Aspire Health Advantage (HMO) offered by Aspire Health Plan

Annual Notice of Changes for 2019

You are currently enrolled as a member of Aspire Health Advantage. 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 1.2 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 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 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** Aspire Health Advantage, you don't need to do anything. You will stay in Aspire Health Advantage.
- 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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Aspire Health Advantage.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.

- Please contact our Member Services number at (855) 570-1600 for additional information. (TTY users should call 711). We are open 8 am to 8 pm PT Monday through Friday (except certain holidays) from April 1 through September 30, and 8 am to 8 pm PT seven days a week for the period of October 1 through March 31.

- This document is also available in large print.

- **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 Aspire Health Advantage

- Aspire Health Plan is an HMO 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.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Aspire Health Advantage 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* 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.	$129.00	$129.00
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,400	$5,000
Doctor office visits	Primary care visits: $0 co-pay per visit Specialist visits: $15 co-pay per visit	Primary care visits: $6 co-pay per visit Specialist visits: $16 co-pay 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.	Days 1-6: $275 co-pay per day Days 7-90: $0 co-pay per day	Days 1-6: $250 co-pay per day Days 7-90: $0 co-pay per day

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $150 on brand name and specialty drugs (tiers 3, 4 and 5) Co-payment/Co-insurance during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network): • **Drug Tier 1:** $2 • **Drug Tier 2:** $8 • **Drug Tier 3:** $45 • **Drug Tier 4:** $95 • **Drug Tier 5:** 30% Ninety (90) day <u>retail</u> cost-sharing (in-network) • **Drug Tier 1:** $4 • **Drug Tier 2:** $16 • **Drug Tier 3:** $90 • **Drug Tier 4:** $190 • **Drug Tier 5:** 30% Ninety (90) day mail-order cost-sharing (in-network) • **Drug Tier 1:** $4 • **Drug Tier 2:** $16 • **Drug Tier 3:** $90 • **Drug Tier 4:** $190 • **Drug Tier 5:** 30%	Deductible: $150 on brand name and specialty drugs (tiers 3, 4 and 5) Co-payment/Co-insurance during the Initial Coverage Stage: Thirty (30) day retail cost-sharing (in network): • **Drug Tier 1:** $4 • **Drug Tier 2:** $8 • **Drug Tier 3:** $45 • **Drug Tier 4:** $95 • **Drug Tier 5:** 30% Ninety (90) day <u>retail</u> cost-sharing (in-network) • **Drug Tier 1:** $12 • **Drug Tier 2:** $24 • **Drug Tier 3:** $135 • **Drug Tier 4:** $285 • **Drug Tier 5:** 30% Ninety (90) day <u>mail-order</u> cost-sharing (in-network) • **Drug Tier 1:** $8 • **Drug Tier 2:** $16 • **Drug Tier 3:** $90 • **Drug Tier 4:** $190 • **Drug Tier 5:** 30%

Annual Notice of Changes for 2019
Table of Contents

SECTION 1 Changes to 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.)	$129.00	$129.00
Enhanced Health Benefit This optional supplemental benefit includes comprehensive dental coverage, an enhanced eyewear benefit, a routine hearing exam and hearing aid benefit, and is available for an additional monthly premium.	$31.00 in additional premium per month if you choose to enroll in this optional coverage.	Not Covered.
Enhanced Benefits – Option A This optional supplemental benefit includes comprehensive dental coverage and an eyewear benefit, and is available for an additional monthly premium.	Not Covered.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.
Enhanced Benefits – Option B This optional supplemental benefit includes comprehensive dental coverage, an eyewear benefit, a routine hearing exam, a hearing aid benefit, 10 additional one-way rides to in-network medical appointments, and 14 meals following each inpatient hospital or skilled nursing facility stay and is available for an additional monthly premium.	Not Covered.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.

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

- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

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	2018 (this year)	2019 (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.	$3,400 In-network.	$5,000 In-network. 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 1.3 – 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 2019 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.
- 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 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 2019 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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Chiropractic services	You pay $0 co-pay for each Medicare-covered chiropractic visit. You pay $0 co-pay for each routine chiropractic visit (up to 6 per year).	You pay $10 co-pay for each Medicare-covered chiropractic visit. You pay $10 co-pay for each routine chiropractic visit (up to 6 per year).
Doctor office visits – Primary care	You pay $0 co-pay for each office visit.	You pay $6 co-pay for each office visit.

Cost	2018 (this year)	2019 (next year)
Doctor office visits – Specialty care	You pay $15 co-pay for each office visit.	You pay $16 co-pay for each office visit.
Durable Medical Equipment	You pay 15% coinsurance for each Medicare-covered item.	You pay 20% coinsurance for each Medicare-covered item.
Emergency care	You pay $80 co-pay for each Medicare-covered emergency room visit.	You pay $90 co-pay for each Medicare-covered emergency room visit.
Enhanced disease management – Life Connections	You pay nothing for the Enhanced Disease Management benefits.	Not Covered.
Enhanced Health Benefit This optional supplemental benefit includes comprehensive dental coverage, an enhanced eyewear benefit, a routine hearing exam and hearing aid benefit, and is available for an additional monthly premium.	$31.00 in additional premium per month if you choose to enroll in this optional coverage.	Not Covered.
Enhanced Benefits – Option A This optional supplemental benefit includes comprehensive dental coverage and an eyewear benefit, and is available for an additional monthly premium.	Not Covered.	$44.90 in additional premium per month if you choose to enroll in this optional coverage.

Cost	2018 (this year)	2019 (next year)
Enhanced Benefits – Option B This optional supplemental benefit includes comprehensive dental coverage, an eyewear benefit, a routine hearing exam, a hearing aid benefit, 10 additional one-way rides to in-network medical appointments, and 14 meals following each inpatient hospital or skilled nursing facility stay, and is available for an additional monthly premium.	Not Covered.	$49.90 in additional premium per month if you choose to enroll in this optional coverage.
Fitness Benefit – Silver&Fit® Exercise and Healthy Aging Program	Not covered.	You pay an annual member fee of $25 for fitness center/YMCA access or an annual member fee of $10 for two home fitness kits.
Hearing Services	You pay $15 co-pay for each Medicare-covered diagnostic hearing exam.	You pay $16 co-pay for each Medicare-covered diagnostic hearing exam.
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.	Days 1-6: $275 co-pay per day Days 7-90: $0 co-pay per day	Days 1-6: $250 co-pay per day Days 7-90: $0 co-pay per day
Inpatient mental health care Includes mental health services that require a hospital stay.	Days 1-5: $275 co-pay per day Days 6-90: $0 co-pay per day	Days 1-5: $250 co-pay per day Days 6-90: $0 co-pay per day

Cost	2018 (this year)	2019 (next year)
Outpatient hospital services and outpatient surgery, including services provided at hospital inpatient facilities and ambulatory surgical centers	You pay $15 co-pay for each Medicare-covered diagnostic colonoscopy and endoscopy surgical procedure at Medicare-covered outpatient facilities.	You pay $16 co-pay for each Medicare-covered diagnostic colonoscopy and endoscopy surgical procedure at Medicare-covered outpatient facilities.
Outpatient mental health care	You pay $15 co-pay for each Medicare-covered individual and group therapy visit.	You pay $16 co-pay for each Medicare-covered individual and group therapy visit.
Outpatient substance abuse services	You pay $15 co-pay for each Medicare-covered individual and group therapy visit.	You pay $16 co-pay for each Medicare-covered individual and group therapy visit.
Podiatry services	You pay $15 co-pay for each Medicare-covered visit.	You pay $16 co-pay for each Medicare-covered visit.
Preventive dental	You pay nothing for preventive dental.	Not Covered.
Routine eye exam	You pay $10 co-pay for each routine eye exam.	Not Covered.
Routine eyewear	You pay one $25 co-pay for eyewear materials (frames, lenses, or contacts).	Not Covered.
Vision care	You pay $15 co-pay for each Medicare-covered exam to diagnose and treat conditions of the eye (including yearly glaucoma screening).	You pay $16 co-pay for each Medicare-covered exam to diagnose and treat conditions of the eye (including yearly glaucoma screening).

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 is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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 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.

If the plan has granted a formulary exception for a non-formulary medication you are taking in 2018, the formulary exception will expire at the end of the calendar year. If you still need the non-formulary medication in 2019, you will need to submit a new formulary exception request prior to the 2019 calendar year.

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, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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 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, 2018, 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 *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 drugs in tiers 3, 4 and 5 until you have reached the yearly deductible.	The deductible is $150 for tiers 3, 4 and 5. 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.	The deductible is $150 for tiers 3, 4 and 5. During this stage, you pay the applicable cost-sharing 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.

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.** 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 $2 per prescription. **Generic:** You pay $8 per prescription. **Preferred Brand:** You pay $45 per prescription. **Non-Preferred Drug:** You pay $95 per prescription. **Specialty:** You pay 30% of the total cost. _____ Once your total drug costs have reached $3,750, 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 $4 per prescription. **Generic:** You pay $8 per prescription. **Preferred Brand:** You pay $45 per prescription. **Non-Preferred Drug:** You pay $95 per prescription. **Specialty:** You pay 30% of the total cost. _____ 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 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

	2018 (this year)	2019 (next year)
Pharmacy Benefits Manager (PBM)	Our PBM is called *National Pharmaceutical Services (NPS)*. Our Mail-Order Pharmacy is called *Integrated Home Mail Order (IHMO) and operates from Omaha, NE.*	Our PBM remains the same and has changed its name to *CastiaRx*. The Mail-Order Pharmacy name has changed to *CastiaRx Home Delivery and is moving to Creve Coeur, MO*.
Cardiac Rehabilitation Services	Prior authorization required for Cardiac Rehabilitation Services.	Prior authorization not required for Cardiac Rehabilitation Services.
Home Health Agency Care	Prior authorization required for Home Health Agency Care.	Prior authorization required for Home Infusion Services. All other medically necessary home health services do not require prior authorization.
Outpatient Rehabilitation Services	Prior authorization required for Outpatient Rehabilitation Services (physical therapy, occupational therapy, and speech therapy).	Prior authorization required for Outpatient Rehabilitation Services (physical therapy, occupational therapy, and speech therapy) after 12 visits in a calendar year, per therapy type.

	2018 (this year)	2019 (next year)
Pulmonary Rehabilitation Services	Prior authorization required for Pulmonary Rehabilitation Services.	Prior authorization not required for Pulmonary Rehabilitation Services.

SECTION 3 Deciding Which Plan to Choose

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

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 2019.

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 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.

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 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, 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.
- 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.

- 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, 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. 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, 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 2.2 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 am and 7 pm, 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 340 Church Street, Salinas, CA 93901. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP office at 831-975-5016.

SECTION 7 Questions?

Section 7.1 – Getting Help from Aspire Health Advantage

Questions? We're here to help. Please call Member Services at (855) 570-1600. (TTY only, call 711). We are available for phone calls October 1 through March 31 – Sunday through Saturday 8 am to 8 pm PT, April 1 through September 30 – Monday through Friday 8 am to 8 pm PT, except certain holidays. Calls 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 Aspire Health Advantage. 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 on the Aspire Health Plan Website. If you have any questions about

the *Evidence of Coverage* or would like a copy mailed to your home, please call Member Services toll free at (855) 570-1600 (TTY users call 711).

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 (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 the *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.

ASPIREHEALTHPLAN

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-570-1600 (TTY: 711).

SPANISH ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-570-1600 (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 1-855-570-1600 (TTY: 711).

VIETNAMESE CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-570-1600 (TTY: 711).

TAGALOG PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-570-1600 (TTY: 711).

KOREAN 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-570-1600 (TTY: 711) 번으로 전화해 주십시오.

ARMENIAN ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-570-1600 (TTY (հեռատիպ)՝ 711):

FARSI توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما رایگان برای 1-855-570-1600 (TTY: 711) تماس بگیرید.

RUSSIAN ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-570-1600 (телетайп: 711).

JAPANESE 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-570-1600 (TTY:711)まで、お電話にてご連絡ください。

ARABIC ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 558 075 0061. (رقم هاتف الصم والبكم : (TTY:117).

PANJABI ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-570-1600 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

MON-KHNER, CAMBODIA បព្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-570-1600 (TTY: 711)។

HMONG LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-570-1600 (TTY: 711).

HINDI ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-570-1600 (TTY: 711) पर कॉल करें।

THAI เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-570-1600 (TTY: 711).