The Health Plan SecureChoice Capitol Plan (PPO) offered by The Health Plan

Annual Notice of Changes for 2021

You are currently enrolled as a member of The Health Plan SecureChoice Capitol Plan (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.2 and 2.5 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 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
  - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit 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, including specialists you see regularly, 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 www.medicare.gov/plan-compare website.
- 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 don't join another plan by **December 7, 2020**, you will be enrolled in The Health Plan SecureChoice Capitol Plan (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in The Health Plan SecureChoice Capitol Plan (PPO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-877-847-7907 for additional information. (TTY users should call 711). Hours are: October 1 to March 31: 8:00 am to 8:00 pm 7 days a week and April 1 to September 30: 8:00 a.m. to 8:00 p.m. Monday through Friday.
- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This document may be available in other formats such as braille, large print or other alternate formats. Please call Member Services at 1-877-847-7907. TTY users should call the state relay number: 711 if you need this document in another format.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About The Health Plan SecureChoice Capitol Plan (PPO)

- The Health Plan SecureChoice (PPO) is a PPO plan with a Medicare contract. Enrollment in The Health Plan SecureChoice (PPO) depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means The Health Plan. When it says “plan” or “our plan,” it means The Health Plan SecureChoice Capitol Plan (PPO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for The Health Plan SecureChoice Capitol Plan (PPO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.healthplan.org/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$66	$98
Deductible	You pay a $500 deductible for all **Out-of-Network** covered services except: Emergency care, Urgently needed services, Emergency Ambulance Transports	You pay a $1500 deductible for all **Out-of-Network** covered services except: Emergency care, Urgently needed services, Emergency Ambulance Transports
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 2.2 for details.)	From network providers: $6,700 From network and out-of-network providers combined: $10,000	From network providers: $6,700 From network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network**: Primary care visits: $10 per visit Specialist visits: $45 per visit **Out-of-Network**: Primary care visits: $25 per visit Specialist visits: $60 per visit	**In-Network**: Primary care visits: $10 per visit Specialist visits: $45 per visit **Out-of-Network**: Primary care visits: $25 per visit Specialist visits: $60 per visit

Cost	2020 (this year)	2021 (next year)
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.	**In-Network**: Days 1-5: $250 copay per day (per admission) Days 6 and 90: $0 copay per day Days 91 and beyond: $0 copay per day. **Out-of-Network**: 30% per admission	**In-Network**: Days 1-5: $250 copay per day (per admission) Days 6 and 90: $0 copay per day Days 91 and beyond: $0 copay per day. **Out-of-Network**: 30% per admission
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $100 Applies to drug Tiers 3, 4 and 5 only Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $3 or $13 • Drug Tier 2: $10 or $20 • Drug Tier 3: $47 or $47 • Drug Tier 4: $100 or $100 • Drug Tier 5: 31%	Deductible: $100 Applies to drug Tiers 3, 4 and 5 only Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $3 or $13 • Drug Tier 2: $10 or $20 • Drug Tier 3: $47 or $47 • Drug Tier 4: $100 or $100 • Drug Tier 5: 31%

Annual Notice of Changes for 2021
Table of Contents

Summary of Important Costs for 2021 1

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in The Health Plan SecureChoice Capitol Plan (PPO) in 2021 4

SECTION 2 Changes to Benefits and Costs for Next Year 4

Section 2.1 – Changes to the Monthly Premium 4
Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts 5
Section 2.3 – Changes to the Provider Network 5
Section 2.4 – Changes to the Pharmacy Network 6
Section 2.5 – Changes to Benefits and Costs for Medical Services 6
Section 2.6 – Changes to Part D Prescription Drug Coverage 7

SECTION 3 Deciding Which Plan to Choose 11

Section 3.1 – If you want to stay in The Health Plan SecureChoice Capitol Plan (PPO) 11
Section 3.2 – If you want to change plans 11

SECTION 4 Deadline for Changing Plans 12

SECTION 5 Programs That Offer Free Counseling about Medicare 12

SECTION 6 Programs That Help Pay for Prescription Drugs 12

SECTION 7 Questions? 13

Section 7.1 – Getting Help from The Health Plan SecureChoice Capitol Plan (PPO) 13
Section 7.2 – Getting Help from Medicare 13

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in The Health Plan SecureChoice Capitol Plan (PPO) in 2021

If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our The Health Plan SecureChoice Capitol Plan (PPO). This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through The Health Plan SecureChoice Capitol Plan (PPO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in The Health Plan SecureChoice Capitol Plan (PPO) and the benefits you will have on January 1, 2021, as a member of The Health Plan SecureChoice Capitol Plan (PPO).

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$66	$98
Monthly Optional Supplemental Dental Premium	$28.50	$28.90

- 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. Please see Section 7 regarding "Extra Help" from Medicare.

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 services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) 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.	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) 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. There are no changes to your Combined maximum out-of-pocket amount for the upcoming benefit year.	$10,000 Once you have paid $10,000 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.	$10,000 Once you have paid $10,000 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

Our network has changed more than usual for 2021. An updated Provider Directory is located on our website at www.healthplan.org/medicare/find-provider. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **We strongly suggest that you review our current Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are still 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, we must 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 to manage 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. 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 www.healthplan.org/medicare/find-pharmacy. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – 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 2021 *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Over the Counter (OTC)	Over the Counter (OTC) is not covered.	**In-Network** You pay a $0 copay This plan covers approved over-the-counter items, up to $60 every quarter. The quarterly credit may be carried over from month to month, but must be used by December 31st. **Out-of-Network** You pay a 30% Coinsurance
Additional Telehealth Services	Additional Telehealth Services is not covered	You pay a $0 copay for Additional Telehealth Services. This coverage must be accessed through our contracted telehealth vendor.
Acupuncture for chronic low back pain	Acupuncture is not covered.	**In-Network**: Primary care visits: You pay a $10 copay per visit Specialist visits: You pay a $45 copay per visit **Out-of-Network**: Primary care visits: You pay a $25 copay per visit Specialist visits: You pay a $60 copay per visit

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." 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. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a 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. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

In most cases, current formulary exceptions will still be covered next year.

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.

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 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 have included 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 didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

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 located on our website at

www.healthplan.org/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible.	The deductible is $100. Applies to Tier 3, 4 and 5 drugs only. During this stage, you pay: **Preferred Generic Drugs (Tier 1)**: Preferred cost-sharing: You pay $3 per prescription. Standard cost-sharing: You pay $13 per prescription. **Generic Drugs (Tier 2)**: Preferred cost-sharing: You pay $10 per prescription. Standard cost-sharing: You pay $20 per prescription. And the full cost of drugs on Preferred Brand Drugs (Tier 3), Non-Preferred Drugs (Tier 4), and Specialty Drugs (Tier 5) until you have reached the yearly deductible.	The deductible is $100. Applies to Tier 3, 4 and 5 drugs only. During this stage, you pay: **Preferred Generic Drugs (Tier 1)**: Standard cost-sharing: You pay $13 per prescription. Preferred cost-sharing: You pay $3 per prescription. **Generic Drugs (Tier 2)**: Standard cost-sharing: You pay $20 per prescription. Preferred cost-sharing: You pay $10 per prescription. And the full cost of drugs on Preferred Brand Drugs (Tier 3), Non-Preferred Drugs (Tier 4), and Specialty Drugs (Tier 5) until you have reached the yearly deductible.

Changes to Your Cost-Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay**	Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic Drugs (Tier 1)**: Preferred cost-sharing: You pay $3 per prescription. Standard cost-sharing: You pay $13 per prescription.	Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic Drugs (Tier 1)**: Standard cost-sharing: You pay $13 per prescription. Preferred cost-sharing: You pay $3 per prescription.

Stage	2020 (this year)	2021 (next year)
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. 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*.	**Generic Drugs (Tier 2):** Preferred cost-sharing: You pay $10 per prescription. Standard cost-sharing: You pay $20 per prescription. **Preferred Brand Drugs (Tier 3):** Preferred cost-sharing: You pay $47 per prescription. Standard cost-sharing: You pay $47 per prescription. **Non-Preferred Drugs (Tier 4):** Preferred cost-sharing: You pay $100 per prescription. Standard cost-sharing: You pay $100 per prescription. **Specialty Drugs (Tier 5):** Preferred cost-sharing: You pay 31% of the total cost. Standard cost-sharing: You pay 31% of the total cost. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	**Generic Drugs (Tier 2):** Standard cost-sharing: You pay $20 per prescription. Preferred cost-sharing: You pay $10 per prescription. **Preferred Brand Drugs (Tier 3):** Standard cost-sharing: You pay $47 per prescription. Preferred cost-sharing: You pay $47 per prescription. **Non-Preferred Drugs (Tier 4):** Standard cost-sharing: You pay $100 per prescription. Preferred cost-sharing: You pay $100 per prescription. **Specialty Drugs (Tier 5):** Standard cost-sharing: You pay 31% of the total cost. Preferred cost-sharing: You pay 31% of the total cost. _____ Once your total drug costs have reached $4,130, 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 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in The Health Plan SecureChoice Capitol Plan (PPO)

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 be enrolled in our The Health Plan SecureChoice Capitol Plan (PPO).

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 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, 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 www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, The 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 The Health Plan SecureChoice Capitol Plan (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from The Health Plan SecureChoice Capitol Plan (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage Plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In West Virginia, the SHIP is called WV SHIP.

WV SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. WV SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call WV SHIP at 1-877-987-4463. You can learn more about WV SHIP by visiting their website (www.wvship.org).

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.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or

- Your State Medicaid Office (applications).

- **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 West Virginia AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call WV ADAP 1-304-232-6822.

SECTION 7 Questions?

Section 7.1 – Getting Help from The Health Plan SecureChoice Capitol Plan (PPO)

Questions? We're here to help. Please call Member Services at 1-877-847-7907. (TTY only, call 711). We are available for phone calls October 1 to March 31: 8:00 a.m. to 8:00 p.m., 7 days a week and April 1 to September 30: 8:00 am to 8:00 pm, Monday through Friday. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for The Health Plan SecureChoice Capitol Plan (PPO). 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 www.healthplan.org/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (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 www.medicare.gov/plan-compare).

Read Medicare & You 2021

You can read *Medicare & You 2021* 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 (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.

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Discrimination is Against the Law

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

- 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 The Health Plan Customer Service Department.

If you believe that The Plan 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: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department 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
1.800.368.1019, 1.800.537.7697 (TDD).

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877- 847-7907（TTY：711）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza lingüística gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 （TTY：711）.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877- 847-7907 (टिटिवाइ: 711).।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.1-877- 847-7907 (TTY: 711). با تماس بگیرید

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877- 847-7907 (TTY: 711).

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TheHealthPlan