MedStar Medicare Choice HMO (HMO) offered by MedStar Family Choice, Inc

Annual Notice of Changes for 2017

You are currently enrolled as a member of MedStar Medicare 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.

Additional Resources

- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 6.1 of this booklet).
- This document may be available in an alternative format such as Braille, large print, or audio.
- Minimum essential coverage (MEC): 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 on the individual requirement for MEC.

About MedStar Medicare Choice HMO

- MedStar Medicare Choice (HMO) has a contract with Medicare. Enrollment in MedStar Medicare Choice depends on contract renewal.
- When this booklet says "we," "us," or "our," it means MedStar Family Choice, Inc.When it says "plan" or "our plan," it means MedStar Medicare Choice HMO.

Nondiscrimination Notice

MedStar Medicare Choice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MedStar Medicare Choice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. MedStar Medicare Choice:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Catherine Kajubi, JD.

If you believe that MedStar Medicare Choice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Catherine Kajubi, JD, Director of Medicare Compliance, 5233 King Ave., Suite 400, Baltimore, MD 21237-4001, Telephone Number: 202-243-5419, Fax Number: 410-350-7440, Catherine.M.Kajubi@medstar.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Catherine Kajubi, JD, Director of Medicare Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Nondiscrimination Statement

English: MedStar Medicare Choice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: MedStar Medicare Choice cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

French: MedStar Medicare Choice respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

French Creole: MedStar Medicare Choice konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Italian: MedStar Medicare Choice è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

Portuguese: MedStar Medicare Choice cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo.

German: MedStar Medicare Choice erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Norwegian: MedStar Medicare Choice overholder gjeldende føderale lover om borgerrettigheter og diskriminerer ikke på grunnlag av etnisitet, farge, nasjonal opprinnelse, alder, funksjonshemning eller kjønn.

Russian: MedStar Medicare Choice соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Persian:

MedStar Medicare Choice زا نینـــاوق قـــوقح نـدمی فـردال هطوبـرم عبـئیت می دنک و هنوگچیـــه بئعضـیی رب ساســا داژن، رنگ تســوپ، تیلصـــا تیلـــمی، نـس، نانـاوتی یا ســنجیت دارفـا لیــاق نمی دوش.

Greek: MedStar Medicare Choice συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

Serbo-Croatian: MedStar Medicare Choice pridržava se važećih saveznih zakona o građanskim pravima i ne pravi diskriminaciju po osnovu rase, boje kože, nacionalnog porijekla, godina starosti, invaliditeta ili pola.

Urdu:
MedStar Medicare Choice ؤیـال طا ق قــافوی رہشی قــوقح ےک نیینــاوق کی لیمعــت نـرکا ےہ روا یہ کہ لسـن، گــنر ، تیمــوق، رمع، روذعمی ںا ســنج کی ںنـباد رپ یئمــازا نیہــن نـرکا۔

Hindi**:** MedStar Medicare Choice लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल,, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Chinese: MedStar Medicare Choice 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Japanese: MedStar Medicare Choice は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Korean: MedStar Medicare Choice 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Vietnamese: MedStar Medicare Choice tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Tagalog: Sumusunod ang MedStar Medicare Choice sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Multi-Language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-222-1041 (TTY: 1-855-250-5604).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-222-1041 (TTY: 1-855-250-5604).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-222-1041 (ATS: 1-855-250-5604).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-222-1041 (TTY: 1-855-250-5604).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-222-1041 (TTY: 1-855-250-5604).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-222-1041 (TTY: 1-855-250-5604).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-222-1041 (TTY: 1-855-250-5604).

Norwegian: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-222-1041 (TTY: 1-855-250-5604).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-222-1041 (телетайп: 1-855-250-5604).

Persian:

هجوت: رگا به بزنا نسرای وگنگ می کنید، یهست ت نابزی بتروص گیارنا برای شما
مهارف می بدشا. اب (1-855-222-1041 (TTY: 1-855-250-5604 متسا دیریگب.

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-222-1041 (TTY: 1-855-250-5604).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-222-1041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-250-5604).

Urdu:

رادربخ: رگا پآ ودرا لوبتے نیہ، وت پآ وک بزنا کی ددم کی خدتام تقم ھنی یئسدبا نیہ ۔ کال
نیرک .(1-855-222-1041 (TTY: 1-855-250-5604

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Hindi**:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-222-1041 (TTY: 1-855-250-5604) पर कॉल करें।

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-222-1041（TTY：1-855-250-5604）。

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-222-1041（TTY: 1-855-250-5604）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-222-1041 (TTY: 1-855-250-5604) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-222-1041 (TTY: 1-855-250-5604).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-222-1041 (TTY: 1-855-250-5604).

Grievance Procedure

It is the policy of MedStar Medicare Choice not to discriminate on the basis of race, color, national origin, sex, age or disability. MedStar Medicare Choice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Catherine Kajubi, JD, Director of Medicare Compliance, 5233 King Ave., Suite 400, Baltimore, MD 21237-4001, Telephone Number: 202-243-5419, Fax Number: 410-350-7440, Catherine.M.Kajubi@medstar.net., who has been designated to coordinate the efforts of MedStar Medicare Choice to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for MedStar Medicare Choice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of MedStar Medicare Choice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of

Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

MedStar Medicare Choice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Think About Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- Check the changes to our benefits and costs to see if they affect you. Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.
- Check the changes to our prescription drug coverage to see if they affect you. Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. 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 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? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

If you decide to stay with MedStar Medicare Choice HMO:

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for MedStar Medicare 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 attached Evidence of Coverage to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$17
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.)	$6,700	$6,700
Doctor office visits	Primary care visits: · $5 copayment per visit Specialist visits: · $45 copayment per visit	Primary care visits: · $5 copayment per visit Specialist visits: · $50 copayment 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.	· $350 copayment per day for days 1-5, per admission for inpatient hospital care. · $0 copayment per day for days 6-90 and beyond for inpatient hospital care. · $300 copayment per day for days 1-5, per admission for inpatient mental health care. · $0 copayment per day for days 6-90 and beyond for inpatient mental health care.	· $350 copayment per day for days 1-5, per admission for inpatient hospital care. · $0 copayment per day for days 6-90 and beyond for inpatient hospital care. · $300 copayment per day for days 1-5, per admission for inpatient mental health care. · $0 copayment per day for days 6-90 and beyond for inpatient mental health care.

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $150 *Deductible applies to tiers 3, 4 and 5. Copayment/ Coinsurance as applicable during the Initial Coverage Stage: · Drug Tier 1: $4 copay for a 30-day supply · Drug Tier 2: $15 copay for a 30-day supply · Drug Tier 3*: $47 copay for a 30-day supply · Drug Tier 4*: $100 copay for a 30-day supply · Drug Tier 5*: 29% coinsurance a 30-day supply	Deductible: $200 *Deductible applies to tiers 3, 4 and 5. Copayment/ Coinsurance as applicable during the Initial Coverage Stage: · Drug Tier 1: $4 copay for a 30-day supply · Drug Tier 2: $15 copay for a 30-day supply · Drug Tier 3*: $47 copay for a 30-day supply · Drug Tier 4*: $100 copay for a 30-day supply · Drug Tier 5*: 29% coinsurance for for a 30-day supply · Drug Tier 6: $3 copay for a 30-day supply

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$17

- 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	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount	$6,700	$6,700
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		• 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 Directory is located on our website at MedStarMedicareChoice.com. You may also call Member Services for updated

provider information or to ask us to mail you a Provider Directory. Please review the 2017 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.
- When possible we will 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 Pharmacy Directory is located on our website at MedStarMedicareChoice.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. Please review the 2017 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 2017 Evidence of Coverage.

Cost	2016 (this year)	2017 (next year)
Lab Services	· You pay a $10 copay for each lab service.	· You pay a $0 copayment for each lab service.
Health and Wellness	· Re-Admission prevention is covered.	· Re-Admission prevention is <u>not</u> covered.
Medicare-covered Dental Services	· You pay a $45 copay for each Medicare-covered dental service.	· You pay a $50 copayment for each Medicare-covered dental service.
Medicare-covered Hearing Services	· You pay a $45 copay for each Medicare-covered hearing service.	· You pay a $50 copayment for each Medicare-covered hearing service.
Medicare-covered Vision Services	· You pay a $45 copay for each Medicare-covered vision service.	· You pay a $50 copayment for each Medicare-covered vision service.
Physician Services (Specialist Visit)	· You pay a $45 copay for each Specialist visit.	· You pay a $50 copayment for each Specialist visit.
Medicare-covered Podiatry Services	· You pay a $45 copay for each Medicare-covered podiatry service.	· You pay a $50 copayment for each Medicare-covered podiatry service.
Outpatient Surgery	· You pay a $250 copay for outpatient surgery visit.	· You pay a $350 each copayment for each outpatient surgery visit.
Routine Vision Services (Vision Hardware)	· $135 allowance to the cost of vision hardware per year.	· $100 allowance to the cost of vision hardware per year.
Urgently Needed Services	· You pay a $45 copay for each urgently needed service visit.	· You pay a $40 copayment for each urgently needed service visit.

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. The Drug List we included in this envelope includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. You can get the complete Drug List by calling Member Services (see the back cover) or visiting our Web site at MedStarMedicareChoice.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. 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 coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

In some instances, if you or your provider received approval for a formulary exception for a prescription drug that is not on our current 2017 formulary, the exception approval will continue to be covered in 2017. However, if your original exception approval letter had a specific timeframe for coverage of the prescription drug that timeframe will still apply (e.g., covered for 3 months), it will not start over in 2017.

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 get "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 6.1 of this booklet.

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

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

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D (Tiers 3-5) drugs until you have reached the yearly deductible.	· The deductible is $150 · During this stage, you pay $4 copay for drugs on Tier 1, $15 copay for drugs on Tier 2, , and the full cost of drugs on Tiers 3-5 until you have reached the yearly deductible.	· The deductible is $200 · During this stage, you pay $4 copay for drugs on Tier 1, $15 copay for drugs on Tier 2, $3 copay for drugs on Tier 6, and the full cost of drugs on Tiers 3-5 until you have reached the yearly deductible.

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	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: Preferred Generic Drugs Tier 1: · You pay $4 per prescription. Generic Drugs Tier 2: · You pay $15 per prescription. Preferred Brand Drugs Tier 3: · You pay $47 per prescription. Non-Preferred Brand Drugs Tier 4: · You pay $100 per prescription. Specialty Drugs Tier 5: · You pay 29% of the cost. Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: Preferred Generic Drugs Tier 1: · You pay $4 per prescription. Generic Drugs Tier 2: · You pay $15 per prescription. Preferred Brand Drugs Tier 3: · You pay $47 per prescription. Non-Preferred Brand Drugs Tier 4: · You pay $100 per prescription. Specialty Drugs Tier 5: · You pay 29% of the cost. Adherence Drugs Tier 6: · You pay $3 per prescription Once your total drug costs have reached $3,700, 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 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in MedStar Medicare 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 2017.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2017, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://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, MedStar Family Choice, 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 MedStar Medicare Choice HMO.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from MedStar Medicare 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 6.1 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 3 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, 2017.

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, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 4 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 Maryland, the SHIP is called Senior Health Insurance Assistance Program (SHIP).

Senior Health Insurance Assistance Program (SHIP) 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. Senior Health Insurance Assistance Program (SHIP) 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 Senior Health Insurance Assistance Program (SHIP) at 800-243-3425 ext. 71108 (TTY, call 7-1-1). You can learn more about Senior Health Insurance Assistance Program (SHIP) by visiting their website (www.aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx).

SECTION 5 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. 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);

- Help from your state's pharmaceutical assistance program. Maryland has a program called Maryland Senior Prescription Drug Assistance Program (SPDAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).

- Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Maryland AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 800-205-6308 (TTY call 800-735-2258).

SECTION 6 Questions?

Section 6.1 – Getting Help from MedStar Medicare Choice HMO

Questions? We're here to help. Please call Member Services at 855-222-1041 (TTY only, call 855-250-5604). We are available for phone calls October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m. Calls to these numbers are free.

Read your 2017 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 2017. For details, look in the 2017 Evidence of Coverage for MedStar Medicare 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. A copy of the Evidence of Coverage is included in this envelope.

Visit our Website

You can also visit our website at MedStarMedicareChoice.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 6.2 – 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 (http://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 http://www.medicare.gov) and click on "Find health & drug plans").

Read Medicare & You 2017

You can read the Medicare & You 2017 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 (http://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.