: (435) 713-1467
Davis: (801) 525-5050
Salt Lake: (385) 468-3200
Summit: (435) 333-1500
Tooele: (435) 277-2440
Utah: (801) 229-3800
Weber: (801) 625-3770
General Statewide Phone: (800) 541-7735
You can learn more about Division of Aging and Adult Services by visiting their website (https://daas.utah.gov/).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the The Ryan White Part B Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (801) 538-6197.

SECTION 6 Questions?

Section 6.1 – Getting Help from Molina Medicare Choice Care (HMO)

Questions? We're here to help. Please call Member Services at (877) 644-0344. (TTY only, call 711). We are available for phone calls 7 days a week, 8:00 a.m. to 8:00 p.m., local time. 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 Molina Medicare Choice Care (HMO). 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.MolinaHealthcare.com/Medicare. 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.MolinaHealthcare.com/Medicare. 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.

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