Virginia Premier Advantage Elite (HMO D-SNP) offered by Virginia Premier

Annual Notice of Changes for 2022

You are currently enrolled as a member of Virginia Premier Advantage Elite. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1, 1.2 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.

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

☐ 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 and 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 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 Virginia Premier Advantage Elite.
- 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 Virginia Premier Advantage Elite.
- 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 1-877-739-1370 for additional information. (TTY users should call 711.) From October 1 to March 31, we are open from 8:00 am to 8:00 pm, 7 days a week. From April 1 through September 30, we are open Monday through Friday, 8:00 am to 8:00 pm. On certain holidays and weekends between April 1 through September 30, your call will be handled by our automated phone system.
- Virginia Premier:
    - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
        - 711 TTY: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
        - Qualified sign language interpreters
        - Written information in other formats (such as large print and accessible electronic formats)
    - Provides free language services to people whose primary language is not English, such as:
        - Qualified interpreters
        - Information written in other languages
- **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 Virginia Premier Advantage Elite

- Virginia Premier is an HMO D-SNP with a Medicare Contract. Enrollment in Virginia Premier Plan depends on contract renewal. The plan also has a written agreement with the Virginia Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means Virginia Premier. When it says "plan" or "our plan," it means Advantage Elite.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Advantage Elite 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 virginiapremier.com/members/medicare-plan-documents/. 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.

These are 2021 cost-sharing amounts and may change for 2022. Advantage Elite will provide updated rates as soon as they are released.

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
Doctor office visits	Primary care visits: $0 Copay per visit Specialist visits:$0 Copay per visit	Primary care visits: $0 Copay per visit Specialist visits:$0 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.	$0	$0
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage:	Deductible: $0 Copayment during the Initial Coverage Stage:

Cost	2021 (this year)	2022 (next year)
	• Drug Tier 1: You pay $0-$3.70 per prescription • Drug Tier 2: You pay $0-$9.20 per prescription	• Drug Tier 1: You pay $0-$3.95 per prescription • Drug Tier 2: You pay $0-$9.85 per prescription
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 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.	$7,550 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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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." 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 **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550	$7,550 Once you have paid $7,550 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 and Pharmacy Directory* is located on our website at virginiapremier.com/members/medicare-plan-documents/. You may also call Member Services for updated provider information or to ask us to mail you *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and 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 and Pharmacy Directory* is located on our website at virginiapremier.com/members/medicare-plan-documents/. You may also call Member Services for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

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

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered)*, in your 2022 *Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at virginiapremier.com/members/medicare-plan-documents/. 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)
Additional Sessions of Smoking and Tobacco Cessation Counseling	Additional Sessions of Smoking and Tobacco Cessation Counseling not covered.	You pay $0 copay for this benefit.
Additional Teleheath Services	Additional Telehealth Services covered.	Additional Telehealth Services not covered.
Comprehensive Dental	There is $3,000 allowance every year.	There is $4,000 allowance every year.

Cost	2021 (this year)	2022 (next year)
Emergency Care	Coinsurance for Medicare-covered Benefits is not waived if admitted to hospital.	Coinsurance for Medicare-covered Benefits is waived if admitted to hospital within 24-hours.
Enhanced Disease Management	COPD Enhanced Disease Management not covered. AccordantCare™ not covered. Onduo not covered.	You pay $0 copay for enhanced disease management for COPD. This is a home-based enhanced disease management program for members with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Prior authorization required. You pay $0 copay for AccordantCare™. The AccordantCare™ Program is designed to help eligible members better manage their clinical conditions and improve their overall health status. You pay $0 copay for OnduoVirtual Diabetes Program. The Onduo Diabetes Program is a virtual care center that provides eligible members with daily access to tools and diabetes experts.

Cost	2021 (this year)	2022 (next year)
Eye Exams- Routine Eye Exams	Routine Eye Exam not covered.	You pay $0 copay for this benefit. 1 exam per 12-months.
Eyewear	There is $250 allowance every year. Frames and Lens Package covered. Eyeglasses or Contact Lenses are covered.	There is $300 allowance every year. Frames and Lens Package not covered. Eyeglasses or Contact Lenses covered.
Fitness Benefit	You pay $0 copay for this benefit. Benefit offered through Silver & Fit.	You pay $0 copay for SilverSneakers® Membership. Benefit offered through SilverSneakers®.
Fitting Evaluation for Hearing Aid	You receive 4 Fitting/Evaluations for Hearing Aids per year.	You receive 3 Fitting/Evaluation for Hearing Aids per year.
Fluoride Treatment	Flouride Treatment not covered.	You pay $0 copay for this benefit. 1 per 12 months.
Health Education	Health Education not covered.	You pay $0 copay for this benefit.
Hearing Aids (all types)	You receive 1 hearing aid every three years. There is $1,250 allowance every three years.	You receive 2 hearing aids every year. There is $2,000 allowance every year.

Cost	2021 (this year)	2022 (next year)
	Prior authorization required.	No prior authorization required.
Medicare Part B Rx Drugs	Medicare Part B Step-Therapy not required.	Medicare Part B Step-Therapy required.
Nurse Advice Line	Nurse Advice Line not covered	You pay $0 copay for this benefit.
Nutritional/Dietary Benefit	Nutritional/Dietary Benefit not covered.	You pay $0 copay for this benefit.
Over-the-counter (OTC) Items	Benefit offered through CVS. Unspent benefit allowance from one quarter does not carry over future quarters. You can place your order by phone, online, or by visiting one of the twelve OTC enabled CVS stores in the state of Virginia.	Benefit offered through Nations OTC. OTC amount will expire at the end of the quarter You can place your order by phone, online, or by mail.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) not covered.	You pay $0 copay for this benefit.
Post-discharge Meals	Post-discharge Meals not covered.	You pay $0 copay for this benefit. Post-discharge meal benefit available for qualifying members after discharge from an inpatient facility, such as an inpatient hospital or skilled nursing facility.

Cost	2021 (this year)	2022 (next year)
		The benefit includes up to 2 meals per day for 28 days delivered to the member's home.
Routine Foot Care	Prior authorization required.	No prior authorization required.
Special Supplemental Benefits for the Chronically Ill (SSBCI) - Grocery Card & Transportation	Special Supplemental Benefits for the Chronically Ill (SSBCI) - Grocery Card not covered. Special Supplemental Benefits for the Chronically Ill (SSBCI) - Transportation not covered.	Special Supplemental Benefits for the Chronically Ill (SSBCI) - Grocery Card You pay $0 copay for this benefit. Eligible members receive a $75 allowance every month to spend on plan-approved grocery products. If you do not use all your monthly grocery benefit amount when you order, the remaining balance will not accumulate to the next grocery benefit period. Special Supplemental Benefits for the Chronically Ill (SSBCI) - Transportation You pay $0 copay for this benefit. Eligible members have up to 24 one-way trips (in addition to the standard supplemental benefit) to non-primarily health-related locations, approved by the plan.

Cost	2021 (this year)	2022 (next year)
Urgently Needed Services	Coinsurance for Medicare-covered Benefits is not waived if admitted to hospital.	Coinsurance for Medicare-covered Benefits is waived if admitted to hospital within 24-hours.
Worldwide Emergency/Urgent Coverage	Worldwide Emergency Transportation not covered. There is no limit to Worldwide Emergency coverage and Urgent coverage.	You pay $0 copay for this benefit. Worldwide Urgent/Emergent Care and Emergency Transportation Service is limited to $50,000.

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. The Drug List we provided electronically 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 Member Services (see the back cover) or visiting our website virginiapremier.com/members/medicare-plan-documents/.

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 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.

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 if you 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 (31-day) supply when you fill your prescription at a network pharmacy that provides	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Cost-share Tier 1:** You pay $0 to $3.70 copay per prescription. **Cost-share Tier 2:** You pay $0 to $9.20 copay per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Cost-share Tier 1:** You pay $0 to $3.95 copay per prescription. **Cost-share Tier 2:** You pay $0 to $9.85 copay per prescription.

Stage	2021 (this year)	2022 (next year)
standard cost sharing. For information about the costs for a long-term supply or for mail-order prescription, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes **to the Coverage Gap and Catastrophic Coverage Stages**

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or 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 *Virginia Premier Advantage Elite*

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 Virginia Premier Advantage Elite.

Section 2.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

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

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

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

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Virginia Premier Advantage Elite.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Virginia Premier Advantage Elite.
- 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 Changing Plans

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

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (VICAP).

(VICAP) 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. VICAP 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 VICAP at 1-800-552-3402 (TTY 711). You can learn more about VICAP by visiting their website (www.vda.virginia.gov/vicap.htm).

For questions about your Department of Medical Assistance Services (DMAS) benefits, contact DMAS at 1-804-786-7933 Monday through Friday from 8:30 a.m. until 5:00 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your DMAS coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare**. Because you have Medicaid, you are already enrolled in "Extra Help" also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **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 Virginia Medication Assistance Program (VA MAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Virginia Medication Assistance Program (VA MAP) at 1-855-362-0658.

SECTION 6 Questions?

Section 6.1 – Getting Help from Advantage Elite

Questions? We're here to help. Please call Member Services at 1-877-739-1370. (TTY only call the Virginia Relay Service at 1-800-828-1120 or 711.) We are available for phone calls 7 days a week from 8:00 a.m. to 8:00 p.m. ET from October 1, 2021 – March 31, 2022. From April 1, 2022 - September 30, 2022, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. On certain holidays and weekends between April 1 through September 30, your call will be handled by our automated phone system. 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 Virginia Premier Advantage Elite.

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 virginiapremier.com/members/medicare-plan-documents/. 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 virginiapremier.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Virginia Department of Medical Assistance Services (DMAS) at 1-804-786-7933. TTY users should call 711.