Aurora CompleteCare (HMO SNP) offered by Independent Care Health Plan

Annual Notice of Changes for 2019

You are currently enrolled as a member of Aurora CompleteCare. 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 2019 Drug List and look in Section 2.6 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 2.3 for information about our Provider/Pharmacy Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?

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- 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, "If you want to change plans," 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 CompleteCare, you don't need to do anything. You will stay in Aurora CompleteCare.
- 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 4.2, page 16 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 Aurora CompleteCare.
- 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 16, or the *Evidence of Coverage* to learn more.

Additional Resources

- Please contact our Customer Service number at 1-800-777-4376 for additional information. TTY users should call 1-800-947-3529. Hours are 24 hours a day, 7 days a week. Office hours are Monday – Friday, 8:30 a.m. to 5:00 p.m.
- Please contact Customer Service at the number above should you require plan materials in another format such as Braille or 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 Aurora CompleteCare

- Aurora CompleteCare (HMO SNP), insured by Independent Care Health Plan, is a Coordinated Care plan with a Medicare contract. Enrollment in the Aurora CompleteCare depends on contract renewal. The plan also has a written agreement with the State Medicaid program to coordinate your Medicaid benefits.
- When this booklet says “we,” “us,” or “our,” it means Independent Care Health Plan. When it says “plan” or “our plan,” it means Aurora CompleteCare.

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Aurora CompleteCare 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 or Summary of Benefits 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 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% to 20% of the cost for Medicare Covered benefits per visit. Specialist visits: 0% or 20% of the cost for Medicare Covered benefits per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your doctor office visits and inpatient hospital stays.	Primary care visits: 0% or 20% of the cost for Medicare Covered benefit per visit. Specialist visits: 0% or 20% of the cost for Medicare Covered benefits per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your doctor office visits and inpatient hospital stays.

Cost	2018 (this year)	2019 (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.	These are 2018 cost sharing amounts. In 2018 the amounts for each benefit period was $0 or: • $1,340 deductible for each benefit period. • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $335 coinsurance per day of each benefit period. • Days 91 and beyond: $670 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. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your doctor office visits and inpatient hospital stays.	These amounts may change for 2019. Aurora CompleteCare will provide updated rates as soon as they are released. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your doctor office visits and inpatient hospital stays.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: You pay a $0 annual deductible. Co-pays 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 co-pay per prescription. • Drug Tier 2 (Brand Drugs): Depending on your income and institutional status, you pay either: $0 or $3.70 or $8.35 co-pay per prescription. • Drug Tier 3 (Specialty Drugs): Depending on your income and institutional status, you pay either: $0 or $3.70 or $8.35 co-pay per prescription. • After your yearly out-of-pocket drug costs reach $5,000, you pay a $0 co-pay.	Deductible: You pay a $0 annual deductible. Co-pays 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 $3.40 co-pay per prescription. • Drug Tier 2 (Brand Drugs): Depending on your income and institutional status, you pay either: $0 or $3.80 or $8.50 co-pay per prescription. • Drug Tier 3 (Specialty Drugs): Depending on your income and institutional status, you pay either: $0 or $3.80 or $8.50 co-pay per prescription. • After your yearly out-of-pocket drug costs reach $5,100, you pay a $0 co-pay.

Cost	2018 (this year)	2019 (next year)
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. If you are eligible for Medicare cost-sharing assistance under Medicaid, 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 out-of-pocket limit for Medicare-covered services. If you are eligible for Medicare cost-sharing assistance under Medicaid, 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.

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from *Aurora Special Needs Plan* to *Aurora CompleteCare.*

Members of the Aurora Special Needs Plan will receive a new member ID card in the mail that will have the Aurora CompleteCare name/logo on it by December 31, 2018. When you receive your ID card with the Aurora CompleteCare name/logo on it, **please destroy your ID card that has the Aurora Special Needs Plan name/logo on it.**

As you receive plan notifications, if applicable to you, related to treatment (prior authorizations, referrals or coverage determination letters), payments (Explanation of Benefits) and plan operations (grievance and appeals letters), and other marketing or communication materials, these letters and notices will be updated with the new name. Again, Aurora Special Needs Plan is changing its name to Aurora CompleteCare effective January 1, 2019.

SECTION 2 Changes to Medicare Benefits and Costs for Next Year

Section 2.1 – 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 Medicaid.)	$0	There is no change for 2019.

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	2018 (this year)	2019 (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. If you are eligible for Medicaid assistance with Part A and Part B co-pays, 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 co-pays) 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.	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.	There is no change for 2019.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider/Pharmacy Directory is located on our website at www.icarehealthplan.org (the directory is also our "Find a Provider" tool on the website). You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. You may also use the request form on our website to have us mail you a Provider/Pharmacy Directory. **Please review the 2019 Provider/Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 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 Provider/Pharmacy Directory is located on our website at www.icarehealthplan.org (the Provider/Pharmacy directory is also our “Find a Provider” tool on the website). You may also call Customer Service for updated provider information, or to ask us to mail you a Provider/Pharmacy Directory. You can also use the request form on our website to request a copy of the Provider/Pharmacy Directory. **Please review the 2019 Provider/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 on the next few pages 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 2019 Evidence of Coverage. The Evidence of Coverage is posted to our website, www.icarehealthplan.org, or you may request a hard copy by calling Customer Service or use the request form on the website.

Cost	2018 (this year)	2019 (next year)
Health Education	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.	You pay nothing. This benefit was Health Education with Transportation in 2018. For 2019, it is called "Health Education". 18 education sessions are included in this benefit. Non-emergency transportation to/from health education classes are covered for 100 one-way trips up to 35 miles. See Non-Emergency Transportation.
Inpatient Hospital Care	These are 2018 cost sharing amounts. In 2018 the amounts for each benefit period was $0 or: • $1,340 deductible for each benefit period. • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $335 coinsurance per day of each benefit period. • Days 91 and beyond: $670 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 2019. Aurora CompleteCare will provide updated rates as soon as they are released.
Please note: Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility for original Medicare Services.		

Cost	2018 (this year)	2019 (next year)
Inpatient Mental Health Care	These are 2018 cost sharing amounts. In 2018 the amounts for each benefit period was $0 or: • $1,340 deductible for each benefit period. • Days 1–60: $0 coinsurance per day of each benefit period. • Days 61–90: $335 coinsurance per day of each benefit period. • Days 91 and beyond: $670 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 2019. Aurora CompleteCare will provide updated rates as soon as they are released.
Skilled Nursing Facility (SNF)	In-Network. Plan covers up to 100 days each benefit period. 3-day prior hospital stay is required. In 2018 the amounts for each benefit period were $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $167.50 coinsurance per day of each benefit period. • Days 101 and beyond: all costs.	These amounts may change for 2019. Aurora CompleteCare will provide updated rates as soon as they are released.
Please note: Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility for original Medicare Services.		

Cost	2018 (this year)	2019 (next year)
Supplemental Benefits		
Supplemental Vision Services	This plan provides a supplemental benefit under Medicare Part C for eye wear of up to $150.00 per calendar year towards the purchase of eyeglass lenses and frames.	This plan provides a supplemental benefit under Medicare Part C for eye wear of up to $450.00 per calendar year towards the purchase of one (1) set of eyeglass lenses and frames per calendar year.
Non-Emergency Transportation	36 one-way trips as part of health education with transportation benefit.	100 one-way trips up to 35 miles. Covered only for travel to/from health education classes and Weight Watchers meetings.
Over-the-Counter (OTC)	In 2018, the $85 per month reset once a quarter. In other words, the dollar amounts expire at the end of each calendar quarter (March 31, June 30, September 30, and December 31) OR if you disenroll before the end of the year.	In 2019, the $85 per month resets annually. The amounts will not expire at the end of each quarter. They accumulate over the calendar year. They expire December 31st or if you disenroll before the end of the year.

Cost	2018 (this year)	2019 (next year)
Supplemental Dental Services	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. 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 visits per calendar year • Simple Restorative Services – Limited to Amalgams/Resins (No root canals/crowns): One restoration per tooth per calendar year. • Extractions: Simple extractions only, no surgical extractions. • Prosthodontics: Basic Partials and Basic Dentures are covered, no coverage for repair. • Emergency Office Visits: Limited to 2 visits per calendar year. You pay nothing when you receive these covered services from network providers.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is located on our website at www.icarehealthplan.org. **You can get the *complete* Drug List** by calling Customer Service (see Section 8.1) or visiting our website www.icarehealthplan.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 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 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. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary day supply provided in all other cases: 31-days of medication rather than the amount provided in 2018 (30-days of medication). (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 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 year, if the date on the approval extends into the next calendar year. A new formulary exception request will need to be submitted when your current exception expires.

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 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	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 Cost-sharing in the Initial Coverage Stage

To learn how co-payments 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 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: **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 co-pay per prescription depending on whether the drug is brand or generic. Once your total drug costs have reached $5,000, you will move to the next stage (the Catastrophic Coverage Stage).	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 $3.40 co-pay per prescription. **Brand Drugs**: You pay a $0 or $3.80 or $8.50 co-pay per prescription. **Specialty Drugs**: You pay a $0 or $1.25 or $3.40, or $3.80 or $8.50 co-pay per prescription depending on whether the drug is brand or generic. Once your total drug costs have reached $5,100, 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 CompleteCare

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 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 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.

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 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.**

As a reminder, *Independent Care Health Plan* offers other Medicare Advantage Prescription Drug plans. These other plans may differ in coverage and provider networks.

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 CompleteCare.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Aurora CompleteCare.
- 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 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 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 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 State Medicaid benefits, contact Wisconsin Department of Health Services at 1-800-362-3002, Monday – Friday, 8:00 a.m. to 6:00 p.m. Central Time. Ask how joining another plan or returning to Original Medicare affects how you get your State 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 day a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** 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 CompleteCare

Questions? We're here to help. Please call Customer Service, at 1-800-777-4376 (TTY users, 1-800-947-3529). We are available for phone calls 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. 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 Aurora CompleteCare. 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 notice which explains how to get 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. As a reminder, our website has the most up-to-date information about our provider network ("Find a Provider" tool) 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 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 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.

SECTION 9 Legal Notices

Notice about Nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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 Customer Service at 1-800-777-4376 (TTY: 1-800-947-3529), 24 hours a day, 7 days a week (office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.).

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@icare-wi.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*.

National Standards for Culturally and Linguistically Appropriate Services

Independent Care Health Plan has adopted all National Standards for Culturally and Linguistically Appropriate Services (CLAS). The National CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for individuals and health care organizations to follow.

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).

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。1-800-777-4376 (TTY: 1-800-947-3529).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-4376 (TTY: 1-800-947-3529).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-777-4376 (رقم هاتف الصم والبكم: 1-800-947-3529).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-4376 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-4376 (TTY: 1-800-947-3529) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-4376 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-777-4376 (TTY: 1-800-947-3529).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-4376 (ATS: 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-777-4376 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-777-4376 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-777-4376 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-4376 (TTY: 1-800-947-3529).