



Simply More (HMO)
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



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 કોલ 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: 귀하께서는 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: คุณมีสิทธิรับข้อมูลนี้และรับความช่วยเหลือในภาษาของคุณได้ฟรี
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 More (HMO) Offered by Simply Healthcare Plans Annual Notice of Changes for 2018

You are currently enrolled as a member of Simply More (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/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 More (HMO), you don't need to do anything. You will stay in Simply More (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 Simply More (HMO).
- If you join by December 7, 2017, your new coverage will start on January 1, 2018.

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 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. EST.
- This document is available to order in Braille, large print and audio tape. To request this document in an alternate format, please call Member Services at the phone number printed on the back of this booklet.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About Simply More (HMO):

- 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 More (HMO).

Summary of important costs for 2018

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

► Summary of important costs for 2018

The table below compares the 2017 costs and 2018 costs for Simply More (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.**

Cost	2017 (this year)	2018 (next year)
<p>Monthly plan premium*</p> <p>*Your premium may be higher or lower than this amount. See Section 1.1 for details.</p>	\$0.00 monthly plan premium	\$0.00 monthly plan premium
<p>Maximum out-of-pocket amount</p> <p>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.)</p>	\$3,400	\$6,700
<p>Doctor office visits</p>	<p>Primary care visits: In network \$0.00 per visit</p> <p>Specialist visits: In network \$20.00 per visit</p>	<p>Primary care visits: In network \$0.00 per visit</p> <p>Specialist visits: In network \$10.00 per visit</p>
<p>Inpatient hospital stays</p> <p>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.</p>	In network Days 1 - 8: \$95.00 per day / Days 9 - 90: \$0.00 per day	In network Days 1 - 8: \$50.00 per day / Days 9 - 90: \$0.00 per day

Summary of important costs for 2018

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

Cost	2017 (this year)	2018 (next year)
<p>Part D prescription drug coverage (See Section 1.6 for details.)</p>	<p>Deductible: N/A</p> <p>Copays during the initial coverage stage:</p> <ul style="list-style-type: none"> ▪ Tier 1: Preferred Generic: \$0.00¹ (30-day supply at retail network pharmacies) ▪ Tier 2: Generic: \$5.00¹ (30-day supply at retail network pharmacies) ▪ Tier 3: Preferred Brand: \$35.00¹ (30-day supply at retail network pharmacies) ▪ Tier 4: Nonpreferred Brand: \$75.00¹ (30-day supply at retail network pharmacies) ▪ Tier 5: Specialty Tier: 33%¹ (30-day supply at retail network pharmacies) 	<p>Deductible: N/A</p> <p>Copays during the initial coverage stage:</p> <ul style="list-style-type: none"> ▪ Tier 1: Preferred Generic: \$0.00¹ (30-day supply at retail network pharmacies) ▪ Tier 2: Generic: \$0.00¹ (30-day supply at retail network pharmacies) ▪ Tier 3: Preferred Brand: \$35.00¹ (30-day supply at retail network pharmacies) ▪ Tier 4: Nonpreferred Brand: \$75.00¹ (30-day supply at retail network pharmacies) ▪ Tier 5: Specialty Tier: 33%¹ (30-day supply at retail network pharmacies)

¹ The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. For more information about the "Extra Help" program, please see Chapter 2, Section 7 of your *Evidence of Coverage*.

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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.)	\$0.00 monthly plan premium	\$0.00 monthly plan premium

- 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 enroll in Medicare prescription drug coverage in the future.
- 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 Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount 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.	\$3,400	\$6,700 Once you have paid \$6,700 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 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 provider, specialists, hospitals, etc.) are in our network.**

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

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

Section 1.4 Changes to the pharmacy network

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

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

An updated *Provider/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

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*.

Cost	2017 (this year)	2018 (next year)
Dental services - Supplemental	<p>You pay a \$0 copay for covered comprehensive dental services.</p> <ul style="list-style-type: none"> ▪ Up to 2 amalgam or resin fillings ▪ Up to 6 simple or surgical extractions per year (in one or more visits) ▪ Medically necessary surgical procedures, includes analgesia ▪ One denture adjustment/reline every year ▪ Complete or partial dentures are not covered 	<p>You pay a \$0 copay for covered comprehensive dental services.</p> <ul style="list-style-type: none"> ▪ Up to 2 amalgam or resin fillings ▪ Up to 6 simple or surgical extractions per year (in one or more visits) ▪ Medically necessary surgical procedures, includes analgesia ▪ One denture adjustment/reline every year ▪ One set of complete or partial dentures every 5 years
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	<p>You pay a \$0 copayment for supplemental routine hearing services.</p> <p>\$1,000 plan total maximum benefit coverage limit for up to 2 hearing aids per calendar year.</p>	<p>You pay a \$0 copayment for supplemental routine hearing services.</p> <p>\$1,500 plan total maximum benefit coverage limit for up to 2 hearing aids per calendar year.</p>
Inpatient hospital care	<p>You pay a \$95 copay for each day, for days 1 - 8 for inpatient acute care.</p> <p>You pay a \$0 copay for each day, for days 9- 90 for inpatient acute care.</p> <p>You pay a \$0 copay for additional days.</p>	<p>You pay a \$50 copay for each day, for days 1 - 8 for inpatient acute care.</p> <p>You pay a \$0 copay for each day, for days 9- 90 for inpatient acute care.</p> <p>You pay a \$0 copay for additional days.</p>
Inpatient mental health care	<p>You pay a \$95 copay for each day, for days 1 - 8 for inpatient mental health care.</p> <p>You pay a \$0 copay for each day, for days 9- 90 for inpatient mental health care.</p>	<p>You pay a \$50 copay for each day, for days 1 - 8 for inpatient mental health care.</p> <p>You pay a \$0 copay for each day, for days 9- 90 for inpatient mental health care.</p>

Over the Counter (OTC) supplemental coverage	You pay a \$0 copay for covered over-the-counter items. You are eligible for a \$15 maximum monthly benefit allowance.	You pay a \$0 copay for covered over-the-counter items. You are eligible for a \$30 maximum monthly benefit allowance.
Physician/Practitioner services, including doctor's office visits	You pay a \$20 copay for Medicare-covered specialist physician office visits.	You pay a \$10 copay for Medicare-covered specialist physician office visits.
Skilled nursing facility (SNF) care	You pay a \$0 copay for each day, for days 1 - 7 for Medicare-covered skilled nursing care in a Skilled Nursing Facility. You pay a \$20 copay for each day, for days 8 - 20 for Medicare-covered skilled nursing care in a Skilled Nursing Facility. You pay a \$40 copay for each day, for days 21 - 100 for Medicare-covered skilled nursing care in a Skilled Nursing Facility.	You pay a \$0 copay for each day, for days 1 - 20 for Medicare-covered skilled nursing care in a Skilled Nursing Facility. You pay a \$40 copay for each day, for days 21 - 100 for Medicare-covered skilled nursing care in a Skilled Nursing Facility.
Vision care - Supplemental	You pay a \$0 copay for covered routine supplemental vision services. \$150 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 other 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 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.

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. If 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 at Chapter 6, Section 6 and Section 7, in the attached *Evidence of Coverage*.)

Changes to the deductible stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly deductible stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to your cost sharing in the initial coverage stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2017 (this year)	2018 (next year)
<p>Stage 2: Initial coverage stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>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 <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our <i>Drug List</i>. To see if your drugs will be in a different tier, look them up on the <i>Drug List</i>.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1: Preferred Generic You pay \$0.00 per prescription.</p> <p>Tier 2: Generic You pay \$5.00 per prescription.</p> <p>Tier 3: Preferred Brand You pay \$35.00 per prescription.</p> <p>Tier 4: Nonpreferred Brand You pay \$75.00 per prescription.</p> <p>Tier 5: Specialty Tier You pay 33% of the total cost.</p> <p>Once your total drug costs have reached \$3,700, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1: Preferred Generic You pay \$0.00 per prescription.</p> <p>Tier 2: Generic You pay \$0.00 per prescription.</p> <p>Tier 3: Preferred Brand You pay \$35.00 per prescription.</p> <p>Tier 4: Nonpreferred Brand You pay \$75.00 per prescription.</p> <p>Tier 5: Specialty Tier You pay 33% of the total cost.</p> <p>Once your total drug costs have reached \$3,750, you will move to the next stage (the Coverage Gap Stage).</p>

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, 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	Member reimbursement requests for medical services must be submitted no

Cost	2017 (this year)	2018 (next year)
	more than two months from the date of service.	more than six months from the date of service.
Part D late-enrollment penalty or plan premium billing	If you did not select the automatic payment option, you will get a monthly bill.	If you did not select the automatic payment option, you will get an annual bill.

Section 3. Deciding which plan to choose

Section 3.1 If you want to stay in Simply More (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 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.**

As a reminder, Simply Healthcare Plans, Inc., 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 Simply More (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Simply More (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:

- Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
- *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 Florida, the SHIP is called Serving Health Insurance Needs of Elders (SHINE).

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.

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 the SHINE at 1-800-963-5337. You can learn more about SHINE by visiting their website <http://www.floridashine.org>.

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 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 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 More (HMO)

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. EST. 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 More (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.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, 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.

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.