# Notice of nondiscrimination

Fallon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Fallon does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Fallon Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at the phone number on the back of your member ID card, or by email at cs@fallonhealth.org.

If you believe that Fallon Health 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:

Compliance Director
Fallon Health
10 Chestnut St.
Worcester, MA 01608

Phone: 1-508-368-9988 (TRS 711)
Email: compliance@fallonhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Director 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, D.C., 20201

Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

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

- This information is available in alternate formats, such as Braille, large print or audio tape.
- **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 Fallon Senior Plan Plus Enhanced Rx HMO-POS

- Fallon Health is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Fallon Health. When it says "plan" or "our plan," it means Fallon Senior Plan Plus Enhanced Rx HMO-POS.

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## Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Fallon Senior Plan Plus Enhanced Rx HMO-POS 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, located on our website at fallonhealth.org/seniorplan, *Evidence of Coverage* to see if other benefit or cost changes affect you.

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Monthly plan premium***<br>* Your premium may be higher or lower than this amount. See Section 1.1 for details. | $142 | $126 |
| **Maximum out-of-pocket amount**<br>This is the most you will pay out-of-pocket for your covered services.<br>(See Section 1.2 for details.) | In-network: $3,400<br>Out-of-network: $5,000 | In-network: $3,400<br>Out-of-network: $5,000 |
| **Doctor office visits** | Primary care visits: $10 per in-network visit; out-of-network not covered<br>Specialist visits: $20 per in- and out-of-network visit | Primary care visits: $10 per in-network visit; out-of-network not covered<br>Specialist visits: $20 per in- and out-of-network visit |
| **Inpatient hospital stays**<br>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. | In-network: You pay a $225 copay for each inpatient hospital stay.<br>There is a $450 maximum out-of-pocket limit every year for inpatient acute hospital care.<br>There is a $450 maximum out-of-pocket limit every year for inpatient rehabilitation hospital care.<br>Out-of-network: You pay a $600 copay for each inpatient hospital stay. | In-network: You pay a $225 copay for each inpatient hospital stay.<br>There is a $450 maximum out-of-pocket limit every year for inpatient acute hospital care.<br>There is a $450 maximum out-of-pocket limit every year for inpatient rehabilitation hospital care.<br>Out-of-network: You pay a $600 copay for each inpatient hospital stay. |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Part D prescription drug coverage**<br>(See Section 1.6 for details.) | Deductible: $0<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br>*Preferred pharmacies*<br>Drug Tier 1:<br>• $1 copay for a 30-day supply<br>• $2 copay for a 60-day supply<br>• $3 copay for a 90-day supply<br>Drug Tier 2:<br>• $7 copay for a 30-day supply<br>• $14 copay for a 60-day supply<br>• $21 copay for a 90-day supply<br>Drug Tier 3:<br>• $37 copay for a 30-day supply<br>• $74 copay for a 60-day supply<br>• $111 copay for a 90-day supply<br>Drug Tier 4:<br>• $86 copay for a 30-day supply<br>• $172 copay for a 60-day supply<br>• $258 copay for a 90-day supply<br>Drug Tier 5:<br>• 33% of the total cost for a 30-day supply | Deductible: $0<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br>*Preferred pharmacies*<br>Drug Tier 1:<br>• $1 copay for a 30-day supply<br>• $2 copay for a 60-day supply<br>• $3 copay for a 90-day supply<br>Drug Tier 2:<br>• $7 copay for a 30-day supply<br>• $14 copay for a 60-day supply<br>• $21 copay for a 90-day supply<br>Drug Tier 3:<br>• $37 copay for a 30-day supply<br>• $74 copay for a 60-day supply<br>• $111 copay for a 90-day supply<br>Drug Tier 4:<br>• $86 copay for a 30-day supply<br>• $172 copay for a 60-day supply<br>• $258 copay for a 90-day supply<br>Drug Tier 5:<br>• 33% of the total cost for a 30-day supply |

| Cost | 2018 (this year) | 2019 (next year) |
| --- | --- | --- |
| | *Standard pharmacies:*<br>Drug Tier 1:<br>• $6 copay for a 30-day supply<br>• $12 copay for a 60-day supply<br>• $18 copay for a 90-day supply<br>Drug Tier 2:<br>• $12 copay for a 30-day supply<br>• $24 copay for a 60-day supply<br>• $36 copay for a 90-day supply<br>Drug Tier 3:<br>• $42 copay for a 30-day supply<br>• $84 copay for a 60-day supply<br>• $126 copay for a 90-day supply<br>Drug Tier 4:<br>• $91 copay for a 30-day supply<br>• $182 copay for a 60-day supply<br>• $273 copay for a 90-day supply<br>Drug Tier 5:<br>• 33% of the total cost for a 30-day supply | *Standard pharmacies:*<br>Drug Tier 1:<br>• $6 copay for a 30-day supply<br>• $12 copay for a 60-day supply<br>• $18 copay for a 90-day supply<br>Drug Tier 2:<br>• $12 copay for a 30-day supply<br>• $24 copay for a 60-day supply<br>• $36 copay for a 90-day supply<br>Drug Tier 3:<br>• $42 copay for a 30-day supply<br>• $84 copay for a 60-day supply<br>• $126 copay for a 90-day supply<br>Drug Tier 4:<br>• $91 copay for a 30-day supply<br>• $182 copay for a 60-day supply<br>• $273 copay for a 90-day supply<br>Drug Tier 5:<br>• 33% of the total cost 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 | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $142 | $126 |

- 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 services for the rest of the year.

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>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. | In-network: $3,400<br>Out-of-network: $5,000 | In-network: $3,400<br>Out-of-network: $5,000<br>Once you have paid $3,400 out-of-pocket for in-network covered services, you will pay nothing for your covered services for the rest of the calendar year.<br>Once you have paid $5,000 out-of-pocket for out-of-network covered services, you will pay nothing for your covered services for the rest of the calendar year. |

## Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at fallonhealth.org/seniorplan. You may also call Customer Service 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 fallonhealth.org/seniorplan. You may also call Customer Service 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) |
|---|---|---|
| **Emergency care** | **In- and Out-of-network**<br>You pay a $100 copay for each Medicare-covered emergency room visit. | **In- and Out-of-network**<br>You pay a $120 copay for each Medicare-covered emergency room visit. |
| **Hearing services** | **In-network**<br>No limit on hearing aids. | **In-network**<br>A limit of 2 hearing aids per year. |
| **Outpatient hospital services** | **In- and Out-of-network**<br>There is no copay for observation services. | **In-network**<br>You pay a $120 copay for observation services.<br>If you are admitted to the hospital on the same day, you do not pay the observation services copay.<br>**Out-of-network**<br>You pay a $200 copay for observation services.<br>If you are admitted to the hospital on the same day, you do not pay the observation services copay. |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers** | **In-network**<br>You pay a $100 copay for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. | **In-network**<br>You pay a $120 copay for each Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. |
| **Supervised Exercise Therapy (SET)** | Supervised Exercise Therapy (SET) is not covered. | **In- and Out-of-network**<br>There is no copayment for Medicare-covered Supervised Exercise Therapy (SET). |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Urgently needed services** | You pay a $100 copay for each urgently needed care visit outside of the United States and its territories. | You pay a $120 copay for each urgently needed care visit outside of the United States and its territories. |

## 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 provided electronically.

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 Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service 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: a 31-day supply of medication rather than the amount provided in 2018 (up to a 98-day supply 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.

If you reside in a long-term care facility, you may receive a maximum 31-day supply with refills as necessary during the first 90 days after the change in the drug list.

Current formulary exceptions are covered for a year from the date of approval. If the request is for less than a year, the request will be approved for an appropriate period of time.

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 30 day, 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 does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service 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, located on our website at fallonhealth.org/seniorplan, *Evidence of Coverage*.)

### 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**<br>During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**<br><br>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*.<br><br>**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:<br><br>**Tier 1:**<br>*Standard cost-sharing:*<br>You pay $6 per prescription.<br>*Preferred cost-sharing:*<br>You pay $1 per prescription.<br><br>**Tier 2:**<br>*Standard cost-sharing:*<br>You pay $12 per prescription.<br>*Preferred cost-sharing:*<br>You pay $7 per prescription.<br><br>**Tier 3:**<br>*Standard cost-sharing:*<br>You pay $42 per prescription.<br>*Preferred cost-sharing:*<br>You pay $37 per prescription.<br><br>**Tier 4:**<br>*Standard cost-sharing:*<br>You pay $91 per prescription.<br>*Preferred cost-sharing:*<br>You pay $86 per prescription.<br><br>**Tier 5:**<br>*Standard cost-sharing:*<br>You pay 33% of the total cost. | Your cost for a one-month supply filled at a network pharmacy:<br><br>**Tier 1:**<br>*Standard cost-sharing:*<br>You pay $6 per prescription.<br>*Preferred cost-sharing:*<br>You pay $1 per prescription.<br><br>**Tier 2:**<br>*Standard cost-sharing:*<br>You pay $12 per prescription.<br>*Preferred cost-sharing:*<br>You pay $7 per prescription.<br><br>**Tier 3:**<br>*Standard cost-sharing:*<br>You pay $42 per prescription.<br>*Preferred cost-sharing:*<br>You pay $37 per prescription.<br><br>**Tier 4:**<br>*Standard cost-sharing:*<br>You pay $91 per prescription.<br>*Preferred cost-sharing:*<br>You pay $86 per prescription.<br><br>**Tier 5:**<br>*Standard cost-sharing:*<br>You pay 33% of the total cost. |

| Stage | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage (continued)** | *Preferred cost-sharing:*<br>You pay 33% of the total cost.<br>_______________<br>Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage). | *Preferred cost-sharing:*<br>You pay 33% of the total cost.<br>_______________<br>Once your total drug costs have reached $3,820, 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 Fallon Senior Plan Plus Enhanced Rx HMO-POS

**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 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 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 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 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, Fallon Health offers other Medicare health plans and Medicare prescription drug 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 Fallon Senior Plan Plus Enhanced Rx HMO-POS.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Fallon Senior Plan Plus Enhanced Rx HMO-POS.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service 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, 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.*

Note: If you’re in a drug management program, you may not be able to change plans.

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 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 Massachusetts, the SHIP is called the Serving the Health Insurance Needs of Everyone (SHINE) Program.

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 1-800-243-4636. You can learn more about SHINE by visiting their website (www.mass.gov/health-insurance-counseling).

## 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 am and 7 pm, 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.** Massachusetts has a program called Prescription Advantage 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 HIV Drug Assistance Program (HDAP), Community Research Initiative/HDAP, Schrafft's Center, 529 Main St., Suite 301, Charlestown, MA 02129. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-228-2714.

# SECTION 6 Questions?

## Section 6.1 – Getting Help from Fallon Senior Plan Plus Enhanced Rx HMO-POS

Questions? We're here to help. Please call Customer Service at 1-800-323-5669. (TTY only, call TRS 711). We are available for phone calls 8 a.m.–8 p.m., Monday–Friday. (Oct. 1–March 31, seven days a week.) 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 Fallon Senior Plan Plus Enhanced Rx HMO-POS. 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 located on our website at fallonhealth.org/seniorplan.

### Visit our Website

You can also visit our website at fallonhealth.org/seniorplan. 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 (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.