Health Partners Plans

Health Partners Medicare Value (HMO) offered by Health Partners Medicare

Annual Notice of Changes for 2018

You are currently enrolled as a member of Health Partners Medicare Value. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1, 1.2, and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ 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 Sections 1.3 and 1.4 for information about our *Provider & 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 3.2 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** Health Partners Medicare Value, you don't need to do anything. You will stay in Health Partners Medicare Value.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Health Partners Medicare Value.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- You can also request this information in alternate formats (such as Braille, large print, CD) by calling Member Relations at 1-866-901-8000 (TTY 711).
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** 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 Health Partners Medicare Value

- Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Health Partners Medicare. When it says “plan” or “our plan,” it means Health Partners Medicare Value.

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Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Health Partners Medicare Value 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 enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	**Primary care visits:** $10 copay per visit **Specialist visits:** $50 copay per visit	**Primary care visits:** $10 copay per visit **Specialist visits:** $50 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$295 copay each day for days 1–6; $180 copay for day 7; $0 copay each day for days 8+	$295 copay each day for days 1–6; $180 copay for day 7; $0 copay each day for days 8–90 $0 copay each day for 60 lifetime reserve days after day 90

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible (all tiers): $350 Copay/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 copay • Drug Tier 2: $20 copay • Drug Tier 3: $47 copay • Drug Tier 4: 34% of the total cost • Drug Tier 5: 26% of the total cost	Deductible (Tiers 3, 4 and 5 only): $350 Copay/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copay • Drug Tier 2: $20 copay • Drug Tier 3: $47 copay • Drug Tier 4: 27% of the total cost • Drug Tier 5: 26% of the total cost

Annual Notice of Changes for 2018
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (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 enroll in Medicare prescription drug coverage in the future.
- 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.

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 services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered 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 & Pharmacy Directory* is located on our website at www.HPPMedicare.com. You may also call Member Relations for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2018 *Provider & 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 & Pharmacy Directory* is located on our website at www.HPPMedicare.com. You may also call Member Relations for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2018 *Provider & Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Emergency Care	You pay a $75 copay	You pay an $80 copay
Inpatient Hospital	You pay a $295 copay each day for days 1–6; $180 copay for day 7; $0 copay each day for days 8+	You pay a $295 copay each day for days 1–6; $180 copay for day 7; $0 copay each day for days 8–90
Inpatient Hospital Additional Days	Plan covers unlimited days per hospital stay.	Plan covers 90 days for each hospital admission/stay. You pay a $0 copay each day for 60 lifetime reserve days after day 90.
Skilled Nursing Facility	You pay a $0 copay each day for days 1–20; $164.50 copay each day for days 21–100	You pay a $0 copay each day for days 1–20; $167.50 copay each day for days 21–100
Vision Care	No supplemental coverage for eyeglasses or contact lenses	$75 plan coverage limit for up to one pair of eyeglasses (lenses and frames) or one pair of contact lenses every two years
Weight Management	You pay a $2 copay for each meeting. Plan will pay Weight Watchers® membership fee. Member must comply with Weight Watchers® general terms of membership. No meals are covered.	Weight Watchers® is not covered.

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." More information about our Drug List is in this envelope.

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.
    - 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 Relations.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Relations to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, 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. (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.

As a **current member**, you may receive up to a temporary 30-day supply of a drug that is affected by negative formulary changes in the new contract year within the first 90 days of renewal. After your first 30-day supply, we will not cover these drugs unless approved through the non-formulary exception process or through prior authorization. If you receive coverage for a temporary medication fill, we will notify you if a formulary exception determination or prior authorization is needed for continued coverage of your medication.

Formulary exceptions are granted for a one-year (365-day) period. If a formulary exception was approved in 2017, it will be good into 2018. A new request will need to be submitted if you want Health Partners Medicare to continue to cover an excepted drug after this one-year period has expired.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2017, please call Member Relations and ask for the "LIS Rider." Phone numbers for Member Relations are in Section 7.1 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 at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (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 $350.	The deductible is $350. During this stage, you pay $4 cost-sharing for drugs on Tier 1, $20 cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copays 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	2017 (this year)	2018 (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: **Preferred Generic:** You pay a $2 copay per prescription. **Generic:** You pay a $20 copay per prescription. **Preferred Brand:** You pay a $47 copay per prescription. **Non-Preferred Drug:** You pay 34% of the total cost. **Specialty:** You pay 26% of the total cost. Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay a $4 copay per prescription. **Generic:** You pay a $20 copay per prescription. **Preferred Brand:** You pay a $47 copay per prescription. **Non-Preferred Drug:** You pay 27% of the total cost. **Specialty:** You pay 26% of the total cost. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Cost	2017 (this year)	2018 (next year)
Inpatient Hospital Benefit Period If you go into a hospital or a skilled nursing facility (SNF) after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital cost sharing for each benefit period. There's no limit to the number of benefit periods.	Original Medicare	Per Admission or Per Stay
Inpatient Hospital Psychiatric Benefit Period If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital cost sharing for each benefit period. There's no limit to the number of benefit periods.	Original Medicare	Per Admission or Per Stay

Cost	2017 (this year)	2018 (next year)
Prior Authorization Some in-network medical services or drugs are covered only if your doctor or other network provider gets "prior authorization" — approval in advance — from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4 of your *Evidence of Coverage*. Covered drugs that need prior authorization are marked in the formulary.	Prior authorization is <u>not</u> required for: • Medicare-covered zero-dollar preventive services	Prior authorization <u>is</u> required for: • Certain Medicare-covered zero-dollar preventive services, such as low-dose CT scan for lung cancer screening
Referral In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Chapter 3, Section 2.3 of your *Evidence of Coverage*. Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Chapter 3, Section 2.2 of your *Evidence of Coverage*).	Referrals are <u>not</u> required for: • Chiropractic services • In-network physician specialists • Podiatry	Referrals <u>are</u> required for: • Chiropractic services • In-network physician specialists • Podiatry

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Health Partners Medicare Value

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 stay enrolled as a member of our plan for 2018.

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 for 2018 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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, Health Partners 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 Health Partners Medicare Value.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Health Partners Medicare Value.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Relations if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 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, 2018.

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 are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE 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. APPRISE 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 APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (www.aging.pa.gov/insurance).

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. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., 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.** Pennsylvania has programs called PACE, PACENET and PACE Plus Medicare that help people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about these programs, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 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 Special Pharmaceutical Benefits Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the SPBP at 1-800-922-9384.

SECTION 7 Questions?

Section 7.1 – Getting Help from Health Partners Medicare Value

Questions? We're here to help. Please call Member Relations at 1-866-901-8000. (TTY only, call 711.) We are available for phone calls 24 hours a day, seven days a week. Calls to these numbers are free.

Read your *2018 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 2018. For details, look in the *2018 Evidence of Coverage* for Health Partners Medicare Value. 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 included in this envelope.

Visit our Website

You can also visit our website at www.HPPMedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy 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

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 2018*

You can read the *Medicare & You 2018* 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.