

CCHP Senior Value Program (HMO) offered by Chinese Community Health Plan

Annual Notice of Changes for 2024

You are currently enrolled as a member of *CCHP Senior Value Program (HMO)*. 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 www.CCHPHealthPlan.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **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.
 - 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, deductibles, 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 www.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 *CCHP Senior Value Program (HMO)*.
- 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 *CCHP Senior Value Program (HMO)*.
- 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

- This document is available for free in *Chinese and Spanish*.
- Please contact our Member Services number at 1-888-775-7888 for additional information. (TTY users should call 1-877-681-8898.) Hours are *7 days a week from 8:00 a.m. to 8:00 p.m. during the open enrollment period (October 1 - March 31). During the non-open enrollment period (April 1 – September 30), the hours are Mondays – Fridays 8:00 a.m. to 8:00 p.m.* This call is free.
- 此文件有其它的語言版本免費提供。了解詳情請致電：1-888-775-7888 與會員服務中心聯絡。(聽力殘障人士請電 TTY1-877-681-8898) · 10月1日至3月31日期間, 每週七天 · 上午 8 時至晚上 8 時 · 4月1日至9月30日期間, 週一至週五 · 上午 8 時至晚上 8 時 · 會員服務中心也有提供免費其它語言的口譯服務。
- Por favor comuníquese con nuestro número de Servicios para Miembros al 1-888-775-7888 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-877-681-8898). El horario es los 7 días de la semana, de 8:00 a. m. a 8:00 p. m. durante el período de inscripción abierta (1 de octubre al 31 de marzo). Durante el período de inscripción no abierta (del 1 de abril al 30 de septiembre), el horario es de lunes a viernes de 8:00 a. m. a 8:00 p. m. Esta llamada es gratis.
- This document may be available in other formats, such as Braille, large print, or alternate formats. You may call member services at 1-888-775-7888 for more information. TTY callers should call 1-877-681-8898.
- **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 CCHP Senior Value Program (HMO)

- CCHP Senior Value Program (HMO) is an HMO plan with a Medicare contract. Enrollment in CCHP Senior Value Program (HMO) depends on contract renewal. The plan also has a written agreement with the California Medicaid program to coordinate your Medicaid benefits.
- When this document says “we,” “us,” or “our”, it means *Chinese Community Health Plan*. When it says “plan” or “our plan,” it means *CCHP Senior Value Program (HMO)*.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for *CCHP Senior Value Program (HMO)* in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
<p>Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.</p>	<p><i>\$0 per month</i></p>	<p><i>\$0 per month</i></p>
<p>Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered services. (See Section 2.2 for details.)</p>	<p><i>\$7,550</i></p>	<p><i>\$7,550</i></p>
<p>Doctor office visits</p>	<p>Primary care visits: <i>\$0 - \$5 per visit</i></p> <p>Specialist visits: <i>\$20 per visit</i></p>	<p>Primary care visits: <i>\$0 - \$5 per visit</i></p> <p>Specialist visits: <i>\$20 per visit</i></p>
<p>Inpatient hospital stays</p>	<p>Days 1-7: <i>\$150 copay/day at Chinese Hospital</i></p> <p>Days 1-7: <i>\$315 copay/day at all other in-network hospitals</i></p> <p>Days 8+: <i>\$0 copay/day</i></p>	<p>Days 1-7: <i>\$150 copay/day at Chinese Hospital</i></p> <p>Days 1-7: <i>\$315 copay/day at all other in-network hospitals</i></p> <p>Days 8+: <i>\$0 copay/day</i></p>
<p>Part D prescription drug coverage (See Section 2.5 for details.)</p>	<p>Deductible: <i>\$0</i> except for covered insulin products and most adult Part D vaccine.</p>	<p>Deductible: <i>\$0</i> except for covered insulin products and most adult Part D vaccines.</p>

<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • <u>Drug Tier 1:</u> Standard cost sharing: \$5 copay for one month (30 day) supply Preferred cost sharing: \$0 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 2:</u> Standard cost sharing: \$12 copay for one month (30 day) supply Preferred cost sharing: \$12 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 3:</u> Standard cost sharing: \$47 copay for one month (30 day) supply Preferred cost sharing: \$47 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 4:</u> Standard cost sharing: \$100 copay for one month (30 day) supply Preferred cost sharing: \$100 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 5:</u> 	<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • <u>Drug Tier 1:</u> Standard cost sharing: \$5 copay for one month (30 day) supply Preferred cost sharing: \$0 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 2:</u> Standard cost sharing: \$12 copay for one month (30 day) supply Preferred cost sharing: \$12 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 3:</u> Standard cost sharing: \$47 copay for one month (30 day) supply Preferred cost sharing: \$47 copay for one month (30 day) supply You pay \$35 per month supply of each covered insulin product on this tier. • <u>Drug Tier 4:</u> Standard cost sharing: \$100 copay for one month (30 day) supply Preferred cost sharing: \$100 copay for one month (30 day) supply You pay \$35 per month supply of each covered
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Standard cost sharing:
31% coinsurance for
one month (30 day)
supply

Preferred cost sharing:
31% coinsurance for one
month (30 day) supply
You pay \$35 per month
supply of each covered
insulin product on this tier.

Catastrophic Coverage:

- During this payment stage, the plan pays most of the cost for your covered drugs.

For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.).

insulin product on this tier.

• Drug Tier 5:

Standard cost sharing:
31% coinsurance for one
month (30 day) supply
Preferred cost sharing:
31% coinsurance for one
month (30 day) supply
You pay \$35 per month
supply of each covered
insulin product on this
tier.

Catastrophic Coverage:

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in CCHP Senior Value Program (HMO) in 2024

If you do nothing by December 7, 2023, we will automatically enroll you in our CCHP Senior Value Program (HMO). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through CCHP Senior Value Program (HMO). If you want to change plans or switch to Original Medicare, you must 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.

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.)	\$0	\$0

- 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.

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 services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
<p>Maximum out-of-pocket amount</p> <p>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.</p>	<p>\$7,550</p>	<p style="text-align: center;">\$7,550</p> <p>Once you have paid \$7,550 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.</p>

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.CCHPHealthPlan.com/Medicare. You may also call Member Services 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 part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

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)
<i>Over-the-Counter (OTC) Items</i>	OTC FlexCard is <u>not</u> covered.	<p>\$30 Allowance per month.</p> <p>You pay \$0 out-of-pocket for an OTC Flex Card, administered by NationsBenefits.</p> <p>Herbal Supplements are being added to the plan approved OTC items.</p> <p>You can order:</p> <ul style="list-style-type: none"> • Online – visit NationsOTC.com/cchp • By Phone – call a NationsOTC Member Experience Advisor 877-211-3132 (TTY: 711), Monday to Friday, excluding holidays. • By Mail – Fill out and return the order form in the NationsOTC Product Catalog. <p><i>You may now also purchase OTC items at participating retail locations.</i></p>

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. **You can get the complete “Drug List”** by calling Member Services (see the back cover) or visiting our website (www.CCHPHealthPlan.com/Medicare).

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 Member Services for more information.

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 have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive “Extra Help” and didn’t receive this insert with this packet, please call Member Services and ask for the LIS Rider.

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	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

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs,	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: Drug Tier 1:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: Drug Tier 1:

and you pay your share of the cost.

The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.

Stage 2: Initial Coverage Stage (continued)

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.”

Most adult Part D vaccines are covered at no cost to you.

Standard cost sharing:
You pay \$5 per prescription.

Preferred cost sharing:
You pay \$0 per prescription

Drug Tier 2:

Standard cost sharing:
You pay \$12 per prescription.

Preferred cost sharing:
You pay \$12 per prescription

Drug Tier 3:

Standard cost sharing:
You pay \$47 per prescription.

Preferred cost sharing:
You pay \$47 per prescription

Drug Tier 4:

Standard cost sharing:
You pay \$100 per prescription.

Preferred cost sharing:
You pay \$100 per prescription

Drug Tier 5:

Standard cost sharing:
You pay \$31% of the total cost.

Standard cost sharing:
You pay \$5 per prescription.

Preferred cost sharing:
You pay \$0 per prescription

You pay \$35 per month supply of each covered insulin product on this tier.

Drug Tier 2:

Standard cost sharing:
You pay \$12 per prescription.

Preferred cost sharing:
You pay \$12 per prescription

You pay \$35 per month supply of each covered insulin product on this tier.

Drug Tier 3:

Standard cost sharing:
You pay \$47 per prescription.

Preferred cost sharing:
You pay \$47 per prescription

You pay \$35 per month supply of each covered insulin product on this tier.

Drug Tier 4:

Stage	2023 (this year)	2024 (next year)
	<p><i>Preferred cost sharing:</i> You pay \$31% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>	<p><i>Standard cost sharing:</i> You pay \$100 per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$100 per prescription</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 5:</p> <p><i>Standard cost sharing:</i> You pay \$31% of the total cost.</p> <p><i>Preferred cost sharing:</i> You pay \$31% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <hr/> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>

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 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 CCHP Senior Value Program (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 *CCHP Senior Value Program (HMO)*.

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. 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, use the Medicare Plan Finder (www.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, *Chinese Community Health Plan* 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 *CCHP Senior Value Program (HMO)*.
- **To change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *CCHP Senior Value Program (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 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.

SECTION 4 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, 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.

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

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In *California*, the SHIP is called *Health Insurance Counseling and Advocacy Program (HICAP)*.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *Health Insurance Counseling and Advocacy Program (HICAP)* 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 *Health Insurance Counseling and Advocacy Program (HICAP)* at 1-800-434-0222. You can learn more about *Health Insurance Counseling and Advocacy Program (HICAP)* by visiting their website (www.aging.ca.gov/hicap).

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.** 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. 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 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).
- **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 e AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call California AIDS Drug Assistance Program (ADAP) – San Francisco County: 1-415-554-9172.

SECTION 7 Questions?

Section 7.1 – Getting Help from CCHP Senior Value Program (HMO)

Questions? We’re here to help. Please call Member Services at 1-888-775-7888. (TTY only, call 1-877-681-8898). We are available for phone 7 days a week from 8:00 a.m. to 8:00 p.m. during the open enrollment period (October 1 - March 31). During the non-open enrollment period (April 1 – September 30), the hours are Mondays – Fridays 8:00 a.m. to 8:00 p.m. Calls to these numbers 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 CCHP Senior Value Program (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.CCHPHealthPlan.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.CCHPHealthPlan.com/Medicare. 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 8.2 – 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 (www.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 www.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 (<https://www.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.