

Aspire Health Advantage Value (HMO) offered by Aspire Health Plan

Annual Notice of Changes for 2016

You are currently enrolled as a member of *Aspire Health Advantage 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.**
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Additional Resources

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our customer service number at toll free (855) 570-1600 or TTY users call 711. We are open 8 am to 8 pm PST Monday through Friday (except certain holidays) from February 15 through September 30 and 8 am to 8 pm PST seven days a week for the period of October 1 through February 14. Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de atención al cliente en (855) 570-1600 or Usuarios de TTY deben llamar al 711. Estamos abiertas de 8 am to 8 pm PST de lunes a viernes (excepto ciertos días festivos) del 15 de febrero al 30 de septiembre y las 8 am to 8 pm PST siete días a la semana para el período del 1 de octubre al 14 de febrero.

Member Services also has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet). Servicios para Miembros también tiene servicios de intérprete de idiomas gratis disponibles para las personas que no hablan inglés (los números telefónicos están impresos en la contraportada de este folleto).

This document is also available in large print.

About Aspire Health Advantage Value

- *Aspire Health Plan is an HMO and HMO-POS plan sponsor with a Medicare contract. Enrollment in Aspire Health Plan depends on contract renewal.*
- When this booklet says “we,” “us,” or “our,” it means *Aspire Health Plan*. When it says “plan” or “our plan,” it means *Aspire Health Advantage Value*.

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It’s important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in **Sections 2.1** and **2.5** for information about benefit and cost changes for our plan.
- Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in **Section 2.6** 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 **Section 2.3** for information about our Provider Directory.
- Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.**

If you decide to stay with *Aspire Health Advantage Value*:

If you want to stay with us next year, it’s easy - you don’t need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2016. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for *Aspire Health Advantage 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	2015 (this year)	2016 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher or lower than this amount. See Section 2.1 for details.</p>	\$49.00	\$31.00
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</p>	\$6,700	\$5,000
<p>Doctor office visits</p>	<p>Primary care visits: \$25.00 per visit</p> <p>Specialist visits: \$35.00 per visit</p>	<p>Primary care visits: \$25.00 per visit</p> <p>Specialist visits: \$35.00 per visit</p>
<p>Inpatient hospital stays</p> <p>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.</p>	<p>Days 1-5: \$300 co-pay per day</p> <p>Days 6-90: \$0 co-pay per day</p>	<p>Days 1-5: \$300 co-pay per day</p> <p>Days 6-90: \$0 co-pay per day</p>

Cost	2015 (this year)	2016 (next year)
<p>Part D prescription drug coverage (See Section 2.6 for details.)</p>	<p><i>Deductible: \$250 on tiers 3, 4 and 5</i></p> <p><i>Co-payment/Co-insurance during the Initial Coverage Stage:</i></p> <p><i>Thirty (30) day retail cost-sharing (in network):</i></p> <ul style="list-style-type: none"> • <i>Drug Tier 1: \$5</i> • <i>Drug Tier 2: \$15</i> • <i>Drug Tier 3: \$45</i> • <i>Drug Tier 4: \$80</i> • <i>Drug Tier 5: 26%</i> <p><i>Ninety (90) day mail-order cost-sharing (in-network)</i></p> <ul style="list-style-type: none"> • <i>Drug Tier 1: \$10</i> • <i>Drug Tier 2: \$30</i> • <i>Drug Tier 3: \$90</i> • <i>Drug Tier 4: \$160</i> • <i>Drug Tier 5: 26%</i> 	<p><i>Deductible: \$280 on tiers 2, 3, 4 and 5</i></p> <p><i>Co-payment/Co-insurance during the Initial Coverage Stage:</i></p> <p><i>Thirty (30) day retail cost-sharing (in network):</i></p> <ul style="list-style-type: none"> • <i>Drug Tier 1: \$4</i> • <i>Drug Tier 2: \$15</i> • <i>Drug Tier 3: \$45</i> • <i>Drug Tier 4: \$85</i> • <i>Drug Tier 5: 26%</i> <p><i>Ninety (90) day <u>retail and mail-order</u> cost-sharing (in-network)</i></p> <ul style="list-style-type: none"> • <i>Drug Tier 1: \$8</i> • <i>Drug Tier 2: \$30</i> • <i>Drug Tier 3: \$90</i> • <i>Drug Tier 4: \$170</i> • <i>Drug Tier 5: 26%</i>

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *Aspire Health Advantage Value* in 2016

If you do nothing to change your Medicare coverage by December 7, 2015, we will automatically enroll you in our *Aspire Health Advantage Value Plan*. This means starting January 1, 2016, you will be getting your medical and prescription drug coverage through *Aspire Health Advantage Value*. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in *Aspire Health Advantage Value* and the benefits you will have on January 1, 2016 as a member of *Aspire Health Advantage Value*.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$49.00	\$31.00
Optional Supplemental Dental Benefit This optional preventive and comprehensive dental coverage is available for an additional monthly premium.	<i>\$29.00 in additional premium per month if you choose to enroll in this optional coverage.</i>	<i>\$29.00 in additional premium per month if you choose to enroll in this optional coverage.</i>

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- 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 2.2 – 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.” Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2015 (this year)	2016 (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.	\$6,700 <i>In-network</i>	\$5,000 <i>In-network</i> Once you have paid \$5,000 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.aspirehealthplan.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2016 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will 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 2.4 – 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 Pharmacy Directory is located on our website at www.aspirehealthplan.org. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2016 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – 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 *2016 Evidence of Coverage*.

Cost	2015 (this year)	2016 (next year)
<i>Diagnostic & Therapeutic Radiological Services</i>	<i>20% of the total cost for Medicare-covered diagnostic radiology services (not including X-rays) and Medicare-covered therapeutic radiology services</i>	<i>\$35 co-pay for Medicare-covered diagnostic radiology services (not including X-rays) and Medicare-covered therapeutic radiology services</i>
<i>Durable Medical Equipment (DME)</i>	<i>20% coinsurance of the total cost for Medicare-covered DME</i>	<i>10% coinsurance of the total cost for Medicare-covered DME</i>
<i>Hearing Services</i>	<i>\$35 co-pay for Medicare-covered diagnostic hearing exams</i>	<i>\$25 co-pay for Medicare-covered diagnostic hearing exams</i>
<i>Lab Services & X-rays</i>	<i>\$10 co-pay for Medicare-covered diagnostic laboratory tests and procedures including X-rays</i>	<i>\$15 co-pay for Medicare-covered diagnostic laboratory tests and procedures including X-rays</i>
<i>Outpatient Hospital Services</i>	<i>\$300 co-pay for Medicare-covered hospital outpatient surgical procedures at Medicare-covered facilities and ambulatory surgical centers</i>	<i>\$300 co-pay for Medicare-covered hospital outpatient surgical procedures and observation services at Medicare-covered facilities and ambulatory surgical centers</i> <i>\$35 co-pay for Medicare-covered colonoscopy and endoscopy surgical procedures at Medicare-covered outpatient facilities</i>

Cost	2015 (this year)	2016 (next year)
<i>Vision Services</i>	\$35 co-pay for Medicare-covered exam	\$25 co-pay for Medicare-covered exam

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is 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. **We encourage current members** to ask for an exception before next year.
 - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or coverage. (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 the plan has granted a formulary exception for a non-formulary medication you are taking in 2015, the formulary exception will expire at the end of the calendar year. If you still need the non-formulary medication in 2016, you will need to submit a new formulary exception request prior to the 2016 calendar year.

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 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 get “Extra Help” and haven’t received this insert by *September 30, 2015*, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services 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	2015 (this year)	2016 (next year)
<p>Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your drugs in tiers 2, 3, 4 and 5 until you have reached the yearly deductible.</p>	<p>The deductible is \$250 for brand name & specialty drugs (tiers 3, 4 and 5).</p> <p>During this stage, you pay the applicable co-payment for drugs on tiers 1 and 2 and the full cost of drugs on tiers 3, 4 and 5 until you have reached the yearly deductible.</p>	<p>The deductible is \$280 for (tiers 2, 3, 4 and 5).</p> <p>During this stage, you pay the applicable co-payment for drugs on tiers 1 and the full cost of drugs on tiers 2, 3, 4 and 5 until you have reached the yearly deductible.</p>

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	2015 (this year)	2016 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>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.</p> <p>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 <i>Evidence of Coverage</i>.</p> <p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Preferred Generic: You pay \$5 per prescription.</p> <p>Non-Preferred Generic: You pay \$15 per prescription.</p> <p>Preferred Brand: You pay \$45 per prescription.</p> <p>Non-Preferred Brand: You pay \$80 per prescription.</p> <p>Specialty: You pay 26% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$2,960, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Preferred Generic: You pay \$4 per prescription.</p> <p>Generic: You pay \$15 per prescription.</p> <p>Preferred Brand: You pay \$45 per prescription.</p> <p>Non-Preferred Brand: You pay \$85 per prescription.</p> <p>Specialty: You pay 26% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$3,310, you will move to the next stage (the Coverage Gap Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Aspire Health Advantage 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 2016.

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 2016 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, 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 <http://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, *Aspire Health Plan* offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change to a **different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *Aspire Health Advantage Value*.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *Aspire Health Advantage Value*.
- 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 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, 2016.

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, 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, 2016, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. 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 *California*, the SHIP is called **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)**.

California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) 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. **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** at *local: 831-655-1334 or toll free: 800-434-0222*. You can learn more about **California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP)** by visiting their website (<http://www.aging.ca.gov/hicap>).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to

75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications);
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the *Monterey County ADAP Office located at 780 Hamilton, Seaside CA 93955. Call the ADAP office at 831-394-4747 for more information.* For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *Ramsell Public Health to speak to a service representative at 888-311-7632.*

SECTION 7 Questions?

Section 7.1 – Getting Help from Aspire Health Advantage Value

Questions? We're here to help. Please call Member Services toll free at: (855)-570-1600. (TTY users call 711). We are available for phone calls *October 1 through February 14 – Sunday through Saturday 8 am to 8 pm February 15 through September 30 – Monday through Friday 8 am to 8 pm except certain holidays.*

Read your 2016 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 2016. For details, look in the 2016 *Evidence of Coverage for Aspire Health Advantage 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.aspirehealthplan.org. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 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 (<http://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 <http://www.medicare.gov> and click on “Find health & drug plans”).

Read *Medicare & You 2016*

You can read the *Medicare & You 2016* 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 (<http://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.