Principle Plan (HMO) offered by CCA Medicare Excel (HMO).

Annual Notice of Changes for 2022

You are currently enrolled as a member of Medicare Principle Plan. 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 3.2 and 3.5 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 3.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 3.3 for information about our *Provider 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 5.2 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 Principle Plan.
- 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 Principle Plan.
- 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

- Please contact our Member Services number at 855-959-5855 for additional information. (TTY users should call 711). Hours are between October 1-March 31: Seven Days a week from 8:00a.m.-8:00p.m. Eastern. April 1-September 30: Monday-Friday from 8:00a.m.-8:00p.m ET.

- We can also give you information in braille, in large print, or other alternate formats at no cost if you need it.
- **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 Principle Plan

- Principle Plan is an HMO with a Medicare contract. Enrollment in Principle Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means: CCA Medicare Excel (HMO, Inc. When it says "plan" or "our plan," it means Principle Plan.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Principle Plan 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.ccahealthmi.org. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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 3.1 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 3.2 for details.)	$5,900	$5,900
Doctor office visits	Primary care visits: $0 copay Specialist visits: $45 copay per visit	Primary care visits: $0 copay Specialist visits: $45 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.	$230 copay per day for days 1 – 7 $0 per day for days 8 - 90	$315 copay per day for days 1 – 6 $0 per day for days 7 - 90

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 3.6 for details.)	Deductible: $125 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Standard: $6 Preferred: $2 • Drug Tier 2 Standard: $15 Preferred: $10 • Drug Tier 3: Standard: $47 Preferred: $47 • Drug Tier 4: Standard: $100 Preferred: $100 • Drug Tier 5: Standard: 30% Preferred: 30%	Deductible: $0 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Standard: $6 Preferred: $2 • Drug Tier 2 Standard: $15 Preferred: $10 • Drug Tier 3: Standard: $47 Preferred: $47 • Drug Tier 4: Standard: $100 Preferred: $100 • Drug Tier 5: Standard: 30% • Preferred: 30%

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from Medicare Principle Plan to Principle Plan.

This name change will not impact any other communications you receive from us. You will receive a new member ID card in the mail in December 2021.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Principle Plan in 2022

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our Principle Plan. This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through Principle Plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Medicare Principle Plan and the benefits you will have on January 1, 2022 as a member of Principle Plan.

SECTION 3 Changes to Benefit and Cost for Next Year

Section 3.1 – 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	There is no change for the upcoming benefit year.

- 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 7 regarding "Extra Help" from Medicare.

Section 3.2 – 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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,900 Once you have paid $5,900 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.	There is no change for the upcoming benefit year.

Section 3.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.ccahealthmi.org. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider 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 3.4 – 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.ccahealthmi.org. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 3.5 – 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.*

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 Services	You pay a $230 copay per day for days 1 – 7. You pay $0 per day for days 8 – 90.	You pay a $315 copay per day for days 1 – 6. You pay $0 per day for days 7 – 90.
Psychiatric Inpatient Hospital Services	You pay a $250 copay per day for days 1 – 7. You pay $0 per day for days 8 – 90.	You pay a $310 copay per day for days 1 – 6. You pay $0 per day for days 7 – 90.
Outpatient Diagnostic Procedures, Tests and Lab Services	You pay $0 for COVID-19 testing and a $20 copay for all other diagnostic procedures and tests. You pay $0 for lab services performed in a Primary Care Physician (PCP) office and a $20 copay for lab services performed in a specialist office or facility.	You pay a $20 copay for diagnostic procedures and tests. You pay $0 for lab services.
Over-the-Counter (OTC) Items	You may purchase up to $400 every year of certain OTC items.	You may purchase up to $375 every year of certain OTC items.
Meal Benefit	You pay $0 for 14 meals in a 7-day period following discharge from the hospital. This benefit is limited to one hospital discharge per year.	You pay $0 for 14 meals in a 7-day period following surgery or discharge from the hospital. This benefit applies to unlimited hospital discharges per year.

Cost	2021 (this year)	2022 (next year)
Preventive Dental Services	You pay $0 for 1 oral exam every 6 months.	You pay $0 for 2 periodic oral exams per year and 1 comprehensive oral exam every 3 years.
	You pay $0 for 1 prophylaxis (cleaning) every 6 months.	You pay $0 for 2 prophylaxis (cleanings) per year.
	You pay $0 for 1 fluoride treatment every 6 months.	You pay $0 for 2 fluoride treatments per year.
	You pay $0 for 1 set of dental x-rays per year.	You pay $0 for 1 set of bitewing X-rays per year, and 1 set of panoramic or full mouth (complete series) X-rays every 3 years. Bitewing X-rays are not payable in the same year as the full mouth series.
	Emergency palliative treatment and brush biopsy procedures are <u>not</u> covered.	You pay $0 for emergency palliative treatment and brush biopsy procedures.
Eye Exams	You pay a $15 copay per visit for Medicare-covered eye exams.	You pay $0 for Medicare-covered eye exams.
	You pay a $15 copay for one routine eye exam per year.	You receive a $200 allowance on a pre-paid Mastercard that can be used to pay for a routine eye exam. This allowance is combined with the allowance for eyeglass lenses, eyeglass frames, contact lenses, and eyewear upgrades combined per year.

Cost	2021 (this year)	2022 (next year)
Eyewear	You pay a $15 copay for Medicare-covered eyewear. Our plan pays up to $100 every year for routine eyeglasses (frames and lenses) or one pair of elective contact lenses. You pay a $15 copay. Upgrades are not covered.	You pay $0 for Medicare-covered eyewear. You receive a $200 allowance on a pre-paid Mastercard that can be used to pay for eyeglass lenses, eyeglass frames, contact lenses, and eyewear upgrades. This allowance is combined with the allowance for routine eye exams.

Section 3.6 – 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 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 (www.ccahealthmi.org).

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

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.

Formulary exceptions carry over from 2020 to 2021 no further action will be needed.

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.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

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

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" if you haven't received this insert by October 1, 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 at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.ccahealthmi.org. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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	The deductible is $125. Does not apply to Tier 1 and Tier 2. During this stage, you pay $6 standard cost sharing and $2 preferred cost sharing for drugs on Tier 1, $15 standard cost sharing and $10 preferred cost sharing for drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	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*.

	2021 (this year)	2022 (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.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. 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*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $6 per prescription. *Preferred cost sharing:* You pay $2 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. **Tier 5 Specialty Tier:** *Standard cost sharing:* You pay 30% of the total cost. *Preferred cost sharing:* You pay 30% of the total cost. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $6 per prescription. *Preferred cost sharing:* You pay $2 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. **Tier 5 Specialty Tier:** *Standard cost sharing:* You pay 30% of the total cost. *Preferred cost sharing:* You pay 30% of the total cost. _____ 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 4 Administrative Changes

Description	2021 (this year)	2022 (next year)
Dental Provider	Dental benefits are provided by Argus.	Dental benefits are provided by Delta Dental of Michigan.
Vision Provider	Vision benefits are provided by Argus.	NationsBenefit administers the pre-paid Mastercard that can be used for routine vision services.
Fax number for appeals and grievances for medical services	813-472-8203	888-918-2993
Address for appeals and grievances for medical services	Medicare Advantage PO Box 25677 Tampa, FL 33622	Medicare Adv AP/GR PO Box 94770 Lubbock, TX 79493 – 4770

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Principle Plan

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

Section 5.2 – 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 7), or call Medicare (see Section 9.2).

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.**

As a reminder, CCA Health 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 Principle Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Principle Plan.
- 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 9.1 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 6 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 7 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 Michigan the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

MMAP 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. MMAP 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 MMAP at 1-800-803-7174. You can learn more about MMAP by visiting their website (www mmapinc.org).

SECTION 8 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 Michigan HIV/AIDS Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-888-826-6565, Monday through Friday 8:00 a.m. to 5:00 p.m.

SECTION 9 Questions?

Section 9.1 – Getting Help from Principle Plan

Questions? We're here to help. Please call Member Services at 855-959-5855. (TTY only, call 711). We are available for phone calls between October 1 - March 31: Seven Days a week from 8:00a.m.-8:00p.m. ET. April 1 - September 30: Monday-Friday from 8:00a.m.-8:00p.m ET. 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 *Principle Plan.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.ccahealthmi.org
You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. 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.ccahealthmi.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 9.2 – 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.