2018
ANNUAL NOTICE OF CHANGES

Important changes to your plan

UnitedHealthcare Dual Complete® (HMO SNP)

Toll-Free **1-800-514-4912,** 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.

UnitedHealthcare®
Community Plan

Y0066_H3387_010_2018 Accepted

UnitedHealthcare Dual Complete® (HMO SNP) offered by UnitedHealthcare

Annual Notice of Changes for 2018

You are currently enrolled as a member of UnitedHealthcare Dual Complete® (HMO 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 1 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 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium 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 2.2 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** UnitedHealthcare Dual Complete® (HMO SNP), you don't need to do anything. You will stay in UnitedHealthcare Dual Complete® (HMO SNP).
- If you want to change to a **different plan** that may better meet your needs, you can switch plans at any time. Your new coverage will begin on the first day of the following month. Look in Section 2 to learn more about your choices.

Additional Resources

- This information is available for free in other languages.
- Please contact our Customer Service number at 1-800-514-4912 for additional information (TTY users should call 711). Hours are 8 a.m. - 8 p.m. local time, 7 days a week.
- Esta información está disponible sin costo en otros idiomas.
- Comuníquese con nuestro Servicio al Cliente al número 1-800-514-4912 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.
- **本文件可以其他形式或語言提供。**
- **如需更多資訊，請與本計劃聯絡，電話號碼是** 1-800-514-4912, TTY：711， **<每週七天， 當地時間上午八時至晚上八時>。**
- 客戶服務部還可以為不能講英語的人提供免費的語言口譯服務（電話號碼可在本手冊的封面找到）。
- This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number at 1-800-514-4912, TTY: 711, 8 a.m. - 8 p.m. local time, 7 days a week, for additional information.

- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About UnitedHealthcare Dual Complete® (HMO 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 New York 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® (HMO SNP).

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for UnitedHealthcare Dual Complete® (HMO 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 enclosed **Evidence of Coverage** to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly Plan Premium* *Your premium may be higher or lower than this amount. (See Section 1.1 for details.)	$41.00	$25.30
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor Office Visits	Primary care visits: You pay a $0 copayment per visit. Specialist visits: You pay a $0 copayment per visit.	Primary care visits: You pay a $0 copayment per visit. Specialist visits: You pay a $0 copayment per visit.
Inpatient Hospital Stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$0 deductible for days 1 to 60; $0 copayment each day for days 61 to 90; $0 copayment each day for days 91 to 150 (lifetime reserve days).	$0 deductible for days 1 to 60; $0 copayment each day for days 61 to 90; $0 copayment each day for days 91 to 150 (lifetime reserve days).
Part D prescription drug coverage (See Section 1.6 for details.)	If you are enrolled in Medicare A and B and receive full Office of	If you are enrolled in Medicare A and B and receive full Office of

Cost	2017 (this year)	2018 (next year)
	Medicaid Management Department of Health (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: Deductible: • $0 or • $82 For generic drugs (including brand drugs treated as generic): • $0 copayment or • $1.20 copayment or • $3.30 copayment or • 15% of the total cost If the total amount you pay for copayments and coinsurance reaches $4,950, your cost sharing amounts will be: • $0 copayment or • $3.30 copayment For all other covered drugs: • $0 copayment or • $3.70 copayment or • $8.25 copayment or • 15% of the total cost If the total amount you pay for copayments and coinsurance reaches	Medicaid Management Department of Health (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: Deductible: • $0 or • $83 For generic drugs (including brand drugs treated as generic): • $0 copayment or • $1.25 copayment or • $3.35 copayment or • 15% of the total cost If the total amount you pay for copayments and coinsurance reaches $5,000, your cost sharing amounts will be: • $0 copayment or • $3.35 copayment For all other covered drugs: • $0 copayment or • $3.70 copayment or • $8.35 copayment or • 15% of the total cost If the total amount you pay for copayments and coinsurance reaches

Cost	2017 (this year)	2018 (next year)
	$4,950, your cost sharing amounts will be: • $0 copayment or • $8.25 copayment	$5,000, your cost sharing amounts will be: • $0 copayment or • $8.35 copayment
	If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs	
	Deductible: $400 You pay 25% of the total cost.	Deductible: $405 You pay 25% of the total cost.

Annual Notice of Changes for 2018
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Section 1: Changes to Benefits and Costs for Next Year

SECTION 1.1: Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly Premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$41.00**	**$25.30**

SECTION 1.2: Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Office of Medicaid Management Department of Health (Medicaid), very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as copays and deductibles) 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.	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

SECTION 1.3: Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at 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 2018 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.

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 provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network.**

SECTION 1.5: 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 **2018 Evidence of Coverage.** A copy of the **Evidence of Coverage** was included in this booklet.

Cost	2017 (this year)	2018 (next year)
Acupuncture Services	You pay a $5 copayment for 12 visits every year.	You pay a $0 copayment for 20 visits every year.
Over-the-Counter Debit Card	Quarterly credit is $108.	Quarterly credit is $125.
Dental Services Comprehensive and Preventive Dental	Comprehensive and Preventive Dental benefits are covered up to a $2,500 benefit maximum. For more information on covered services, please refer to the enclosed Evidence of Coverage.	Comprehensive and Preventive Dental benefits are covered up to a $3,000 benefit maximum. For more information on covered services, please refer to the enclosed Evidence of Coverage.
Diabetes Self-Management Training, Diabetic Services and Supplies	You pay a $0 copayment. We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2 System, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio®	You pay a $0 copayment. We only cover blood glucose monitors and test strips from the following brands: OneTouch Ultra®2, OneTouch UltraMini®, OneTouch Verio®, OneTouch Verio® IQ,

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	2017 (this year)	2018 (next year)
	Sync, OneTouch Verio® IQ, OneTouch Verio® Flex System Kit, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus. 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.	OneTouch Verio® Flex, ACCUCHEK® Nano SmartView, ACCUCHEK® Aviva Plus, ACCUCHEK® Guide, and ACCUCHEK® 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.
Hearing Services Hearing Aids	Up to $1,000 for 2 hearing aid(s) every 2 years.	Up to $2,000 for 2 hearing aid(s) every 2 years.
Meal Benefit	Meal Benefit is not covered.	Covered up to one time per calendar year immediately following an inpatient hospital stay if recommended by a provider. Benefit guidelines: - Coverage for up to 42 meals delivered to your home for a duration of up to 14 days. - First meal delivery may take up to 72 hours after ordered. - Some restrictions and limitations may apply.

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	2017 (this year)	2018 (next year)
Personal Medical Emergency Response System	Personal Medical Emergency Response System is not covered.	With the Personal Medical Emergency Response System help is only a button away. The Personal Emergency Response System can give you peace of mind knowing that in any emergency situation you can get help quickly, 24 hours a day at no additional cost. The lightweight button can be worn on your wrist or as a pendant and may automatically detect falls depending on the model chosen. Please refer to Additional Benefits Contact List in Chapter 2 Section 10 of this booklet for contracted provider information.

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 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." **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 **one-time,** 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.

If you have obtained approval for a 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 will 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.

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" and haven't received this insert by September 30, 2017, 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 enclosed **Evidence of Coverage.**)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $82, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your deductible is $400.	Your deductible amount is either $0 or $83 , depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.) If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your deductible is $405.

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	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your **Evidence of Coverage.**	Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing: **Generic drugs (including brand drugs treated as generic):** If you are enrolled in Medicare A and B and receive full Office of Medicaid Management Department of Health (Medicaid) benefits, and depending on your	Your cost for a one-month (30-day) supply filled at a network pharmacy with standard cost-sharing: **Generic drugs (including brand drugs treated as generic):** If you are enrolled in Medicare A and B and receive full Office of Medicaid Management Department of Health (Medicaid) benefits, and depending on your

Stage	2017 (this year)	2018 (next year)
	income and institutional status, you pay one of the following amounts: • $0 copayment or • $1.20 copayment or • $3.30 copayment or • 15% of the total cost **For all other covered drugs:** If you are enrolled in Medicare A and B and receive full Office of Medicaid Management Department of Health (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: • $0 copayment or • $3.70 copayment or • $8.25 copayment or • 15% of the total cost	income and institutional status, you pay one of the following amounts: • $0 copayment or • $1.25 copayment or • $3.35 copayment or • 15% of the total cost **For all other covered drugs:** If you are enrolled in Medicare A and B and receive full Office of Medicaid Management Department of Health (Medicaid) benefits, and depending on your income and institutional status, you pay one of the following amounts: • $0 copayment or • $3.70 copayment or • $8.35 copayment or • 15% of the total cost
	If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drug costs	
	For all covered drugs: You pay 25% of the total cost _____ Once your total drugs costs have reached $3,700, you will move to	**For all covered drugs:** You pay 25% of the total cost _____ Once your total drugs costs have reached $3,750, you will move to

Stage	2017 (this year)	2018 (next year)
	the next stage (the Coverage Gap Stage).	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 UnitedHealthcare Dual Complete® (HMO 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 2018.

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 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan, at any time,
- **– OR–** You can change to Original Medicare at any time.

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 2018,** 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, 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® (HMO 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® (HMO 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 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.

  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 3: Deadline for Changing Plans

Because you are eligible for both Medicare and Medicaid you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Section 4: 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 New York, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

Health Insurance Information Counseling and Assistance Program (HIICAP) 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. Health Insurance Information Counseling and Assistance Program (HIICAP) 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 Health Insurance Information Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

For questions about your Office of Medicaid Management Department of Health benefits, contact Office of Medicaid Management Department of Health, at 1-800-541-2831, 8 a.m. - 5 p.m. ET, Monday - Friday. TTY users should call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Office of Medicaid Management Department of Health coverage.

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.** 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.** New York has a program called New York State EPIC 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 6: Questions?

SECTION 6.1: Getting Help from UnitedHealthcare Dual Complete® (HMO SNP)

Questions? We're here to help. Please call Customer Service at 1-800-514-4912. (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 2018 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 2018. For details, look in the 2018 **Evidence of Coverage** for UnitedHealthcare Dual Complete® (HMO 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** is included in this booklet.

Visit our Website

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

SECTION 6.2: Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (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 2018

You can read the **Medicare & You 2018** 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 6.3: Getting Help from Medicaid

To get information from Office of Medicaid Management Department of Health (Medicaid), you can call Office of Medicaid Management Department of Health (Medicaid) at 1-800-541-2831. TTY users should call 711.

UnitedHealthcare Dual Complete® (HMO SNP) Customer Service:

Call **1-800-514-4912**

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.

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Hot Springs, AR 71903-9675

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