

2019 ANNUAL NOTICE OF CHANGES



Important changes to your plan

UnitedHealthcare Dual Complete® Choice (Regional PPO SNP)



Toll-free **1-866-480-1086**, TTY **711**

8 a.m. - 8 p.m. local time, 7 days a week



www.UHCCommunityPlan.com

Do we have the right address for you?

If not, please let us know so we can keep you informed about your plan.



Annual Notice of Changes for 2019



You are currently enrolled as a member of Care Improvement Plus® Dual Advantage (Regional PPO SNP).

Next year, there will be some changes to the plan's costs and benefits. **This booklet tells about the changes.**

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Section 2 for information about benefit and cost changes for our plan.

- Check the changes in the booklet to our prescription drug coverage to see if they affect you.
 - Will your drugs be covered?
 - Are your drugs in a different tier, with different cost sharing?
 - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
 - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
 - Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.
 - Your drugs costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit <https://go.medicare.gov/drugprices>. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 2.3 for information about our Provider Directory.
- Think about your overall health care costs.
 - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
 - How much will you spend on your premium and deductibles?
 - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area.
 - Use the personalized search feature on the Medicare Plan Finder at <https://www.medicare.gov> website. Click “Find health & drug plans.”
 - Review the list in the back of your Medicare & You handbook.
 - Look in Section 3.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Care Improvement Plus® Dual Advantage (Regional PPO SNP), you don’t need to do anything. You will stay in Care Improvement Plus® Dual Advantage (Regional PPO SNP).
- If you want to change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 3 to learn more about your choices.

4. ENROLL: To change plans, join a plan between now and **December 31, 2018**

- If you **don’t join another plan by December 31, 2018**, you will stay in Care Improvement Plus® Dual Advantage (Regional PPO SNP).
- If you **join another plan by December 31, 2018**, your new coverage will start on the first day of the following month.
- Starting in 2019, there are new limits on how often you can change plans. Look in Section 4 to learn more.

Additional Resources

- This document is available for free in other languages.

- Please contact our Customer Service number at 1-866-480-1086 for additional information (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.
- Este documento está disponible sin costo en otros idiomas.
- Comuníquese con nuestro Servicio al Cliente al número 1-866-480-1086 para obtener información adicional (los usuarios de TTY deben llamar al 711). El horario es de 8 a.m. a 8 p.m., hora local, los 7 días de la semana.
- This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number at 1-866-480-1086, TTY: 711, 8 a.m. - 8 p.m. local time, 7 days a week, for additional information.
- 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 UnitedHealthcare Dual Complete® Choice (Regional PPO SNP)

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.
- The plan also has a written agreement with the Texas Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for UnitedHealthcare Dual Complete® Choice (Regional PPO SNP) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this Annual Notice of Changes** and review the **Evidence of Coverage**, which is available online or by calling Customer Service, to see if other benefit or cost changes affect you. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2018 (this year)	2019 (next year)
<p>Monthly Plan Premium*</p> <p>*Your premium may be higher or lower than this amount. (See Section 2.1 for details.)</p>	\$0	\$0
<p>Maximum out-of-pocket amounts</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</p>	<p>From network providers: \$0</p> <p>From in-network and out-of-network providers combined: \$6,700</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered in-network Part A and Part B services.</p>	<p>From network providers: \$0</p> <p>From in-network and out-of-network providers combined: \$6,700</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered in-network Part A and Part B services.</p>
<p>Doctor Office Visits</p>	<p>Primary care visits: You pay a \$0 copayment per visit (in-network).</p> <p>You pay a \$0 copayment per visit (out-of-network).</p> <p>Specialist visits: You pay a \$0 copayment per visit (in-network).</p>	<p>Primary care visits: You pay a \$0 copayment per visit (in-network).</p> <p>You pay a \$0 copayment per visit (out-of-network).</p> <p>Specialist visits: You pay a \$0 copayment per visit (in-network).</p>

Cost	2018 (this year)	2019 (next year)
	You pay a \$0 copayment per visit (out-of-network).	You pay a \$0 copayment per visit (out-of-network).
<p>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.</p>	<p>You pay a \$0 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (in-network).</p> <p>You pay a \$1,300 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (out-of-network).</p>	<p>You pay a \$0 copayment for each Medicare-covered hospital stay for unlimited days (in-network).</p> <p>You pay a \$1,300 copayment (or the 2019 Original Medicare amount, whichever is less) for each Medicare-covered hospital stay for unlimited days (out-of-network).</p>
<p>Part D prescription drug coverage (See Section 2.6 for details.)</p>	<p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:</p> <p>Deductible:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 or <input type="checkbox"/> \$83 <p>For generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$1.25 copayment or <input type="checkbox"/> \$3.35 copayment or 	<p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:</p> <p>Deductible:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 or <input type="checkbox"/> \$85 <p>For generic drugs (including brand drugs treated as generic):</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$1.25 copayment or <input type="checkbox"/> \$3.40 copayment or

Cost	2018 (this year)	2019 (next year)
	<p><input type="checkbox"/> 15% of the total cost</p> <p>If the total amount you pay for copayments and coinsurance reaches \$5,000, your cost sharing amounts will be:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.35 copayment</p> <p>For all other covered drugs:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.70 copayment or <input type="checkbox"/> \$8.35 copayment or <input type="checkbox"/> 15% of the total cost</p> <p>If the total amount you pay for copayments and coinsurance reaches \$5,000, your cost sharing amounts will be:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$8.35 copayment</p>	<p><input type="checkbox"/> 15% of the total cost</p> <p>If the total amount you pay for copayments and coinsurance reaches \$5,100, your cost sharing amounts will be:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.40 copayment</p> <p>For all other covered drugs:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.80 copayment or <input type="checkbox"/> \$8.50 copayment or <input type="checkbox"/> 15% of the total cost</p> <p>If the total amount you pay for copayments and coinsurance reaches \$5,100, your cost sharing amounts will be:</p> <p><input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$8.50 copayment</p>
If you do not qualify for “Extra Help” from Medicare to help pay for your prescription drug costs		
	<p>Deductible: \$405 You pay 25% of the total cost.</p>	<p>Deductible: \$415 You pay 25% of the total cost.</p>

Annual Notice of Changes for 2019

Table of Contents

Summary of Important Costs for 2019.....	5
SECTION 1: We Are Changing the Plan’s Name.....	9
SECTION 2: Changes to Medicare Benefits and Costs for Next Year.....	9
Section 2.1: Changes to the Monthly Premium.....	9
Section 2.2: Changes to Your Maximum Out-of-Pocket Amounts.....	9
Section 2.3: Changes to the Provider Network.....	11
Section 2.4: Changes to the Pharmacy Network.....	11
Section 2.5: Changes to Benefits and Costs for Medical Services.....	11
Section 2.6: Changes to Part D Prescription Drug Coverage.....	18
SECTION 3: Deciding Which Plan to Choose.....	22
Section 3.1: If You Want to Stay in UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).....	22
Section 3.2: If You Want to Change Plans.....	22
SECTION 4: Changing Plans.....	23
SECTION 5: Programs That Offer Free Counseling about Medicare and Medicaid.....	24
SECTION 6: Programs That Help Pay for Prescription Drugs.....	24
SECTION 7: Questions?.....	25
Section 7.1: Getting Help from UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).....	25
Section 7.2: Getting Help from Medicare.....	25
Section 7.3: Getting Help from Medicaid.....	26

Section 1: We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from Care Improvement Plus® Dual Advantage (Regional PPO SNP) to UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).

We will mail you a new member ID card. If you have questions, or if your member ID card is damaged, lost, or stolen, call Customer Service at 1-866-480-1086 (TTY users should call 711) right away and we will send you a new card.

You will see the new plan name reflected on future communications where the plan name is referenced.

Section 2: Changes to Medicare Benefits and Costs for Next Year

SECTION 2.1: Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly Premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	\$0	\$0

SECTION 2.2: Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. These limits are called the “maximum out-of-pocket amounts.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
<p>In-network maximum out-of-pocket amount</p> <p>Because our members also get assistance from Texas Medicaid Health and Human Services Commission (Medicaid), very few members ever reach this out-of-pocket maximum.</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p> <p>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	<p>\$0</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>	<p>\$0</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Because our members also get assistance from Texas Medicaid Health and Human Services Commission (Medicaid), very few members ever reach this out-of-pocket maximum.</p> <p>Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.</p>	<p>\$6,700</p> <p>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 from in-network or out-of-network providers for the rest of the calendar year.</p>	<p>\$6,700</p> <p>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 from in-network or out-of-network providers for the rest of the calendar year.</p>

SECTION 2.3: 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 www.UHCCommunityPlan.com. 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 2.4: 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 www.UHCCommunityPlan.com. You may also call Customer Service for updated pharmacy 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 2.5: Changes to Benefits and Costs for Medical Services

Please note that **the Annual Notice of Changes** only tells you about changes to your Medicare benefits and costs.

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**. A copy of the **Evidence of Coverage** can be viewed online. A hard copy can be mailed to you by requesting one from Customer Service.

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a \$0 copayment amount.

Cost	2018 (this year)	2019 (next year)
<p>Dental Services Preventive Dental Services</p>	<p><u>Not</u> Covered.</p>	<p>\$0 copayment for covered services (in-network).</p> <p>50% coinsurance for covered services (out-of-network).</p> <p>Preventive Dental services include exams, cleanings and x-rays.</p> <p>Benefit is combined in and out-of-network.</p> <p>Limitations and exclusions apply.</p> <p>For more information, please refer to your Evidence of Coverage.</p>
<p>Diabetes Self-Management Training, Diabetic Services and Supplies</p>	<p>You pay a \$0 copayment (in-network). We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2, OneTouch UltraMini®, OneTouch</p>	<p>You pay a \$0 copayment (in-network). We only cover ACCU-CHEK® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio® IQ,</p>

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2018 (this year)	2019 (next year)
	<p>Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Nano SmartView, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, and ACCU-CHEK® Aviva Connect. Other brands are not covered by our plan. If you use a brand of supplies that is not covered by our plan, you should speak with your doctor to get a new prescription for a covered brand.</p>	<p>OneTouch Verio® Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan. If you use a brand of supplies that is not covered by our plan, you should speak with your doctor to get a new prescription for a covered brand.</p>

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2018 (this year)	2019 (next year)
<p>Fitness Program</p>	<p>This benefit gives you access to one Fitbit® activity tracker at no additional cost every year. This device may help improve or maintain good health by tracking your physical activity and exercise. Benefit includes coverage for specific models, please go to www.fitbit.com/store/UHC Medicare for details.</p>	<p>Renew Active™ is a fitness program for body and mind that includes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Standard membership access to participating fitness locations <input type="checkbox"/> Online brain exercises and activities <input type="checkbox"/> An in-person fitness orientation <p>An at-home fitness kit is available for members living 15 miles or more from a participating fitness center location.</p> <p>There is no visit or use fee for standard membership when you use network service providers.</p> <p>Additionally, this benefit gives you access to one Fitbit® activity tracker at no additional cost every 2 years. This device may help improve or maintain good health by tracking your physical activity and exercise. Benefit includes coverage for specific models, please go to</p>

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2018 (this year)	2019 (next year)
		<p>www.fitbit.com/store/UHC for details.</p> <p>This provider must be used for the in-network and out-of-network benefit.</p>
Health Products Benefit	\$275 credit quarterly. Benefit combined in and out-of-network.	\$305 credit quarterly. Benefit combined in and out-of-network.
Hearing Services Hearing Aids	You pay a \$0 copay for each Behind-the-Ear hearing aid or Open-Fit In-the-Canal hearing aid. Limited to 2 hearing aids/devices per year. Benefit is combined in and out-of-network.	You receive a \$2,000 credit for hearing aids every 2 years. Benefit is combined in and out-of-network.
Inpatient Hospital Care	You pay a \$0 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (in-network).	You pay a \$0 copayment for each Medicare-covered hospital stay for unlimited days (in-network).
Inpatient Hospital Care	You pay a \$1,300 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (out-of-network).	You pay a \$1,300 copayment (or the 2019 Original Medicare amount, whichever is less) for each Medicare-covered hospital stay for unlimited days (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2018 (this year)	2019 (next year)
Inpatient Mental Health Care	You pay a \$1,300 copayment. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (out-of-network).	You pay a \$1,300 copayment (or the 2019 Original Medicare amount, whichever is less). Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days (out-of-network).
Medicare Part B Prescription Drugs - Step Therapy	Not Applicable	There may be effective, lower-cost drugs that treat the same medical condition. If you are prescribed a new medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover this drug.
Skilled Nursing Facility (SNF) Care	You pay the Original Medicare cost sharing amount for inpatient services: \$0 copayment each day for days 1 to 20.	You pay the Original Medicare cost sharing amount for 2019 which will be set by CMS in the fall of 2018. These are 2018 cost sharing amounts and may change for 2019. Our

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Cost	2018 (this year)	2019 (next year)
	\$167.50 copayment each day for days 21 to 100 (out-of-network).	plan will provide updated rates as soon as they are released. \$0 copayment each day for days 1 to 20. \$167.50 each day for days 21 – 100 (out-of-network).
Solutions for Caregivers	<u>Not</u> covered.	You pay \$0 copayment Solutions for Caregivers services available, 24 hours a day, 7 days a week. You may choose one of the following options: hourly care management services (up to 3 hours a year), or a telephonic consultation and caregiver care plan, or an in-home assessment
Transportation (additional routine)	\$0 copayment for 6 one-way trips per calendar year (combined in and out-of-network).	\$0 copayment for 12 one-way trips per calendar year (in-network). 75% coinsurance for 12 one-way trips per calendar year (out-of-network). Trips are combined in and out-of-network.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

SECTION 2.6: Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” **You can get the complete Drug List** by calling Customer Service (see the back cover) or visiting our website (www.UHCCommunityPlan.com).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
 - To learn what you must do to ask for an exception, see Chapter 9 of your **Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** or call 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 at least 31-days of medication rather than the amount provided in 2018 (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 have obtained approval for a drug list (formulary) exception this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. After the date of expiration on your approval letter, you may need to obtain a new approval in order for the plan to continue to cover the drug, if the drug still requires an exception and you and your doctor feel it is needed. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage or call Customer Service.

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 at least a 30-day supply rather than a 60-day refill of your brand name drug at a network pharmacy.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** 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. Because you receive “Extra Help” you will receive a “LIS Rider” by September 30, 2018. If you don’t receive it, please call Customer Service and ask for the "LIS Rider" to be sent to you. Phone numbers for Customer Service are in Section 7.1 of this booklet.

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

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

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	Your deductible amount is either \$0 or \$83,	Your deductible amount is either \$0 or \$85,

Stage	2018 (this year)	2019 (next year)
<p>During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible.</p>	<p>depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p> <p>If you do not qualify for “Extra Help” from Medicare to help pay for your prescription drug costs, your deductible is \$405.</p>	<p>depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p> <p>If you do not qualify for “Extra Help” from Medicare to help pay for your prescription drug costs, your deductible is \$415.</p>

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)
<p>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.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage.</p>	<p>Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing:</p> <p>Generic drugs (including brand drugs treated as generic):</p> <p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you</p>	<p>Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing:</p> <p>Generic drugs (including brand drugs treated as generic):</p> <p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you</p>

Stage	2018 (this year)	2019 (next year)
	<p>pay one of the following amounts:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$1.25 copayment or <input type="checkbox"/> \$3.35 copayment or <input type="checkbox"/> 15% of the total cost <p>For all other covered drugs:</p> <p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.70 copayment or <input type="checkbox"/> \$8.35 copayment or <input type="checkbox"/> 15% of the total cost 	<p>pay one of the following amounts:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$1.25 copayment or <input type="checkbox"/> \$3.40 copayment or <input type="checkbox"/> 15% of the total cost <p>For all other covered drugs:</p> <p>If you are enrolled in Medicare A and B and receive full Texas Medicaid Health and Human Services Commission (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts:</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$0 copayment or <input type="checkbox"/> \$3.80 copayment or <input type="checkbox"/> \$8.50 copayment or <input type="checkbox"/> 15% of the total cost
	<p>If you do not qualify for “Extra Help” from Medicare to help pay for your prescription drug costs</p>	
	<p>For all covered drugs:</p> <p>You pay 25% of the total cost</p> <p>_____</p> <p>Once your total drugs costs have reached \$3,750, you will move to the next stage (the Coverage Gap Stage).</p>	<p>For all covered drugs:</p> <p>You pay 25% of the total cost</p> <p>_____</p> <p>Once your total drugs costs have reached \$3,820, you will move to the next stage (the Coverage Gap Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your **Evidence of Coverage**.

Section 3: Deciding Which Plan to Choose

SECTION 3.1: If You Want to Stay in UnitedHealthcare Dual Complete® Choice (Regional PPO SNP)

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, you will automatically stay enrolled as a member of our plan for 2019.

SECTION 3.2: If You Want to Change Plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

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

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. To learn more about Original Medicare and the different types of Medicare plans, read **Medicare & You 2019**, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, UnitedHealthcare Insurance Company or one of its affiliates 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 UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from UnitedHealthcare Dual Complete® Choice (Regional PPO SNP).
- 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 7.1 of this booklet).
 - – **or** – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

Section 4: Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from now until December 31. 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. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.3 of the **Evidence of Coverage**.

Note: Effective January 1, 2019, 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 5: Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Texas, the SHIP is called Texas Department of Aging and Disability Services (HICAP).

Texas Department of Aging and Disability Services (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. Texas Department of Aging and Disability Services (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 Texas Department of Aging and Disability Services (HICAP) at 1-800-252-9240.

For questions about your Texas Medicaid Health and Human Services Commission benefits, contact Texas Medicaid Health and Human Services Commission, at 1-800-335-8957, 7 a.m. - 7 p.m. CT, Monday - Friday. TTY users should call 1-512-424-6597. Ask how joining another plan or returning to Original Medicare affects how you get your Texas Medicaid Health and Human Services Commission coverage.

Section 6: 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.** Because you have Medicaid, you are already enrolled in ‘Extra Help,’ also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, 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.** Texas has a program called Texas Kidney Health Care Program 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 Chapter 2, Section 3 of your **Evidence of Coverage**).

- **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 ADAP in your State. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP in your State. You can find your State's ADAP contact information in Chapter 2 of the **Evidence of Coverage**.

Section 7: Questions?

SECTION 7.1: Getting Help from UnitedHealthcare Dual Complete® Choice (Regional PPO SNP)

Questions? We're here to help. Please call Customer Service at 1-866-480-1086. (TTY only, call 711.) We are available for phone calls 8 a.m. - 8 p.m. local time, 7 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 UnitedHealthcare Dual Complete® Choice (Regional PPO SNP). 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** can be reviewed online. A hard copy can be mailed to you by requesting one from Customer Service.

Visit our Website

You can also visit our website at www.UHCCCommunityPlan.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).

SECTION 7.2: Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on “Find health & drug plans”).

Read Medicare & You 2019

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

SECTION 7.3: Getting Help from Medicaid

To get information from Texas Medicaid Health and Human Services Commission (Medicaid), you can call Texas Medicaid Health and Human Services Commission (Medicaid) at 1-800-335-8957. TTY users should call 1-512-424-6597.



**UnitedHealthcare Dual Complete® Choice (Regional PPO SNP)
Customer Service:**

Call **1-866-480-1086**

Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free. 8 a.m. - 8 p.m. local time, 7 days a week.

Write P.O. Box 29675
Hot Springs, AR 71903-9675

Website **www.UHCCommunityPlan.com**