Inter Valley Health Plan

For health. Not for profit.

Inter Valley Health Plan Service To Seniors (HMO)
offered by Inter Valley Health Plan

Annual Notice of Changes for 2016

You are currently enrolled as a member of Inter Valley Health Plan Service To Seniors (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

- This information is available for free in other languages.
- Please contact our Member Care Team number at 1-800-251-8191 for additional information. (TTY/TDD users should call 1-800-505-7150.) Hours are between 7:30 a.m. and 8:00 p.m., seven days a week.
- Our Member Care Team also has free language interpreter services available for non-English speakers.
- Esta información puede obtenerse gratuitamente en otros idiomas. Comuníquese con nuestros Servicios para Miembros al 1-800-251-8191 para obtener más información. (Los usuarios TTY/TDD deberán llamar al 1-800-505-7150). El horario es de 7:30 a.m. a 8:00 p.m., los siete días de la semana. Los Servicios para Miembros también tienen servicios de intérpretes de idiomas para las personas que no hablan inglés.
- This information is available in a different format, including large print and Spanish. Please call our Member Care Team at 1-800-251-8191 (TTY/TDD only, call 1-800-505-7150) if you need plan information in another format or language.

About Inter Valley Health Plan Service To Seniors (HMO)

- Inter Valley Health Plan is a not-for-profit HMO with a Medicare contract. Enrollment in Inter Valley Health Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means *Inter Valley Health Plan*. When it says "plan" or "our plan," it means *Inter Valley Health Plan Service To Seniors (HMO)*.

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 1.2 and 1.5 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/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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Inter Valley Health Plan Service To Seniors (HMO):

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

If you decide to <u>change</u> 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, 2016. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for Inter Valley Health Plan Service To Seniors (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	2015 (this year)	2016 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
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	$2,000
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit
In-patient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0 Copay for each Medicare-covered hospital stay.	$0 Copay for each Medicare-covered hospital stay.

Cost	2015 (this year)	2016 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Copays during the Initial Coverage Stage: • Drug Tier 1: $5 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 2: $15 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 3: $39 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 4: $79 per prescription for a 30-day supply filled at a network pharmacy Drug Tier 5: 33% of the total cost per prescription for a 30-day supply filled at a network pharmacy	Copays during the Initial Coverage Stage: • Drug Tier 1: $5 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 2: $17.50 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 3: $47 per prescription for a 30-day supply filled at a network pharmacy • Drug Tier 4: $95 per prescription for a 30-day supply filled at a network pharmacy Drug Tier 5: 33% of the total cost per prescription for a 30-day supply filled at a network pharmacy

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- 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	2015 (this year)	2016 (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 out-of-pocket limit Once you have paid $3,400 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.	$2,000 out-of-pocket limit Once you have paid $2,000 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.ivhp.com. You may also call our Member Care Team for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2016 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.
- 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 Provider/Pharmacy Directory is located on our website at www.ivhp.com.You may also call our Member Care Team for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2016 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 *2016 Evidence of Coverage*.

Cost	2015 (this year)	2016 (next year)
Annual Maximum out-of-pocket amount	You pay no more than $3,400 for services you receive from in-network providers	You pay no more than $2,000 for services you receive from in-network providers
Emergency Care	$65 copay for Medicare-covered emergency room visits	$75 copay for Medicare-covered emergency room visits
Urgently Needed Care	$0 copay for in-area Medicare-covered urgent care visits. $30 copay for Medicare-covered urgent care visits when temporarily outside the Plan's service area.	$0 copay for Medicare-covered urgent care visits.
Gym/Health Club Membership	$0 copay each year for gym/health club membership	We cover an allowance of up to $20 each month toward gym/health club membership dues.
Routine Chiropractic Services	$25 copay for up to 12 routine chiropractic visit(s) every year.	Not covered
Outpatient Radiation Therapy	There is an annual maximum member out-of-pocket amount of $1,000 for Medicare-covered outpatient radiation therapy.	There is no service specific maximum out-of-pocket amount for Medicare-covered outpatient radiation therapy.

Cost	2015 (this year)	2016 (next year)
Medicare Part B drugs	You pay 15% of the cost for Medicare-covered Part B-covered drugs, including Part B- covered chemotherapy drugs. There is an annual maximum member out-of-pocket amount of $1,500 for Medicare-covered Part B drugs.	You pay 0-15% of the cost for Medicare-covered Part B-covered drugs, including Part B- covered chemotherapy drugs. You pay $0 for Medicare-covered Part B medications provided in conjunction with routine dialysis services. You pay 15% for all the other Medicare-covered Part B drugs. There is no service specific maximum out-of-pocket amount for Medicare-covered Part B drugs.
Routine Dental (Basic Dental Benefit)	You pay $10 - 20 for fluoride treatment, depending on the service. You pay $4 - 10 for oral exams, depending on the service You pay $10 - 360 for restorative dental services, depending on the procedure. You pay $4 – 680 for Prosthodontics and Oral/ Maxillofacial surgery, depending on the procedure. Services must be provided by your selected participating general dentist in order to be covered. Please review Chapter 4 of the Evidence of Coverage (EOC) for detailed copays and services.	You pay $10 - 12 for fluoride treatment, depending on the service. You pay $4 for oral exams, depending on the service You pay $25 - 530 for restorative dental services, depending on the procedure. You pay $0 – 680 for Prosthodontics and Oral/ Maxillofacial surgery, depending on the procedure. Services must be provided by your selected participating general dentist in order to be covered. Please review Chapter 4 of the Evidence of Coverage (EOC) for detailed copays and services

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 our Pharmacy Specialist.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call our Pharmacy Specialist to ask for a list of covered drugs that treat the same medical condition.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

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 will send 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 October 1, 2015, please call our Member Care Team and ask for the "LIS Rider." Phone numbers for our Member Care Team 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 5 and 6, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2015 (this year)	2016 (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	2015 (this year)	2016 (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) 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 4 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:** You pay $5 per prescription **Generic Drugs:** You pay $15 per prescription **Preferred Brand Drugs:** You pay $39 per prescription. **Non-Preferred Brand Drugs:** You pay $79 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once your total drug costs have reached $2,960, 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:** You pay $5 per prescription **Generic Drugs:** You pay $17.50 per prescription **Preferred Brand Drugs:** You pay $47 per prescription. **Non-Preferred Brand Drugs:** You pay $95 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once your total drug costs have reached $3,310, 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 5 and 6, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Inter Valley Health Plan SERVICE TO SENIORS (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 2016.

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 2016 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 2016*, 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, *Inter Valley 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 Inter Valley Health Plan Service To Seniors (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Inter Valley Health Plan Service To Seniors (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact our Member Care Team 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/TDD 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, 2016.

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, 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, 2016, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. 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 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 at1-800-434-0222 – calls to this number are free.

You can write to HICAP at:

Los Angeles County: Health Insurance Counseling and Advocacy Program (HICAP), Center for Health Care Rights, 520 S. Lafayette Park Place, Suite 214, Los Angeles, CA 90057.

Riverside County: Health Insurance Counseling and Advocacy Program (HICAP), HICAP of Riverside County, 9121 Haven Avenue, Suite 120, Rancho Cucamonga, CA 91739.

San Bernardino County: Health Insurance Counseling and Advocacy Program (HICAP), San Bernardino County HICAP , 9121 Haven Avenue, Suite 120, Rancho Cucamonga, CA 91739

You can learn more about HICAP by visiting their website (www.aging.ca.gov/hicap).

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/TDD 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/TDD users should call, 1-800-325-0778 (applications); or
- Your State Medicaid (Medi-Cal) 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 California provider for the ADAP program, Ramsell Corporation. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ramsell Corporation at 1-888-311-7632 - calls to this number are free. You can learn more about Ramsell Corporation by visiting their website (www.ramsellcorp.com).

SECTION 6 Questions?

Section 6.1 – Getting Help from Inter Valley Health Plan SERVICE TO SENIORS (HMO)

Questions? We're here to help. Please call our Member Care Team at 1-800-251-8191. (TTY/TDD only, call 1-800-505-7150). We are available for phone calls between the hours of 7:30 a.m. and 8:00 p.m., seven days a week. Calls to these numbers are free.

Read your 2016 *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 2016. For details, look in the 2016 Evidence of Coverage for Inter Valley Health Plan Service To Seniors (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.ivhp.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 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/TDD 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 2016*

You can read the *Medicare & You 2016* 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/TDD users should call 1-877-486-2048.

Inter Valley Health Plan

For health. Not for profit.

800-251-8191

TTY/TDD 800-505-7150

7:30 am to 8 pm, 7 days a week.

300 S. Park Avenue

PO Box 6002, Pomona, CA 91769-6002

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