Simply healthcare

Simply Complete (HMO SNP)
Offered by Simply Healthcare Plans

Annual Notice of Changes for 2018

Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

1-877-577-0115, TTY **711**

simplycomplete (HMO SNP)

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It's important we treat you fairly
That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Member Services for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Grievance and Appeals Department in writing, 9250 W. Flagler Street, Suite 600; Miami, FL 33174-3460. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language
Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call Member Services.

English: You have the right to get this information and help in your language for free. Call Member Services for help.

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma de forma gratuita. Llame al número de Servicios al Afiliado para obtener ayuda.

Amharic:
ይህንን መረጃ የማግኘትና በቋንቋዎ እርዳታ የማግኘት መብት አለዎት:: እርዳታ ለማግኘት የደንበኞች አገልግሎት ይደውሉ::

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل بخدمة العملاء للمساعدة.

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請致電客戶服務部尋求協助。

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour obtenir de l'aide, veuillez appeler le service client.

German: Sie haben das Recht, diese Informationen und Unterstützung kostenfrei in Ihrer eigenen Sprache zu erhalten. Bitte rufen Sie den Kundendienst an, um Hilfe anzufordern.

Gujarati: તમને તમારી ભાષામાં આ જાણકારી અને મદદ મફત મેળવવાનો હક છે. મદદ માટે ગ્રાહક સેવા નંબર પર કૉલ કરો.

Haitian: Ou gen dwa resevwa enfòmasyon sa a ak asistans nan lang ou pale a pou gratis. Rele nimewo Sèvis Kliyan an pou jwenn èd.

Italian: Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il Servizio clienti.

Korean: 귀하께는 본 정보와 도움을 비용없이 귀하의 언어로 받으실 권리가 있습니다. 도움을 받으시려면 고객 서비스부로 연락해 주십시오.

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. Zadzwoń pod numer Działu Obsługi Klienta w celu uzyskania pomocy.

Portuguese: Você tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o Atendimento ao Cliente para obter ajuda.

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания клиентов.

Tagalog: May karapatan kang makuha ang impormasyon at tulong na ito sa sarili mong wika ng walang kabayaran. Tumawag sa Serbisyo para sa mga Kustomer para matulungan ka.

Thai: คุณมีสิทธิ์รับข้อมูลนี้และรับความช่วยเหลือในภาษาของคุณได้ฟรี
ติดต่อฝ่ายบริการลูกค้าสำหรับความช่วยเหลือ

Vietnamese: Bạn có quyền được biết về thông tin này và được hỗ trợ bằng ngôn ngữ của bạn miễn phí. Hãy liên hệ với Dịch vụ khách hàng để được hỗ trợ.

Simply Complete (HMO SNP) Offered by Simply Healthcare Plans Annual Notice of Changes for 2018

You are currently enrolled as a member of Simply Complete (HMO SNP). 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 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/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.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

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

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

☐ If you want to **keep** Simply Complete (HMO SNP), you don't need to do anything. You will stay in Simply Complete (HMO SNP).

☐ 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 3.2, page 6 to learn more about your choices.

Additional Resources:

- ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-577-0115 (TTY: 711).
- Please contact our Member Services number at 1-877-577-0115 for additional information. (TTY users should call 711.) From October 1 to February 14, we are open seven days a week from 8 a.m. – 8 p.m., EST. From February 15 to September 30, we are open Monday through Friday, 8 a.m. – 8 p.m. EST.
- This document may be available in other formats such as Braille, large print or other alternate formats. For additional information call Member Services at 1-877-577-0115.
- **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 Simply Complete (HMO SNP):

- Simply Healthcare Plans, Inc. is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.
- When this booklet says "we," "us" or "our" it means Simply Healthcare. When it says "plan" or "our plan," it means Simply Complete (HMO SNP).

Summary of important costs for 2018

The table below compares the 2017 costs and 2018 costs for Simply Complete (HMO SNP) 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 enclosed *Summary of Benefits* 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 1.1 for details.	$0 monthly plan premium	$0 monthly plan premium
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0 copayment	$0 copayment
Part D prescription drug coverage* (See Section 1.6 for details.)	Deductible: Because you receive "Extra Help" with your prescription drugs, this payment stage does not apply. Please see Section 1.6, *Programs that help pay for prescription drugs.*	Deductible: Because you receive "Extra Help" with your prescription drugs, this payment stage does not apply. Please see Section 1.6, *Programs that help pay for prescription drugs.*
	Copays during the initial coverage stage: ▪ **Drug Tier 1: Preferred Generic $0** copayment (30 day supply at retail network pharmacies)*	Copays during the initial coverage stage: ▪ **Drug Tier 1: Preferred Generic $0** copayment (30 day supply at retail network pharmacies)*

Summary of important costs for 2018

If you have any questions, please call 1-877-577-0115.

Cost	2017 (this year)	2018 (next year)
	▪ **Drug Tier 2: Generic** **$0** copayment (30 day supply at retail network pharmacies)*	▪ **Drug Tier 2: Generic** **$0** copayment (30 day supply at retail network pharmacies)*
	▪ **Drug Tier 3: Preferred Brand** **$0-$8.25**** copayment (30 day supply at retail network pharmacies)*	▪ **Drug Tier 3: Preferred Brand** **$0-$8.35**** copayment (30 day supply at retail network pharmacies)*
	▪ **Drug Tier 4: Nonpreferred Brand** **$0-$8.25**** copayment (30 day supply at retail network pharmacies)*	▪ **Drug Tier 4: Nonpreferred Brand** **$0-$8.35**** copayment (30 day supply at retail network pharmacies)*
	▪ **Drug Tier 5: Specialty Tier** **$0-$8.25**** copayment (30 day supply at retail network pharmacies)*	▪ **Drug Tier 5: Specialty Tier** **$0-$8.35**** copayment (30 day supply at retail network pharmacies)*
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	Your coverage under Florida Medicaid provides coverage for Medicare cost sharing applied to covered services.	Your coverage under Florida Medicaid provides coverage for Medicare cost sharing applied to covered services.

**Your costs will be the same if you use a pharmacy that offers standard cost sharing or a pharmacy that offers preferred cost sharing.*

***The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your LIS Rider for the specific amount you pay.*

Annual Notice of Changes for 2018
Table of contents

Section 1. Changes to benefits and costs for next year

Section 1.1 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 monthly plan premium	$0 monthly plan premium

Section 1.2 Changes to your maximum out-of-pocket amount

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

Cost	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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	Your coverage under Florida Medicaid provides coverage for Medicare cost sharing applied to covered services.	Your coverage under Florida Medicaid provides coverage for Medicare cost sharing applied to covered services. Once you have paid $3,400 out of pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 Changes to the provider network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.mysimplymedicare.com. You may also call Member Services for updated provider

information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2018 *Provider/Pharmacy Directory* to see if your providers (primary care providers, specialists, hospitals, etc.) are in our network.**

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

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

Section 1.4 Changes to the pharmacy network

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

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

An updated *Provider/Pharmacy Directory* is located on our website at www.mysimplymedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2018 *Provider/Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 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.*

Cost	2017 (this year)	2018 (next year)
Diabetes self-management training, diabetic services and supplies	You pay a $0 copay for Urine Test Strips to test glucose levels.	This plan does not cover Urine Test Strips to test glucose levels.

Hearing services - Supplemental	You pay a $0 copayment for supplemental routine hearing services. $1,000 plan total maximum benefit coverage limit for up to 2 hearing aids per calendar year.	You pay a $0 copayment for supplemental routine hearing services. $1,500 plan total maximum benefit coverage limit for up to 2 hearing aids per calendar year.
Over the Counter (OTC) supplemental coverage	You pay a $0 copay for covered over-the-counter items. You are eligible for a $30 maximum monthly benefit allowance.	You pay a $0 copay for covered over-the-counter items. You are eligible for a $42 maximum monthly benefit allowance.
Transportation	You pay a $0 copay for covered supplemental routine transportation. You are covered for 14 one-way trips per year for access to medical care.	You pay a $0 copay for covered supplemental routine transportation. You are covered for unlimited trips per year for access to medical care.
Vision care - Supplemental	You pay a $0 copay for covered routine supplemental vision services. $200 maximum benefit coverage amount per calendar year for contact lenses and/or eyewear (lenses and frames).	You pay a $0 copay for covered routine supplemental vision services. $275 maximum benefit coverage amount per calendar year for contact lenses and/or eyewear (lenses and frames).

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.

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

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

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

In some situations, we are required to cover a **one-time,** temporary supply of a nonformulary 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.

Formulary exceptions are granted for a 12-month period. If you are granted a formulary exception, you and your doctor will receive a letter with the termination date of the exception. If you wish to continue the exception, a new request is required. We encourage current members to ask for an exception before next year.

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. Because you receive "Extra Help" and haven't received this insert by September 30, 2017, please call Member Services and ask for the *"LIS Rider."* Phone numbers for Member Services are in Section 7.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the yearly deductible stage and the initial coverage stage. (Most members do not reach the other two stages – the coverage gap stage or the catastrophic coverage stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.) Your *Evidence of Coverage* booklet, which provides details about your health and prescription drug coverage, will be mailed to you before December 31, 2017.

Changes to the deductible stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly deductible stage	Because you receive "Extra Help" with your prescription drugs, this payment stage does not apply to you. Please see Section 6, Programs that help pay for prescription drugs.	Because you receive "Extra Help" with your prescription drugs, this payment stage does not apply to you. Please see Section 6, Programs that help pay for prescription drugs.

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	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing*:	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing*:

Stage	2017 (this year)	2018 (next year)
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.*	**Tier 1: Preferred Generic** You pay $0.00 per prescription. **Tier 2: Generic** You pay $0.00 per prescription. **Tier 3: Preferred Brand** You pay $0-$8.25 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. **Tier 4: Nonpreferred Brand** You pay $0-$8.25 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. **Tier 5: Specialty Tier** You pay $0-$8.25 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. Once your total drug costs have reached $3,700, you will move to the next stage (the coverage gap stage).	**Tier 1: Preferred Generic** You pay $0.00 per prescription. **Tier 2: Generic** You pay $0.00 per prescription **Tier 3: Preferred Brand** You pay $0-$8.35 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. **Tier 4: Nonpreferred Brand** You pay $0-$8.35 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. **Tier 5: Specialty Tier** You pay $0-$8.35 per prescription. The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your *LIS Rider* for the specific amount you pay. Once your total drug costs have reached $3,750, you will move to the next stage (the coverage gap stage).

**Your costs will be the same if you use a pharmacy that offers standard cost sharing or a pharmacy that offers preferred cost sharing.*

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, Section 6 and Section 7, in your *Evidence of Coverage*.

Section 2. Administrative changes

Cost	2017 (this year)	2018 (next year)
Member Reimbursement Requests	Member reimbursement requests for medical services must be submitted no more than two months from the date of service.	Member reimbursement requests for medical services must be submitted no more than six months from the date of service.

Section 3. Deciding which plan to choose

Section 3.1 If you want to stay in Simply Complete (HMO SNP)

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 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 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 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To **change to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from Simply Complete (HMO SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Simply Complete (HMO SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - *-- or --* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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

Section 4. Deadline for changing plans

Because you are eligible for Medicare and Full Medicaid Benefits 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 5. 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 Florida, the SHIP is called Serving Health Insurance Needs of Elders (SHINE).

Serving Health Insurance Needs of Elders (SHINE) 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. Serving Health Insurance Needs of Elders (SHINE) 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 Serving Health Insurance Needs of Elders (SHINE) at 1-800-963-5337. TTY users should call 1-800-955-8770. You can learn more about Serving Health Insurance Needs of Elders (SHINE) by visiting their website (http://www.floridashine.org).

For questions about your Florida Medicaid benefits, contact Florida Agency for Health Care Administration at 1-888-419-3456 from 8:00 a.m. - 6:00 p.m. Monday through Friday. TTY users should call 1-800-955-8771. Ask how joining another plan or returning to Original Medicare affects how you get your Florida Medicaid coverage.

Section 6. 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, seven days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription cost-sharing assistance for persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs or how to enroll in the program, please call Florida AIDS Drug Assistance Program at 1-800-352-2437 (1-800-FLA-AIDS) English / 1-800-545-7432 (1-800-545-SIDA) Español / TTY: 1-888-503-7118.

Section 7. Questions?

Section 7.1 Getting help from Simply Complete (HMO SNP)

Questions? We're here to help. Please call Member Services at 1-877-577-0115. (TTY only, call 711.) We are available for phone calls from October 1 to February 14, we are open 7 days a week, from 8 a.m. - 8 p.m., EST. From February 15 to September 30, we are open Monday through Friday 8 a.m. – 8 p.m. 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 Simply Complete (HMO SNP). 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. We will send you a copy of the *Evidence of Coverage* by December 31, 2017.

Visit our website

You can also visit our website at www.mysimplymedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/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, seven 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, seven days a week. TTY users should call 1-877-486-2048.

Section 7.3 Getting help from Medicaid

To get information from Medicaid, you can call Florida Agency for Health Care Administration at 1-888-419-3456. TTY users should call 1-800-955-8771.

Simply Healthcare Plans, Inc. is a Medicare-contracted coordinated care plan that has a Medicaid contract with the State of Florida Agency for Health Care Administration to provide benefits or arrange for benefits to be provided to enrollees. Enrollment in Simply Healthcare Plans, Inc. depends on contract renewal.