Aurora Special Needs Plan (HMO SNP) offered by Independent Care Health Plan

Annual Notice of Changes for 2018

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and 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 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 4.2 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** Aurora Special Needs Plan, you don't need to do anything. You will stay in Aurora Special Needs Plan.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans at any time. Your new coverage will begin on the first day of the following month. Look in section 4.2, page 18 to learn more about your choices.

Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Aurora Special Needs Plan

- The *i*Care Aurora Special Needs Plan (HMO SNP) is a Coordinated Care plan with a Medicare Advantage contract and a contract with the Wisconsin Medicaid Program. Enrollment in the *i*Care Aurora Special Needs Plan depends on contract renewal. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
- When this booklet says "we," "us," or "our," it means Independent Care Health Plan (*i*Care). When it says "plan" or "our plan," it means Aurora Special Needs Plan.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Aurora Special Needs Plan 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	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	**$0** (You must continue to pay your Medicare Part B premium, unless it is paid by Medicaid or another third-party.)	**$0** (You must continue to pay your Medicare Part B premium, unless it is paid by Medicaid or another third-party.)
Doctor office visits	Primary care visits: 0% or 0% to 20% of the cost for Medicare Covered benefits per visit Specialist visits: 0% or 0% to 20% of the cost for Medicare Covered benefits per visit	Primary care visits: 0% or 0% to 20% of the cost for Medicare Covered benefit per visit Specialist visits: 0% or 0% to 20% of the cost for Medicare Covered benefits per visit

Cost	2017 (this year)	2018 (next year)
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**.**	In 2017 the amounts for each benefit period were $0 or: • $1,316 deductible for each benefit period. • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $329 coinsurance per day of each benefit period. • Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.	These amounts may change for 2018.

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: You pay a $0 annual deductible. Copays during the Initial Coverage Stage: • Drug Tier 1: (Generic Drugs, including brand drugs treated as generic) Depending on your income and institutional status, you pay either: $0 or $1.20 or $3.30 copay per prescription. • After your yearly out-of-pocket drug costs reach $4,950, you pay a $0 copay. • Drug Tier 2: (Brand Drugs) Depending on your income and institutional status, you pay either: $0 or $3.70 or $8.25 copay per prescription.	Deductible: You pay a $0 annual deductible. Copays during the Initial Coverage Stage: • Drug Tier 1: (Generic Drugs, including brand drugs treated as generic) Depending on your income and institutional status, you pay either: $0 or $1.25 or $3.35 copay per prescription. • After your yearly out-of-pocket drug costs reach $5,000, you pay a $0 copay. • Drug Tier 2: (Brand Drugs) Depending on your income and institutional status, you pay either: $0 or $3.70 or $8.35 copay per prescription.
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 2.2 for details.)	$6,700 out-of-pocket limit for Medicare-covered services.	$6,700 out-of-pocket limit for Medicare-covered services.

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Aurora Special Needs Plan in 2018

If you do nothing to change your Medicare coverage in 2017, we will automatically enroll you in our Aurora Special Needs Plan. This means starting January 1, 2018, you will be getting your medical and prescription drug coverage through Aurora Special Needs Plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you are eligible for Low Income Subsidies, you can change plans at any time.

The information in this document tells you about the differences between your current benefits in Aurora Special Needs Plan and the benefits you will have on January 1, 2018, as a member of Aurora Special Needs Plan.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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 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	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** 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	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 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.icarehealthplan.org/aurora. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 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 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.icarehealthplan.org/aurora. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

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

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

Cost	2017 (this year)	2018 (next year)
***Depending on your level of Medicaid Eligibility, you may not have any cost sharing responsibility for original Medicare Services.**		

Cost	2017 (this year)	2018 (next year)
Health Education with Transportation	Health education is not a covered benefit.	You pay nothing. The Health Education with Transportation benefit provides members with the ability to attend health education sessions to reinforce healthy behaviors, which leads to better outcomes. The Plan will pay registration fees for selected courses. Additionally, transportation is provided to and from health education sessions for up to 36 one-way trips annually, up to 35 miles. Prior authorization is required

Cost	2017 (this year)	2018 (next year)
Inpatient Hospital Care	• In 2017 the amounts for each benefit period were $0 or: • $1,316 deductible for each benefit period.* • Days 1–60: $0 coinsurance for each benefit period.* • Days 61–90: $329 coinsurance per day of each benefit period.* • Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).* Beyond lifetime reserve days: all costs.*	These amounts may change for 2018.

Cost	2017 (this year)	2018 (next year)
Inpatient Mental Health Care	In 2017 the amounts for each benefit period were $0 or: • $1,316 deductible for each benefit period.* • Days 1–60: $0 coinsurance per day of each benefit period.* • Days 61–90: $329 coinsurance per day of each benefit period.* • Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).* • Beyond lifetime reserve days: all costs.* • 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.*	These amounts may change for 2018.

Cost	2017 (this year)	2018 (next year)
Skilled Nursing Facility (SNF)	In 2017 the amounts for each benefit period were $0 or: • Days 1–20: $0 for each benefit period.* • Days 21–100: $164.50 coinsurance per day of each benefit period.* • Days 101 and beyond: all costs.*	These amounts may change for 2018.

Supplemental Dental Services	Supplemental Dental services under Medicare Part C for preventive and comprehensive dental services limited to a total of $750 per calendar year. **Preventive** • Oral Exams and cleaning: Up to 2 per calendar year. • Dental X-Rays: Up to 1 per calendar year. X-Rays are limited to either 1 panoramic or 1 full set per calendar year. **Comprehensive** • Diagnostic services: Up to 2 per calendar year. • Restorative services: Up to 2 per calendar year. • Endodontics/Periodontics/ • Extractions: Up to 2 per calendar year. Simple Restorations are limited to Amalgams/Resigns (No root canals/crowns) – 1 restoration per tooth per calendar year. - Simple Extractions - No surgical extractions. Emergency Office Visits are limited to 2 visits per calendar year. You pay nothing when you receive these covered services from network providers.	Supplemental Dental services under Medicare Part C for preventive and comprehensive dental services limited to a total of $2,500 per calendar year. **Preventive** • Oral Exams and cleaning: Up to 2 per calendar year. • Dental X-Rays: Up to 1 per calendar year. X-Rays are limited to either 1 panoramic or 1 full set per calendar year. **Comprehensive** • Diagnostic Services: Up to 2 per calendar year • Restorative Services: Up to 2 per calendar year • Extractions: Up to 2 per calendar year • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Up to 2 per calendar year • Simple Restorations are limited to Amalgams/Resins (No root canals or crowns) –1 restoration per tooth per calendar year • Simple extractions - No surgical extractions. • Basic Partials and Basic Dentures are covered, no coverage for repair. • Emergency Office Visits are limited to 2 visits per calendar year.

Cost	2017 (this year)	2018 (next year)
		You pay nothing when you receive these covered services from network providers.
Meals Benefit	You pay nothing. Up to 28 days of meals (maximum 56 meals provided). Prior authorization may be required. May require a referral from your doctor.	You pay nothing. Up to 28 days of meals (maximum 84 meals provided) Prior authorization is required. Requires a referral from your doctor.
Over-the-Counter Items	$42 per month for over-the-counter "Drug Store" type items. Unused amounts roll over to the next month. Unused amounts do not roll over to the next calendar year.	$85 per month for over-the-counter "Drug Store" type items. Balances are re-set each calendar quarter, which end on the last days of March, June, September, and December. Unused amounts do not roll over to the next calendar year.

Cost	2017 (this year)	2018 (next year)
Remote Access Technology (Telehealth)	Remote access technology is not a covered benefit.	You pay nothing. If you have high-speed Internet access you can connect to an Urgent Care Provider, a Behavioral Health Specialist or a Nutritionist via a live, two-way video through your home computer or smart phone using Amwell's telehealth application. You can have a two-way video conference with a provider 24 hours-a-day, 7 days-a-week. You can also visit *i*Care's Milwaukee office to use Amwell Health Kiosk during regular business hours (Monday – Friday, 8:30 a.m. to 5:00 p.m). Maximum of 12 visits per calendar year.

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." An updated Drug List is located on our website. **You can get the *complete* Drug List** by calling Customer Service (see the back cover) or visiting our website (www.icarehealthplan.org/aurora).

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 Customer Service.

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

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage 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.

In most cases, formulary exceptions are approved for a time period of one year. When your formulary exception is approved, we send you a letter with the dates of approval. The approval may extend into the next coverage year. A new formulary exception request will need to be submitted when your current exception expires.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 8.1 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	2017 (this year)	2018 (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 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	2017 (this year)	2018 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic Drugs:** You pay a $0 or $1.20 or $3.30 co-pay per prescription **Brand Drugs:** You pay a $0 or $3.70 or $8.25 co-pay per prescription **Specialty Drugs:** You pay a $0 or $1.20 or $3.30 or $3.70 or $8.25 copay per prescription depending on whether the drug is brand or generic. _____	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Generic Drugs:** You pay a $0 or $1.25 or $3.35 co-pay per prescription **Brand Drugs:** You pay a $0 or $3.70 or $8.35 co-pay per prescription **Specialty Drugs:** You pay a $0 or $1.25 or $3.35 or $3.70 or $8.35 copay per prescription depending on whether the drug is brand or generic. _____

Stage 2: Initial Coverage Stage (continued)		
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost-sharing; 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.	Once you have paid $4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid $5,000 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 3 Changes to your Medicaid Benefits

For changes to your Medicaid benefits please see your Evidence of Coverage.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Aurora Special Needs Plan

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 2018.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan at any time,
- -- *OR*-- You can change to Original Medicare at any time.

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 2018*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aurora Special Needs Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Aurora Special Needs Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 8.1 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 5 Deadline for Changing Plans

Because you are eligible for both Medicare and Medicaid you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called Wisconsin Board of Aging & Long Term Care.

The Wisconsin Board of Aging & Long Term Care 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 Wisconsin Board of Aging & Long Term Care 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 Wisconsin Board of Aging & Long Term Care at 1-800-242-1060. You can learn more about the Wisconsin Board of Aging & Long Term Care by visiting their website (www.longtermcare.wi.gov).

For questions about your Wisconsin Medicaid benefits, contact Wisconsin Department of Health Services at 1-800-362-3002, Monday – Friday, 8:00 am to 6:00 pm Central Time. Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Wisconsin has a program called SeniorCare that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 6 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain

criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Wisconsin AIDS/HIV Health Insurance Premium Subsidy Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-991-5532.

SECTION 8 Questions?

Section 8.1 – Getting Help from Aurora Special Needs Plan

Questions? We're here to help. Please call Customer Service, at 1-855-818-1129 (TTY users, 1-800-947-3529), 24 hours-a-day, 7 days-a-week (office hours: Monday-Friday, 8:30 a.m. to 5:00 p.m), or visit www.icarehealthplan.org/aurora. Calls to these numbers are free.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Aurora Special Needs Plan. 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.icarehealthplan.org/aurora. 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 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the

Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2018*

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 8.3 – Getting Help from Medicaid

To get information from Medicaid you can call the Wisconsin Department of Health Services at 1-800-362-3002. TTY users should call 1-888-701-1251.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Care Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Kandi Lortie.

If you believe that Independent Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Quality Improvement Specialist Kandi Lortie, 1555 N. RiverCenter Dr., Suite 206, Milwaukee, WI 53212, 1-800-777-4376 (TTY: 1-800-947-3529), 414-231-1094, klortie@icarehealthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Quality Improvement Specialist Kandi Lortie is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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