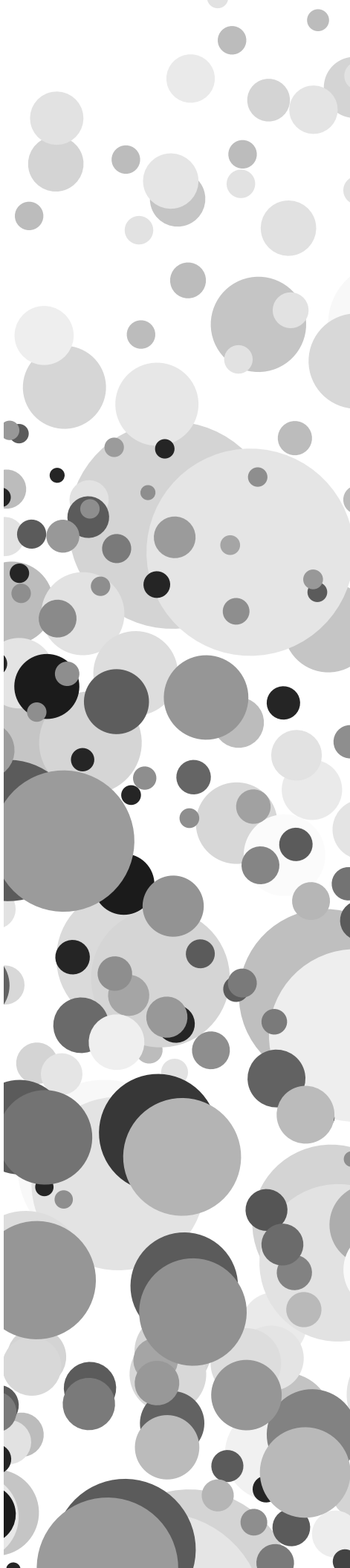
SOUTH COUNTRY
HEALTH ALLIANCE
Bringing Wellness Home

AbilityCare (HMO SNP)
offered by South Country Health Alliance

Annual Notice of Changes for 2019

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



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SCHA Member Services 1-866-567-7242, TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန္ဉ်, ကိးဘဉ်လီတဲစီနီ်ဂ်ံလၢထးအံၤန္ဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

CB5 MCOs 3-18

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (SCHA) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: SCHA provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** SCHA Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Language Assistance Services: SCHA provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** SCHA Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by SCHA. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:
Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:
Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

SCHA Complaint Notice

You have the right to file a complaint with SCHA if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Attn: Civil Rights Coordinator
South Country Health Alliance
2300 Park Drive, Suite 100
Owatonna, MN 55060
Toll Free: 866-567-7242
TTY: 800-627-3529 or 711
Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

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 is important to review your coverage now to make sure they will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 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 and 1.4 for information about our *Provider and Pharmacy Directory*.

□ **Think about your overall health care costs.**

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do the 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 chioce 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** AbilityCare, you don't need to do anything. You will stay in AbilityCare.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in section 3, page 6 to learn more about your choices.

4. **ENROLL**: To change plans, join a plan between now and **December 31, 2018**

- If you **don't join another plan by December 31, 2018**, you will stay in AbilityCare.
- If you **join another plan by December 31, 2018**, your new coverage will start the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in section 4, page 7 to learn more.

Additional Resources

- Please contact our Member Services number at 1-866-567-7242 for additional information (TTY users should call 1-800-627-3529 or 711). From October through March, hours are 8 a.m. to 8 p.m., 7 days a week. From April through September, hours are 8 a.m. to 8 p.m., Monday - Friday.
- If you ask, we will give you this information in another form, such as Braille, large print, or on audio tape. Call Member Services at the number above.
- **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 AbilityCare

AbilityCare (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in AbilityCare depends on contract renewal.

When this booklet says "we," "us," or "our," it means South Country Health Alliance. When it says "plan" or "our plan," it means AbilityCare.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for AbilityCare 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.	**$0**	**$0**
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 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.	$0	$0
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copays during the Initial Coverage Stage: • Tier 1 generic drugs: $0/$1.25/$3.35 • Tier 1 brand drugs: $0/$3.70/$8.35	Deductible: $0 Copays during the Initial Coverage Stage: • Tier 1 generic drugs: $0/$1.25/$3.40 • Tier 1 brand drugs: $0/$3.80/$8.50
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 You are not responsible for paying any out of pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$6,700 You are not responsible for paying any out of pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services

Annual Notice of Changes for 2019

Table of Contents

SECTION 1 Changes to Medicare Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium, unless it is paid for you by **Medical Assistance** (Medicaid).)	$0	$0

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

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

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medical Assistance (Medicaid), very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) 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

Section 1.3 Changes to the Provider Network

There are changes to our network of providers for next year.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year.

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

Section 1.5 There Are No Changes to Your Benefits or Amounts You Pay for Medical Services

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

Our benefits and what you pay for these covered medical services will be exactly the same in 2019 as they are in 2018.

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. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website www.mnscha.org.

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

If you are affected by a change in drug coverage, you can:

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

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (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.

Most current formulary exceptions will be covered through 2019.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We 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 December 31, 2018, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are listed 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Copayments in the Initial Coverage Stage

To learn how copayments 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 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. For information about the costs for a long-term supply, 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: **Tier 1 generic drugs:** You pay $0/$1.25/$3.35 **Tier 1 brand drugs:** You pay 0/$3.70/$8.35 Once you have paid $5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 generic drugs:** You pay $0/$1.25/$3.40 **Tier 1 brand drugs:** You pay 0/$3.80/$8.50 Once you have paid $5,100 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Administrative Changes

Prior authorization requirements for some services will change in 2019. South Country recommends referring to the *Evidence of Coverage* for a complete list of service details. A copy of the *Evidence of Coverage* is located on our website at www.mnscha.org. You may also call member services to ask us to mail an *Evidence of Coverage.*

	2018 (this year)	2019 (next year)
Prior authorization requirement limit for Durable Medical Equipment (DME-POS) and related supplies	Prior authorization required for any DME item with a cost of $750 or more	Prior authorization required for any DME item with a cost of $1500 or more
Cardiovascular (heart) rehabilitation services	Prior authorization may be required	No prior authorization required
Acupuncture	Prior authorization required	No prior authorization required
Vision Care	No prior authorization required for contact lenses	Prior authorization required for contact lenses
Cosmetic Surgery	No prior authorization required	Prior authorization required for all cosmetic surgeries
Genetic Testing	No prior authorization required	Prior authorization required for all genetic testing services
Non-emergency, non-urgent health care services from out-of-network health care providers	Prior authorization required	Prior authorization required, except for out-of-network services provided in Minnesota
Out-of-State, Out-of-Network Inpatient Hospital Care	Prior authorization required for admissions	Notification required for out-of-network admissions in Minnesota, North Dakota, South Dakota, Iowa, and Wisconsin. Prior authorization required for out-of-network admissions in all other states

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in AbilityCare

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

Section 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 at any time,
- – *OR* – You can change to Original Medicare at any time. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

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

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 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 and drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

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

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Changing Plans

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

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medical Assistance (Medicaid), those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage*.

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

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare and Medical Assistance (Medicaid)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Minnesota the SHIP is called the Senior LinkAge Line®.

The Senior LinkAge Line® is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Senior LinkAge Line® counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call The Senior LinkAge Line® at 1-800-333-2433 (TTY only, call 711) You can learn more about The Senior LinkAge Line® by visiting their website (http://www.seniorlinkageline.com/).

Minnesota also has a state program called **Disability Hub MN**, which is an independent program that gives free local health insurance counseling for people with disabilities. **Disability Hub MN** is independent (not connected with any insurance company or health plan). Trained **Disability Hub MN** counselors can help you understand your options to combine your Medical Assistance (Medicaid) and Medicare through one managed care plan and understand your Medicare Part D plan choices. You can call **Disability Hub MN** at 1-866-333-2466 (TTY only, call 711). You can learn more about **Disability Hub MN** by visiting their website (https://disabilityhubmn.org).

For questions about your Medical Assistance (Medicaid) benefits, contact Minnesota Health Care Programs (MHCP) Member Help Desk, at 1-800-657-3739, Monday – Friday, 8 am – 5 pm. TTY users should use your preferred relay service. Ask how joining another plan or returning to Original Medicare affects how you get your Medical Assistance (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

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

SECTION 7 Questions?

Section 7.1 Getting Help from AbilityCare

Questions? We're here to help. Please call Member Services at 1-866-567-7242 (TTY users should call 1-800-627-3529 or 711). From October hrough March, we are available for phone calls between 8 a.m. and 8 p.m., 7 days a week. From April through September, we are available for phone calls between 8 a.m. and 8 p.m., Monday through Friday. 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 AbilityCare. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.mnscha.org. You may also call member services to ask us to mail an *Evidence of Coverage.*

Visit our Website

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

Section 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 *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 Getting Help from Medical Assistance (Medicaid)

To get information from Medical Assistance (Medicaid), you can call the Department of Human Services at 1-800-657-3739 (outside Twin Cities metro area) or 1-651-431-2670 (Twin Cities metro area). TTY users should call 1-800-627-3429 or 711, Monday - Friday, 8 a.m. to 5 p.m.