ANNUAL NOTICE OF CHANGE

2019

Alignment Health Plan
My Choice Plan (HMO) 001
Los Angeles, Orange, Riverside
and San Bernardino Counties

ALIGNMENT HEALTH PLAN

H3815_19036EN_M Accepted

Alignment Health Plan My Choice (HMO) offered by Alignment Health Plan

Annual Notice of Changes for 2019

You are currently enrolled as a member of Alignment Health Plan My Choice (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 1.5 and 1.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 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** Alignment Health Plan My Choice (HMO), you don't need to do anything. You will stay in Alignment Health Plan My Choice (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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Alignment Health Plan My Choice (HMO).
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-866-634-2247 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., 7 days a

week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

- Esta información está disponible gratis en otros idiomas. Si desea información adicional,comuníquese con Servicios para Miembros al 1-877-399-2247 para obtener másinformación. (Los usuarios de TTY deben llamar al 711). Las horas del servicio son de 8a.m. a 8 p. m., los 7 días de la semana (excepto el Día de Acción de Gracias y Navidad)desde el 1.° de Octubre hasta el 31 de Marzo, y de lunes a viernes (excepto los feriados)desde el 1 de Abril hasta el 30 de Septiembre.
- If you would like to receive this Annual Notice of Changes in an alternate format (e.g., Braille, or large print) please contact our Member Services number at 1-866-634-2247 (TTY users should call 711). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Alignment Health Plan My Choice (HMO)

- Alignment Health Plan My Choice (HMO) is an HMO plan with a Medicare contract. Enrollment in Alignment Health Plan My Choice (HMO), depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Alignment Health Plan. When it says "plan" or "our plan," it means Alignment Health Plan My Choice (HMO).

Alignment Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak Spanish or Chinese, language assistance services, free of charge, are available to you. Call 1-866-634-2247 (TTY: 711).

Alignment Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN : Si usted habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llama al 1-877-399-2247 (TTY: 711).

Alignment Health Plan**遵守所有聯邦民權法的規定，沒有種族 、膚色 、出生國 、年齡 、殘障或性別的歧視。**注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-634-2247 (TTY: 711)

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Alignment Health Plan My Choice (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 *Evidence of Coverage*, which is available on our website, at alignmenthealthcare.com, to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0.00	$0.00
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.)	$3,400.00	$3,400.00
Doctor office visits	Primary care visits: $0.00 per visit Specialist visits: $0.00 per visit	Primary care visits: $0.00 per visit Specialist visits: $0.00 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.	Days 1 — 3: $50.00 copay Days 4 — 90: $0.00 copay (unlimited days per admission)	Days 1 — 3: $50.00 copay Days 4 — 90: $0.00 copay (unlimited days per admission)

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Cost-sharing during the initial coverage stage (up to a 30-day supply) Deductible: $0.00 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 - Preferred cost-sharing: $1.00 copay - Standard cost-sharing: $8.00 copay • Drug Tier 2 - Preferred cost-sharing: $5.00 copay - Standard cost-sharing: $12.00 copay • Drug Tier 3 - Preferred cost-sharing: $30.00 copay - Standard cost-sharing: $37.00 copay • Drug Tier 4 - Preferred cost-sharing: $75.00 copay - Standard cost-sharing: $82.00 copay • Drug Tier 5 - Preferred cost-sharing: 33% coinsurance - Standard cost-sharing: 33% coinsurance	Cost-sharing during the initial coverage stage (up to a 30-day supply) Deductible: $0.00 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 - Preferred cost-sharing: $1.00 copay - Standard cost-sharing: $8.00 copay • Drug Tier 2 - Preferred cost-sharing: $5.00 copay - Standard cost-sharing: $12.00 copay • Drug Tier 3 - Preferred cost-sharing: $30.00 copay - Standard cost-sharing: $37.00 copay • Drug Tier 4 - Preferred cost-sharing: $75.00 copay - Standard cost-sharing: $82.00 copay • Drug Tier 5 - Preferred cost-sharing: 33% coinsurance - Standard cost-sharing: 33% coinsurance

Cost	2018 (this year)	2019 (next year)
	• Drug Tier 6 - Preferred cost-sharing: $3.00 copay - Standard cost-sharing: $3.00 copay	• Drug Tier 6 - Preferred cost-sharing: $3.00 copay - Standard cost-sharing: $3.00 copay

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0.00	$0.00

- 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 Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (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.	$3,400.00	$3,400.00 Once you have paid $3,400.00 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 Directory is located on our website at alignmenthealthplan.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

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

Section 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at alignmenthealthplan.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 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 *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Ambulance Services	You pay a $125.00 copay for Medicare-covered Ambulance Services (waived if admitted)	You pay a $125.00 copay for Medicare-covered Air and Ground Ambulance Services (waived if admitted)
Chiropractic Services	You pay a $10.00 copay for Medicare covered chiropractic services	You pay a $0.00 copay for Medicare covered chiropractic services
Dental Services	Maximum Plan Benefit Coverage amount of $1,250.00 per year	No Maximum Plan Benefit Coverage amount
Enhanced Disease Management	You pay a $0.00 copay for Enhanced Disease Management	Enhanced Disease Management is not covered
Emergency Care/Post-Stabilization Care	You pay a $75.00 copay (NOT waived if admitted)	You pay a $75.00 copay (Waived if admitted within 48 hours)
Health Education	You pay a $0.00 copay for Health Education	Health Education is not covered
Nursing Hotline	You pay a $0.00 copay for each Nurse Hotline service	Nurse Hotline is not covered

Cost	2018 (this year)	2019 (next year)
Outpatient Hospital	You pay a $100.00 copay for Medicare-covered Outpatient Hospital Services	You pay a $100.00 copay for Medicare-covered Outpatient Hospital Services You pay a $0.00 copay for Medicare-covered Observation Services
Part B Drugs		Certain Part B drugs may be subject to step therapy requirements.
Podiatry Services	You pay a $5.00 copay per Medicare covered visit You pay a $5.00 copay unlimited routine visits	You pay a $0.00 copay per Medicare covered visit Routine podiatry is not covered
Psychiatric Services	You pay a $40.00 copay for each Medicare-covered individual or group therapy visit with a psychiatrist	You pay a $20.00 copay for each Medicare-covered individual or group therapy visit with a psychiatrist
Supervised Exercise Therapy	Supervised Exercise Therapy is not covered	You pay a $0.00 copay for Supervised Exercise Therapy
Web/Phone-based Technologies	Web/Phone-based Technologies is not covered	You pay a $0.00 copay for Web/Phone-based Technologies

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 located on our website at alignmenthealthplan.com.

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 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 temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days supply for LTC and 30 days supply for retail of medication rather than the amount provided in 2018 (98 days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Members who are receiving drugs as a result of an approved formulary exception received an approval letter informing them when the exception will expire. A new formulary exception request must be submitted prior to the expiration date on the letter to ensure continuity of your treatment.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with

notice 30, rather than 60, days before we make the change. Or we will give you a 31 days supply for LTC and 30 days supply for retail, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** 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, 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, Sections 6 and 7, in the *Evidence of Coverage on our website at alignmenthealthplan.com*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how 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	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. The costs in this row are for a one-month (30-day retail network and 31-day long term care) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 Preferred Generic Drugs:** Standard cost-sharing: You pay $8.00 per prescription Preferred cost-sharing: You pay $1.00 per prescription **Tier 2 Generic Drugs:** Standard cost-sharing: You pay $12.00 per prescription Preferred cost-sharing: You pay $5.00 per prescription **Tier 3 Preferred Brand Drugs:** Standard cost-sharing: You pay $37.00 per prescription Preferred cost-sharing: You pay $30.00 per prescription. **Tier 4 Non-Preferred Brand Drugs:** Standard cost-sharing: You pay $82.00 per prescription Preferred cost-sharing: You pay $75.00 per prescription **Tier 5 Specialty Drugs:** Standard cost-sharing: You pay 33% of the cost Preferred cost-sharing: You pay 33% of the cost	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 Preferred Generic Drugs:** Standard cost-sharing: You pay $8.00 per prescription Preferred cost-sharing: You pay $1.00 per presciption **Tier 2 Generic Drugs:** Standard cost-sharing: You pay $12.00 per prescription Preferred cost-sharing: You pay $5.00 per prescription **Tier 3 Preferred Brand Drugs:** Standard cost-sharing: You pay $37.00 per prescription Preferred cost-sharing: You pay $30.00 per prescription **Tier 4 Non-Preferred Brand Drugs:** Standard cost-sharing: You pay $82.00 per prescription Preferred cost-sharing: You pay $75.00 per prescription **Tier 5 Specialty Drugs:** Standard cost-sharing: You pay 33% of the cost Preferred cost-sharing: You pay 33% of the cost

Stage	2018 (this year)	2019 (next year)
	Tier 6 Select Care Drugs: Standard cost-sharing: You pay: $3.00 per prescription Preferred cost-sharing: You pay $3.00 per prescription Once your total drug costs have reached $3,750.00, you will move to the next stage (the Coverage Gap Stage)	**Tier 6 Select Care Drugs:** Standard cost-sharing: You pay $3.00 per prescription Preferred cost-sharing: You pay $3.00 per prescription Once your total drug costs have reached $3,820.00, you will move to the next stage (the Coverage Gap Stage)

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

Cost	2018 (this year)	2019 (next year)
Service Area	**Full County:** Los Angeles **Partial County:** Orange, Riverside, San Bernardino	**Full County:** Los Angeles, Orange, Riverside, San Bernardino

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Alignment Health Plan My Choice (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 2019.

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 2019 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 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, Alignment Health Plan 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 Alignment Health Plan My Choice (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Alignment Health Plan My Choice (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, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. 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, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 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 California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

HICAP 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. HICAP 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 HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (https://www.aging.ca.gov/hicap/).

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).

SECTION 7 Questions?

Section 7.1 – Getting Help from Alignment Health Plan My Choice (HMO)

Questions? We're here to help. Please call Member Services at 1-866-634-2247. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Alignment Health Plan My Choice (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. The *Evidence of Coverage* is available on our website, at alignmenthealthcare.com.

Visit our Website

You can also visit our website at alignmenthealthplan.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 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 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.