Optima Medicare Prime (HMO) offered by Optima Medicare

Annual Notice of Changes for 2023

You are currently enrolled as a member of Optima Medicare Prime. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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.optimahealth.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 2023 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 2023* 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, 2022, you will stay in Optima Medicare Prime.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Optima Medicare Prime (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

- Please contact our Member Services number at 1-800-927-6048 for additional information. TTY users should call the Virginia Relay Service at 1-800-828-1120 or 711. Our hours are from October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET. From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system allows you to obtain information on many topics related to your plan.
- This information is available in large print and audio.
- **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 Optima Medicare Prime

- Optima Medicare Prime is an HMO plan with a Medicare contract. Enrollment in Optima Medicare depends on contract renewal.
- When this document says "we," "us," or "our", it means Optima Medicare. When it says "plan" or "our plan," it means Optima Medicare Prime.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Optima Medicare Prime (HMO). **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$62	$63
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$5,500	$5,500
Doctor office visits	Primary care visits: $0 Copay per visit Specialist visits: $15 Copay per visit	Primary care visits: $0 Copay per visit Specialist visits: $10 Copay per visit
Inpatient hospital stays	$230 copay per day for days 1-6 $0 copay per day for days 7 and beyond 60-day benefit period.	$210 copay per day for days 1-6 $0 copay per day for days 7 and beyond 60-day benefit period.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $130; applies to drugs in Tiers 4 and 5. Copayment/Coinsurance during the Initial Coverage	Deductible: $130; applies to drugs in Tiers 4 and 5. Copayment/Coinsurance during the Initial Coverage

Cost	2022 (this year)	2023 (next year)
	Stage, for a one-month supply: • Drug Tier 1: *Standard:* $5 copay *Preferred:* $0 copay • Drug Tier 2: *Standard:* $15 copay *Preferred:* $8 copay • Drug Tier 3: *Standard:* $45 copay *Preferred:* $40 copay • Drug Tier 4: *Standard:* $95 copay *Preferred:* $90 copay • Drug Tier 5: *Standard:* 30% coinsurance *Preferred:* 30% coinsurance	Stage, for a one-month supply: • Drug Tier 1: *Standard:* $5 copay *Preferred:* $0 copay • Drug Tier 2: *Standard:* $15 copay *Preferred:* $8 copay • Drug Tier 3: *Standard:* $45 copay *Preferred:* $40 copay • Drug Tier 4: *Standard:* $95 copay *Preferred:* $90 copay • Drug Tier 5: *Standard:* 30% coinsurance *Preferred:* 30% coinsurance

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$62	$63

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

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,500 Once you have paid $5,500 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.	$5,500 Once you have paid $5,500 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 and Pharmacy Networks

Updated directories are also located on our website at optimahealth.com/members/medicare/provider-and-pharmacy-directories. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *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 2023 *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 1.4 – 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	2022 (this year)	2023 (next year)
Bathroom Safety Devices	This is not a covered service.	Members may obtain up to two bathroom safety devices in a calendar year for a $0 copay. Please see Evidence of coverage for additional details. You pay a $0 copay for up to two covered bathroom devices per year.
Chiropractic Services	You pay $15 minimum copay for this benefit.	You pay a $10 copay for this benefit.
Chiropractic Services- Routine Care	You pay $15 minimum copay for this benefit.	You pay a $10 copay for this benefit.

Cost	2022 (this year)	2023 (next year)
Comprehensive Dental	You pay a $100 copay for Comprehensive Dental benefits	You pay a $75 copay for Comprehensive Dental benefits
	There is $2000 allowance Every Year.	There is $3500 allowance Every Year.
	Non-Routine Comprehensive Dental benefits are covered with a $100 copay.	Non-Routine Comprehensive Dental benefits are not covered.
	Diagnostic benefits are limited to 1 visit/year with a $100 copay.	Diagnostic benefits are not limited and have a $75 copay.
	Restorative benefits are limited to 1 visit/year with a $100 copay.	Restorative benefits are not limited and have a $75 copay.
	Endodontic benefits are limited to 1 visit/year with a $100 copay.	Endodontic benefits are not limited and have a $75 copay.
	Periodontic benefits are limited to 1 visit/year with a $100 copay.	Periodontic benefits are not limited and have a $75 copay.
	Extractions benefits are limited to 1 visit/year with a $100 copay.	Extractions benefits are not limited and have a $75 copay.
	Prosthodontics, Other Oral/Maxillofacial Surgery, and Other Services are limited to 1 visit/year with a $100 copay.	Prosthodontics, Other Oral/Maxillofacial Surgery, and Other Services are not limited and have a $75 copay.

Cost	2022 (this year)	2023 (next year)
		Please review EOC for additional coverage detail.
Diabetes Supplies and Services	You pay a 20% coinsurance for Diabetic supplies and services. Diabetic supplies and Services are not limited to specified manufacturers.	You pay a 20% coinsurance for Diabetic supplies and services. Diabetic supplies are limited to Abbott and Lifescan manufacturers.
Enhanced Disease Management	COPD360 is a home-based enhanced disease management program for members with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Prior authorization is required. The AccordantCare™ Program is designed to help members better manage their clinical conditions and improve their overall health status. This specialized education and support program is offered to members with complex conditions.	COPD360 is no longer a covered benefit. AccordantCare™ is no longer a covered benefit. We offer a program designed to help members better manage their clinical conditions and improve their overall health status. This specialized education and support program is offered to members with complex conditions. No Authorizations are required for Enhanced Disease Management.
In-Home Support Services	In-Home Support Services consist of a combination of non-clinical hands-on care and assistance with activities of daily living. Coverage is	You will pay $0 copay for help with Instrumental Activities of Daily Living. Some of the services include but are not limited to

Cost	2022 (this year)	2023 (next year)
	up to 20 hours post-inpatient discharge. Maximum of 60 hours annually for In-Home Support Services. Benefit is limited to 3 post-inpatient discharges. Prior authorization is required.	assisting members with transportation to include grocery shopping, medication pick up, and doctor's appointments, technical guidance, care gap reminders, light house help, light exercise and activity. Members are eligible for 90 hours per year of In-Home Support Services. No Prior Authorization is required
Inpatient Acute Medicare-covered stay	$0 per stay. You pay a $230 copay per day for days 1-6. You pay a $0 copayment for days 7-90.	$0 per stay. You pay a $210 copay per day for days 1-6. You pay a $0 copayment for days 7-90.
Inpatient Psychiatric Medicare-covered	You pay a $230 copay per day for days 1-6. You pay a $0 copayment for days 7-90.	You pay a $210 copay per day for days 1-6. You pay a $0 copayment for days 7-90.
Medicare-covered Hearing Exams	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Medicare-covered Podiatry Services	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Medicare-covered Therapeutic Radiological Services	You pay a $35 copay for this benefit at a specialist office. You pay 20% minimum	You pay a $10 copay for this benefit at a specialist office. You pay 20% minimum

Cost	2022 (this year)	2023 (next year)
	coinsurance for this benefit at all other locations.	coinsurance for this benefit at all other locations.
Mental Health Specialty Services- Medicare-covered Group Sessions	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Mental Health Specialty Services- Medicare-covered Individual Sessions	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Occupational Therapy Services	You pay a $25 copay for this benefit.	You pay a $10 copay for this benefit.
Other Health Care Professional Services	You pay a $0 copay for this benefit at a PCP. You pay a $15 copay for this benefit at a specialist.	You pay a $0 copay for this benefit at a PCP. You pay a $10 copay for this benefit at a specialist.
Physical Therapy and Speech Pathology Services	You pay a $25 copay for this benefit.	You pay a $10 copay for this benefit.
Physician Specialist Services	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Preventive Dental	You pay $0 copay for 1 oral exam each year. You pay $0 copay for 1 Dental X-Ray each year.	You pay $0 copay for 2 oral exam each year. You pay $0 copay for 2 Dental X-Ray each year.
Psychiatric Services- Group Sessions	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.

Cost	2022 (this year)	2023 (next year)
Psychiatric Services- Individual Sessions	You pay a $15 copay for this benefit.	You pay a $10 copay for this benefit.
Skilled Nursing Facility (SNF) Medicare-covered stay	You pay a $0 copayment for days 1-20. You pay a $188 copay per day for days 21-100.	You pay a $0 copayment for days 1-20. You pay a $196 copay per day for days 21-100.

Section 1.5 – 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.

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.**

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 does 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. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, 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.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on even if you haven't paid your deductible.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 4 (Non-Preferred) drugs and Tier 5 (Specialty) drugs until you have reached the yearly deductible.	The Deductible is $130 During this stage you pay (for a 30-day supply): • $5 copay for drugs on Tier 1 (Preferred Generic) – Standard cost sharing. • $0 copay for drugs on Tier 1 (Preferred Generic) – Preferred cost sharing. • $15 copay for drugs on Tier 2 (Non-Preferred Generic) – Standard cost sharing. • $8 copay for drugs on Tier 2 (Non-Preferred Generic) – Preferred cost sharing. • $45 copay for drugs on Tier 3 (Preferred Brand) – Standard cost sharing. • $40 copay for drugs on Tier 3 (Preferred Brand) – Preferred cost sharing. • The full cost of drugs on Tier 4 (Non-Preferred)	The Deductible is $130 During this stage you pay (for a 30-day supply): • $5 copay for drugs on Tier 1 (Preferred Generic) – Standard cost sharing. • $0 copay for drugs on Tier 1 (Preferred Generic) – Preferred cost sharing. • $15 copay for drugs on Tier 2 (Non-Preferred Generic) – Standard cost sharing. • $8 copay for drugs on Tier 2 (Non-Preferred Generic) – Preferred cost sharing. • $45 copay for drugs on Tier 3 (Preferred Brand) – Standard cost sharing. • $40 copay for drugs on Tier 3 (Preferred Brand) – Preferred cost sharing. • The full cost of drugs on Tier 4 (Non-Preferred) drugs and Tier 5 (Specialty

Stage	2022 (this year)	2023 (next year)
	drugs and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	Tier) until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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 that provides standard cost sharing. For information about the costs for a long-term supply; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. 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 filled at a network pharmacy with standard cost sharing: **Tier 1 - Preferred Generic:** *Standard cost sharing*: You pay $5 copay per prescription. *Preferred cost sharing:* You pay $0 per prescription **Tier 2 - Generic:** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $8 per prescription **Tier 3 - Preferred Brand:** *Standard cost sharing:* You pay $45 copay per prescription. *Preferred cost sharing:* You pay $40 per prescription **Tier 4 - Non-Preferred Drug:** *Standard cost sharing:*	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 - Preferred Generic:** *Standard cost sharing:* You pay $5 copay per prescription. *Preferred cost sharing:* You pay $0 per prescription **Tier 2 - Generic:** *Standard cost sharing:* You pay $15 copay per prescription. *Preferred cost sharing:* You pay $8 per prescription **Tier 3 - Preferred Brand:** *Standard cost sharing:* You pay $45 copay per prescription. *Preferred cost sharing:* You pay $40 per prescription **Tier 4 - Non-Preferred Drug:** *Standard cost sharing:*

Stage	2022 (this year)	2023 (next year)
	You pay $95 copay per prescription. *Preferred cost sharing:* You pay $90 per prescription **Tier 5 - Specialty Tier:** *Standard cost sharing:* You pay 30% coinsurance of the total cost. *Preferred cost sharing:* You pay 30% coinsurance of the total cost Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	You pay $95 copay per prescription. *Preferred cost sharing:* You pay $90 per prescription **Tier 5 - Specialty Tier:** *Standard cost sharing:* You pay 30% coinsurance of the total cost. *Preferred cost sharing:* You pay 30% coinsurance of the total cost Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Administrative Changes

We want to let you know about an upcoming change to our Pharmacy Benefit Manager (PBM). A PBM is a company that is contracted to administer drug benefit programs including processing of prescription drug claims.

Description	2022 (this year)	2023 (next year)
Change of Pharmacy Benefit Manager (PBM)	Optum Rx®	Express Scripts®, Inc.
The Plan's mail-order services will change. For more information about the plan's mail-order services review the Evidence of Coverage section 2.3 Using the plan's mail-order service.	Optum Rx®	Express Scripts® Pharmacy

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Optima Medicare Prime*

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 Optima Medicare Prime.

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 2023 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 1.1 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Optima Medicare 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 Optima Medicare Prime.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Optima Medicare Prime.
- 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, 2023.

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, 2023, 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, 2023.

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 Virginia, the SHIP is called the Virginia Insurance Counseling and Assistance Program (coordinated through the Virginia Division for the Aging).

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).

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, 1-800-375-0778; 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 Virginia Medication Assistance Program (VA MAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-855-362-0658.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Optima Medicare Prime*

Questions? We're here to help. Please call Member Services at 1-800-927-6048. (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 – March 31. From April 1 - September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET. Outside of these times, our interactive voice response system allows you to obtain information on many topics related to your plan. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Optima Medicare Prime. 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 optimahealth.com/members/medicare/documents-and-forms. 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 optimahealth.com/members/optima-medicare-hmo/. 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 (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 2023*

Read the *Medicare & You 2023* handbook. Every 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 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.