Providence Medicare Align Group Plan + RX (HMO) offered by Providence Health Assurance

Annual Notice of Changes for 2018

You are currently enrolled as a member of Providence Medicare Align Group Plan + RX (HMO). Next year, there will be some changes to the plan’s costs and benefits. This booklet tells about the changes.

- You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

What to do now

1. **ASK: Which changes apply to you**

   - Check the changes to our benefits and costs to see if they affect you.
     - It’s important to review your coverage now to make sure it will meet your needs next year.
     - Do the changes affect the services you use?
     - Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

   - Check the changes in the booklet to our prescription drug coverage to see if they affect you.
     - Will your drugs be covered?
     - Are your drugs in a different tier, with different cost-sharing?
     - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
     - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
     - Review the 2018 Drug List and look in Section 1.6 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 1.3 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 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.
  - Review the list in the back of your Medicare & You handbook.
  - Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. **CHOOSE:** Decide whether you want to change your plan

  - If you want to **keep** Providence Medicare Align Group Plan + RX (HMO), you don’t need to do anything. You will stay in Providence Medicare Align Group Plan + RX (HMO).
  - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15 and December 7, 2017**

  - If you **don’t join by December 7, 2017**, you will stay in Providence Medicare Align Group Plan + RX (HMO).
  - If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.
Additional Resources

- 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 Providence Medicare Align Group Plan + RX (HMO)

- Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with a Medicare and Oregon Health Plan contract. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

- When this booklet says “we,” “us,” or “our,” it means Providence Health Assurance. When it says “plan” or “our plan,” it means Providence Medicare Align Group Plan + RX (HMO).
# Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Providence Medicare Align Group Plan + RX (HMO) 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 attached Evidence of Coverage to see if other benefit or cost changes affect you.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong>*</td>
<td>Starting January 1, 2017 please check with your retiree benefits office regarding any changes in the monthly premium that you pay.</td>
<td>Starting January 1, 2018 please check with your retiree benefits office regarding any changes in the monthly premium that you pay.</td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td>Primary care visits: a $15 copay per visit</td>
<td>Primary care visits: a $15 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visits: a $20 copay per visit</td>
<td>Specialist visits: a $20 copay per visit</td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td>You pay a $100 copay each day for days 1-5 and a $0 copay each day for days 6 and beyond for Medicare-covered inpatient hospital care.</td>
<td>You pay a $100 copay each day for days 1-5 and a $0 copay each day for days 6 and beyond for Medicare-covered inpatient hospital care.</td>
</tr>
<tr>
<td>Cost</td>
<td>2017 (this year)</td>
<td>2018 (next year)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Deductible: $0</td>
<td>Deductible: $0</td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td>Coinsurance during the Initial Coverage Stage:</td>
<td>Coinsurance during the Initial Coverage Stage:</td>
</tr>
<tr>
<td>• Drug Tier 1 (Generic): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td>• Drug Tier 1 (Generic): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 2 (Preferred Brand Name): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td>• Drug Tier 2 (Preferred Brand Name): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 3 (Non-Preferred Brand Name): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td>• Drug Tier 3 (Non-Preferred Brand Name): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>2017 (this year)</td>
<td>2018 (next year)</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Part D prescription drug coverage (continued)</td>
<td>• Drug Tier 4 (Specialty): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
<td>• Drug Tier 4 (Specialty): 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy</td>
</tr>
<tr>
<td>(See Section 1.6 for details.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annual Notice of Changes for 2018

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>Starting January 1, 2017 please check with your retiree benefits office regarding any changes in the monthly premium that you pay.</td>
<td>Starting January 1, 2018 please check with your retiree benefits office regarding any changes in the monthly premium that you pay.</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>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.</td>
<td>$1,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.</td>
<td></td>
</tr>
</tbody>
</table>

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.ProvidenceHealthPlan.com/PHIP. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. Please review the 2018 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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

Our network has changed more than usual for 2018. An updated Provider and Pharmacy Directory is located on our website at www.ProvidenceHealthPlan.com/PHIP. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **We strongly suggest that you review our current Provider and Pharmacy Directory to see if your pharmacy is still in our network.**
Section 1.5 – Changes to Benefits and Costs for Medical Services

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

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Nutrition Therapy (non-Medicare-covered)</td>
<td>Medical nutrition therapy is not covered for every medical condition.</td>
<td>You pay a $0 copay for medical nutrition therapy ordered by a physician, regardless of your medical condition.</td>
</tr>
<tr>
<td>Vision Care</td>
<td>You have an allowance of up to $100 for routine eyeglass frames or contacts every two calendar years. Basic lenses are covered in full. Vision hardware upgrades are not covered.</td>
<td>You have an allowance of up to $100 every two calendar years for routine vision hardware (prescription contacts, prescription lenses, frames, and/or upgrades, such as tinting). You pay a $0 copay for vision hardware upgrades.</td>
</tr>
<tr>
<td>Vision Service Plan (VSP) administers the routine vision exam and hardware coverage.</td>
<td>You can get your routine vision hardware and annual routine vision exam from any qualified provider.</td>
<td></td>
</tr>
</tbody>
</table>

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 in this envelope. Our drug list is also available online at www.ProvidenceHealthPlan.com/PHIP.

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.**
  - 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 other 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 the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you had an approved formulary exception during the previous year, a new request may need to be submitted for the current year. To see if you need a new formulary exception request, you may call Customer Service.

### Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by September 30, 2017, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage.*)
Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Stage</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 1 Generic Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
<td><strong>Tier 1 Generic Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 2 Preferred Brand Name Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
<td><strong>Tier 2 Preferred Brand Name Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 3 Non-Preferred Brand Name Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
<td><strong>Tier 3 Non-Preferred Brand Name Drugs:</strong> You pay 40% of the total cost up to a maximum of $250.</td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>Stage 2: Initial Coverage Stage (continued)</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4 Specialty Drugs:</td>
<td>You pay 40% of the total cost up to a maximum of $250.</td>
<td>You pay 40% of the total cost up to a maximum of $250.</td>
</tr>
<tr>
<td>Once you have paid $4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
<td>Once you have paid $5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
<td></td>
</tr>
</tbody>
</table>

### Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*
## SECTION 2 Administrative Changes

<table>
<thead>
<tr>
<th>Cost</th>
<th>2017 (this year)</th>
<th>2018 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change to in-network pharmacy</td>
<td>Wellpartner Pharmacy is an in-network pharmacy.</td>
<td>Wellpartner Pharmacy is an out-of-network pharmacy. You will need to transfer your prescription to an in-network pharmacy before 1/1/2018. Call Customer Service for details.</td>
</tr>
<tr>
<td>Humulin products</td>
<td>All Humulin insulin products are Brand.</td>
<td>All Humulin insulin products are Generic.</td>
</tr>
<tr>
<td>Mail-Order pharmacy</td>
<td>Preferred Mail Order Pharmacy Network has preferred cost-sharing.</td>
<td>Mail Order Pharmacy Network has preferred cost-sharing.</td>
</tr>
<tr>
<td>Mailing address to request reimbursement</td>
<td>Providence Health Assurance Attn: Claims P.O. Box 3125 Portland, OR 97208-3125</td>
<td>Providence Health Assurance Attn: Pharmacy Services P.O. Box 4327 Portland, OR 97208-4327</td>
</tr>
<tr>
<td>Prescription drug long-term supplies</td>
<td>Prescription drugs available for an extended day supply are not limited to a 1-month supply for the first fill.</td>
<td>Prescription drugs available for an extended day supply are limited to a 1-month supply for the first fill.</td>
</tr>
<tr>
<td>Cost</td>
<td>2017 (this year)</td>
<td>2018 (next year)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Requesting reimbursement for a bill you have received</td>
<td>Send us your request for payment, along with your bill and documentation of any payment you have made.</td>
<td>Send us your request for payment, along with your bill and documentation of any payment you have made.</td>
</tr>
<tr>
<td></td>
<td>Optional claim form is available on our web site at <a href="https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms">https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms</a> or call Customer Service and ask for the form.</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 3 Deciding Which Plan to Choose**

**Section 3.1 – If you want to stay in Providence Medicare Align Group Plan + RX (HMO)**

*To stay in our plan you don’t need to do anything.* If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

**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 2018 follow these steps:

**Step 1: Learn about and compare your choices**

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 7.2).
You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click “Find health & drug plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

As a reminder, Providence Medicare Advantage Plans offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

**Step 2: Change your coverage**

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Providence Medicare Align Group Plan + RX (HMO).

- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Providence Medicare Align Group Plan + RX (HMO).

- 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 7.1 of this booklet).
  - **or** – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

**SECTION 4 Deadline for Changing Plans**

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2018.

**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 are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

**SECTION 5 Programs That Offer Free Counseling about Medicare**

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance Program (SHIBA). In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (also SHIBA).
SHIBA 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. SHIBA 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 SHIBA in Oregon at 1-800-722-4134 (TTY 711). You can call SHIBA in Washington at 1-800-562-6900 (TTY 360-586-0241). You can learn more about SHIBA by visiting their website (www.oregon.gov/DCBS/SHIBA or www.insurance.wa.gov/shiba).

**SECTION 6 Programs That Help Pay for Prescription Drugs**

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through CAREAssist in Oregon or Early Intervention Program (EIP) in Washington. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist at 971-673-0144 or 1-800-805-2313 or EIP at 1-877-376-9316.

**SECTION 7 Questions?**

**Section 7.1 – Getting Help from Providence Medicare Align Group Plan + RX (HMO)**

Questions? We’re here to help. Please call Customer Service at 503-574-8000 or 1-800-603-2340. (TTY only, call 711). We are available for phone calls 8 a.m. to 8 p.m. (Pacific Time), seven days a week. 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 Providence Medicare Align Group Plan + RX (HMO). 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.ProvidenceHealthPlan.com/PHIP. 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 2018***

You can read the *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.