Elderplan for Medicaid Beneficiaries (HMO SNP) offered by Elderplan, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of Elderplan for Medicaid Beneficiaries (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 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 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. 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 in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider and Pharmacy Directory.

□ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

□ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

□ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 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 want to **keep** Elderplan for Medicaid Beneficiaries (HMO SNP), you don't need to do anything. You will stay in Elderplan for Medicaid Beneficiaries (HMO SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Your new coverage will begin on the first day of the following month. Look in section 2.2, page 31 to learn more about your choices.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-353-3765 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week.
- This information is available in different formats, including Braille, large print, or other alternate formats.

- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Elderplan for Medicaid Beneficiaries (HMO SNP)

- Elderplan for Medicaid Beneficiaries (HMO SNP) is a health plan with a Medicare contract. Enrollment in Elderplan for Medicaid Beneficiaries (HMO SNP) depends on a contract renewal.
- When this booklet says "we," "us," or "our," it means Elderplan, Inc. When it says "plan" or "our plan," it means Elderplan for Medicaid Beneficiaries (HMO SNP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Elderplan for Medicaid Beneficiaries (HMO SNP) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the Evidence of Coverage located on our website at www.elderplan.org to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 or $39.00 for your Part D Premium	$0 or $39.30 for your Part D Premium
Deductible	$0 or $183 for the Medicare In-Network Deductible	$0 or $185 for the Medicare In-Network Deductible

Cost	2018 (this year)	2019 (next year)
Deductible (continued)	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Doctor office visits	Primary care visits: 0% or 20% per visit Specialist visits: 0% or 20% per visit	Primary care visits: 0% or 20% per visit Specialist visits 0% or 20% per visit
Doctor office visits (continued)	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.
Inpatient hospital stays	In 2018 the amounts for each benefit period are $0 or:	In 2019 the amounts for each benefit period are $0 or:

Cost	2018 (this year)	2019 (next year)
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**.**	$1,340 deductible for each benefit period Days 1-60: $0 copayment per day Days 61-90: $335 copayment per day Days 91-150: $670 copayment per lifetime reserve day (up to 60 days over your lifetime) Beyond lifetime reserve days: you pay all costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	$1,364 deductible for each benefit period Days 1-60: $0 copayment per day Days 61-90: $341 copayment per day Days 91and beyond: $682 copayment per lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: you pay all costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2018 (this year)	2019 (next year)
		Authorization is required, except in an emergency.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage	Deductible: $405 Coinsurance during the Initial Coverage Stage: Drug Tier 1: Depending on your income and institutional status, for all covered drugs you pay 25% coinsurance or: For generic drugs (including brand drugs treated as generic), either: $0 copayment; or $1.25 copayment; or $3.35 copayment	Deductible: $0, $85 or $415 Coinsurance or copayment during the Initial Coverage Stage: Drug Tier 1: You pay 25% coinsurance or*: For generic drugs (including brand drugs treated as generic), either: $0 copayment; or $1.25 copayment; or $3.40 copayment; or 15% of the total cost

(See Section 1.6 for details.)	For all other drugs, either: $0 copayment; or $3.70 copayment; or $8.35 copayment	For all other drugs, either: $0 copayment; or $3.80 copayment; or $8.50 copayment; or 15% of the total cost *Depending on your income and institutional status. If you are eligible for Low Income Subsidy (LIS), you may be eligible for reduced cost-sharing.
Part D prescription drug coverage (continued)		

Cost	2018 (this year)	2019 (next year)
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.)	$6,700 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-of-pocket amount for covered Part A and Part B services.	$6,700 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-of-pocket amount for covered Part A and Part B services.

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SECTION 1 Changes to Medicare Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or $39.00 For your Part D Premium	$0 or $39.30 For your Part D Premium

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

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

Cost	2018 (this year)	2019 (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.	$6,700 Once you have paid $6,700 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.	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider and Pharmacy Directory is located on our website at www.elderplan.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2019 Provider and Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we 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 and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Provider and Pharmacy Directory is located on our website at www.elderplan.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2019 Provider and Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

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

We are changing our coverage for certain medical services next year. The information below describes these changes. For details

about the coverage and costs for these services, see Chapter 4, Benefits Chart (what is covered and what you pay), in your 2019 Evidence of Coverage.

Cost	2018 (this year)	2019 (next year)
Health and Wellness Education Programs	Gym membership is not covered These programs include written health education materials $0 copay	These programs include written health education materials, and gym membership. $0 Copay The Silver & Fit® Exercise and Healthy Aging program provides Elderplan members access to participating fitness centers and YMCAs. The fitness center membership includes standard center services such as access to cardiovascular equipment free weights resistance training equipment group exercise classes.

Cost	2018 (this year)	2019 (next year)
Emergency care	0% or 20% coinsurance (up to $80) for each visit* If you are admitted to the hospital within 24 hours for the same condition, the copayment is waived. Applies to Part B Deductible. * If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	0% or 20% coinsurance (up to $90) for each visit* If you are admitted to the hospital within 24 hours for the same condition, the copayment is waived. Does not apply to Part B Deductible. * If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Urgently Needed Services	0% or 20% of the total cost (up to $65) for each visit* Coinsurance is waived if admitted to hospital within 24 hours.	0% or 20% of the total cost (up to $65) for each visit* Coinsurance is waived if admitted to hospital within 24 hours.

Cost	2018 (this year)	2019 (next year)
Urgently Needed Services (continued)	Applies to Part B Deductible. * If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	Does not apply to Part B Deductible. * If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Worldwide Emergency/ Urgent Coverage	You pay a $65 copay for Worldwide Emergency/Urgent Coverage Services (waived if admitted to hospital). The maximum benefit amount is $50,000.	You pay a $0 copay for Worldwide Emergency/Urgent Coverage Services (waived if admitted to hospital). The maximum benefit amount is $50,000.
Other Healthcare Professionals	Authorization is required.	Authorization is only required for in-home visits billed by a Nurse Practitioner or Physician Assistant directly.

Cost	2018 (this year)	2019 (next year)
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	You pay 0% or 20% of total cost for Medicare covered Lab services	You pay a $0 copay for Medicare covered Lab services
Over the Counter Rx (OTC)	You may purchase up to $85 every month of certain OTC items on a debit card provided by Elderplan. OTC benefit dollars cannot be carried over to the next month.	You may purchase up to $88 every month of certain OTC items on a debit card provided by Elderplan. OTC benefit dollars cannot be carried over to the next month.
Hearing Services	Routine Hearing Exam is not covered. Fitting/Evaluation for Hearing Aid is not covered. You pay a $0 copay for hearing aid(s) up to $1,000 total for	Routine Hearing Exam is covered. You pay a $0 copay for 1 Routine Hearing Exam every 3 years. Fitting/Evaluation for Hearing Aid is covered.

Cost	2018 (this year)	2019 (next year)
Hearing Services (continued)	both ears combined every 3 years.	You pay a $0 copay for 1 Fitting/Evaluation for Hearing Aid every 3 years. You pay a $0 copay for hearing aid(s) up to $1,300 total for both ears combined every 3 years.
In-Network Plan Deductible applies to:	Cardiac Rehabilitation Services; Intensive Cardiac Rehabilitation Services; Pulmonary Rehabilitation Services; Partial Hospitalization; Home Health Services; Primary Care Physician Services; Chiropractic Services;	Cardiac Rehabilitation Services; Intensive Cardiac Rehabilitation Services; Pulmonary Rehabilitation Services; Partial Hospitalization; 6: Home Health Services; Primary Care Physician Services; Chiropractic Services;

Cost	2018 (this year)	2019 (next year)
In-Network Plan Deductible applies to: (continued)	Occupational Therapy Services; Physician Specialist Services; Mental Health Specialty Services; Podiatry Services; Other Health Care Professional; Psychiatric Services; Physical Therapy and Speech-Language Pathology Services; Diagnostic Procedures / Tests / Lab Services; Therapeutic Radiological Services; Outpatient X-Ray Services; Outpatient Hospital Services; Ambulatory Surgical Center (ASC) Services; Outpatient Substance Abuse; Outpatient Blood Services;	Occupational Therapy Services; Physician Specialist Services; Mental Health Specialty Services; Podiatry Services; Other Health Care Professional; Psychiatric Services; Physical Therapy and Speech-Language Pathology Services; Diagnostic Procedures / Tests / Lab Services; Therapeutic Radiological Services; Outpatient X-Ray Services; Outpatient Hospital Services; Observation Services; Ambulatory Surgical Center (ASC) Services; Outpatient Substance Abuse;

Cost	2018 (this year)	2019 (next year)
In-Network Plan Deductible applies to: (continued)	Ambulance Services; Durable Medical Equipment (DME); Prosthetics / Medical Supplies; Diabetic Supplies and Services; Dialysis Services; Kidney Disease Education Services; Glaucoma Screening; Diabetes Self-Management Training; Other Medicare-covered Preventive Services; Comprehensive Dental	Outpatient Blood Services; Ground Ambulance Services; Air Ambulance Services; Durable Medical Equipment (DME); Prosthetics / Medical Supplies; Diabetic Supplies and Services; Dialysis Services; Kidney Disease Education Services; Glaucoma Screening; Diabetes Self-Management Training
Vision Care	Routine Eye Exam is not covered. Eyewear is not covered.	Routine Eye Exam is covered. You pay a $0 copay for 1 Routine Eye Exam every year. Eyewear is covered. You pay a $0 copay for eyewear up to a

Cost	2018 (this year)	2019 (next year)
Vision Care (continued)		$100 limit per calendar year. Eyewear provided after cataract surgery is not subject to this $100 limit.
Supervised Exercise Therapy (SET)	Supervised Exercise Therapy (SET) is not covered.	You pay 20% of the total cost for each Supervised Exercise Therapy (SET) session.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List has been 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 Member Services (see the back cover) or visiting our website (www.elderplan.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 prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days of medication rather than the amount provided in 2018 (at least 91 days and up to 98 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug

covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

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 2019, 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. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill 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.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30 day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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 the 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 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. Because you receive "Extra Help" please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (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 is $405 (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $0, $85, or $415 (Look at the separate insert, the "LIS Rider," for your deductible amount.) If you are eligible for Low Income Subsidy (LIS), you may be eligible for reduced cost-sharing.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **You pay 25% of the total cost or*:** For generic drugs (including brand drugs treated as generic), either: $0 copayment; or $1.25 copayment; or $3.35 copayment	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1:** You pay 25% of the total cost or*: For generic drugs (including brand drugs treated as generic), either: $0 copayment; or $1.25 copayment; or $3.40 copayment; or 15% of the total cost

Stage	2018 (this year)	2019 (next year)
		For all other drugs, either: $0 copayment; or $3.80 copayment; or $8.50 copayment; or 15% of the total cost *Depending on your income or institutional status

Stage	2018 (this year)	2019 (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; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	For all other drugs, either: $0 copayment; or $3.70 copayment; or $8.35 copayment * Depending on your income and institutional status _____ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Elderplan for Medicaid Beneficiaries (HMO SNP)

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, you will automatically stay enrolled as a member of our plan for 2019.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 2.2), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Elderplan Inc. 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 *Elderplan for Medicaid Beneficiaries.*
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Elderplan for Medicaid Beneficiaries.
- To **change to Original Medicare without a prescription drug plan**, you must either:

- Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
- – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 31. The change will take effect on January 1, 2019.

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. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage.*

Note: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called the Office for the Aging Health Insurance Information, Counseling and Assistance Program (HIICAP). The Office for the Aging Health Insurance Information, Counseling and Assistance Program (HIICAP) 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. The Office for the Aging Health Insurance Information, Counseling and Assistance Program (HIICAP). 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 The Office for the Aging Health Insurance Information, Counseling and Assistance Program (HIICAP) at (212) 602-4180 (Inside Boroughs) or 1-800-701-0501(Outside Boroughs). You can learn more about The Office for the Aging

Health Insurance Information, Counseling and Assistance Program (HIICAP) by visiting their website (http://www.aging.ny.gov/healthbenefits/).

For questions about your New York State Department of Health Medicaid benefits, contact the New York State Department of Health (Social Services) office HRA Medicaid Helpline at 1-888-692-6116. TTY users can call 711. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Department of Health Medicaid benefits coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

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

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

- **Help from your state's pharmaceutical assistance program.** New York has a program called the Elderly Pharmaceutical Insurance Coverage Program (EPIC) 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 (the name and phone numbers for this organization are in Section 4 of this booklet).
- **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 New York AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

SECTION 6 Questions?

Section 6.1 – Getting Help from Elderplan for Medicaid Beneficiaries (HMO SNP)

Questions? We're here to help. Please call Member Services at 1-800-353-3765. (TTY only, call 711.) (TTY only, call 711.) We are available for phone calls 8a.m. to 8p.m., 7 days a week. Calls to these numbers are free to these numbers are free.

Read your 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Elderplan for Medicaid Beneficiaries (HMO SNP). 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.

Visit our Website

You can also visit our website at www.elderplan.org. As a reminder, our website has the most up-to-date information about our provider network (Provider and Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read *Medicare & You 2019* 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 (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call *the New York State Department of Health (Social Services) office HRA Medicaid Helpline at 1-888-692-6116. TTY users can call 711.*

Elderplan, Inc.

Notice of Nondiscrimination – Discrimination is Against the Law

Elderplan/HomeFirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that Elderplan/HomeFirst has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

Civil Rights Coordinator
6323 7th Ave
Brooklyn, NY, 11220
Phone: 1-877-326-9978, TTY 711
Fax: 1-718-759-3643

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, Civil Rights Coordinator, is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-800-353-3765 (TTY: 711).

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-353-3765 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-353-3765 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-353-3765 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-353-3765 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-353-3765 (TTY: 711)번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-353-3765 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט
.1-800-353-3765 (TTY: 711)

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন 1-800-353-3765 (TTY: 711)৷

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-353-3765 (TTY: 711).

(Arabic)ملحوظة: إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في ASL، فإن خدمات المساعدة اللغوية تتوافر لك مجانا. اتصل برقم
.1-800-353-3765 (TTY: 711)

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-353-3765 (ATS: 711).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
.1-800-353-3765 (TTY: 711)

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-353-3765 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-353-3765 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-353-3765 (TTY: 711).