Community Health Plan of Washington (CHPW) Dual Select (HMO D-SNP) offered by Community Health Plan of Washington

Annual Notice of Changes for 2024

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

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

What to do now

1. ASK: Which changes apply to you

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

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

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2023, you will stay in *CHPW Dual Select*.
   - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with *CHPW MA Dual Plan*.
   - Look in section 3.2, page 13 to learn more about your choices.
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

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

About *CHPW Dual Select*

- Community Health Plan of Washington is an HMO Plan with a Medicare contract and a contract with the Washington State Medicaid Program. Enrollment in Community HealthPlan of Washington depends on contract renewal.
- When this document says "we," "us," or "our," it means *Community Health Plan of Washington*. When it says "plan" or "our plan," it means *CHPW Dual Select*.

Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for *CHPW Dual Select* in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Washington State Apple Health (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$41.00	$40.60
Doctor office visits	Primary care visits: $0 copayment or 20% per visit Specialist visits: $0 copayment or 20% per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: No change Specialist visits: No change If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.
Inpatient hospital stays	For Medicare-covered hospital stays: With full Medicaid cost share assistance, you pay a $0 copayment. Without Medicaid cost share assistance, you are subject to the Original Medicare cost sharing amounts for 2023.	For Medicare-covered hospital stays: With full Medicaid cost share assistance, you pay a $0 copayment. Without Medicaid cost share assistance, you are subject to the Original Medicare cost sharing amounts for 2024, which

Cost	2023 (this year)	2024 (next year)
		will be set by CMS in the fall of 2023. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. $1,600 deductible for days 1 to 60; $400 copayment each day for days 61 to 90; $800 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0-$505 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $0	Deductible: $0-$545 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $0
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$8,300 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum	$8,850 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-

Cost	2023 (this year)	2024 (next year)
	out-of-pocket amount for covered Part A and Part B services.	of-pocket amount for covered Part A and Part B services.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *CHPW Dual Select* in 2024

On January 1, 2024, *Community Health Plan of Washington* will be transitioning you from *CHPW MA Dual Plan* to *CHPW Dual Select*. The information in this document tells you about the differences between your current benefits in *CHPW MA Dual Plan* and the benefits you will have on January 1, 2024 as a member of *CHPW Dual Select*.

If you do nothing in 2023, we will automatically enroll you in our *CHPW Dual Select plan*. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through *CHPW Dual Select*. If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2024.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$41.00	$40.60

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,300	$8,850 Once you have paid $8,850 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 2.3 – Changes to the Provider and Pharmacy Networks

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

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

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

Section 2.4 – Changes to Benefits and Costs for Medical Services

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

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

Cost	2023 (this year)	2024 (next year)
Dental Services (Supplemental)	You pay nothing for supplemental preventive and comprehensive services up to $5,000 combined total benefit limit per year. You pay 100% of any costs over the plan benefit limit.	You pay nothing for supplemental preventive and comprehensive services up to $500 combined total benefit limit per year. You pay 100% of any costs over the plan benefit limit. Covered supplemental dental services are provided through Delta Dental of Washington and are only covered when provided by a Delta Dental network dentist. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit deltadentalwa.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by out of network dentists. For questions about this benefit, please call Customer Service. Prior authorization rules may apply.
Emergency Care	$0 copayment or 20% coinsurance (up to $95) for each Medicare-covered emergency room visit.	$0 copayment or 20% coinsurance (up to $100) for each Medicare-covered emergency room visit.

Cost	2023 (this year)	2024 (next year)
Grocery Card Medicare approved CHPW to provide these benefits as part of the Value-Based Insurance Design (VBID) program. This program lets Medicare try new ways to improve Medicare Advantage plans. For more information about VBID benefits, please contact Customer Service.	You pay nothing for a prepaid grocery card up to the $50 per month limit	Not Covered
Hearing Services (supplemental)	You pay nothing for one routine hearing exam per year and one hearing aid fitting/evaluation per year. Hearing aids and related supplies for both ears covered up to a combined limit of $2,250 every calendar year.	You pay nothing for one routine hearing exam per year and one hearing aid fitting/evaluation per year. Hearing aids and related supplies for both ears covered up to a combined limit of $2,250 every calendar year. Limit one per ear, per year.
Over-the-Counter (OTC) Card	You pay nothing for over-the counter (OTC) products, up to the $125 per month limit.	Not Covered
Transportation (Supplemental)	You pay nothing for up to 75 one-way trips to plan approved locations each year.	Not Covered
Urgently Needed Services	$0 copayment or 20% coinsurance (up to $60) for each Medicare-covered urgent care visit.	$0 copayment or 20% coinsurance (up to $55) for each Medicare-covered urgent care visit.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

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

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

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

Starting in 2024, we may immediately remove a brand name drug on our "Drug List" if, at the same time, we replace it with a new generic version on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our "Drug List," but immediately move it to a different cost-sharing tier or add new restrictions or both.

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

Changes to Prescription Drug Costs

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Your deductible amount is $0 to $505, depending on the level of "Extra Help" you receive.	Your deductible amount is $0 to $545, depending on the level of "Extra Help" you receive.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: You pay $0 per prescription	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: You pay $0 per prescription

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued) 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; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $5,030, 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**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *CHPW Dual Select*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our *CHPW Dual Select*.

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 plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Community Health Plan of Washington offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *CHPW Dual Select*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *CHPW Dual Select*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
    - – *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 to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

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

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

Because you have Washington State Apple Health (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

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

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA at 1-800-562-6900.You can learn more about SHIBA by visiting their website (insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba).

For questions about your Washington State Apple Health (Medicaid) benefits, contact Washington State Health Care Authority, 1-800-562-3022, TTY 1-800-848-5429, available 7:30am to 5:00pm, Monday through Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Washington State Apple Health (Medicaid) coverage.

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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Washington has a program called Washington State Health Insurance Pool (WSHIP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Washington State Early Intervention Program (EIP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call EIP at 1-877-376-9316 or email Ask.EIP@doh.wa.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from *CHPW Dual Select*

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

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for *CHPW Dual Select.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at medicare.chpw.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at medicare.chpw.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

Section 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

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

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medicaid

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

This page intentionally left blank