AlohaCare Advantage Plus (HMO SNP) offered by AlohaCare

Annual Notice of Changes for 2020

You are currently enrolled as a member of AlohaCare Advantage Plus. 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 Sections 1.5 and 1.6 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 2020 Drug List and look in Section 1.6 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 [https://go.medicare.gov/drugprices](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, including specialists you see regularly, in our network?
   - What about the hospitals or other providers you use?
• Look in Section 1.3 and 1.4 for information about our Provider & Pharmacy Directory.

☐ Think about your overall health care costs.

• How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
• How much will you spend on your premium 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 AlohaCare Advantage Plus, you don’t need to do anything. You will stay in AlohaCare Advantage Plus.

• 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 2.2, page 11 to learn more about your choices.

4. ENROLL: To change plans, join a plan between October 15 and December 7, 2019

• If you don’t join another plan by December 7, 2019, you will stay in AlohaCare Advantage Plus.

• If you join another plan between October 15 and December 7, 2019, your new coverage will start on January 1, 2020.

Additional Resources

• Please contact our Member Services number at 1-866-973-6395 for additional information. (TTY/TDD users should call 1-877-447-5990.) Hours are from October 1 to March 31, 7 days a week, 8 a.m. to 8 p.m., Hawaii time. From April 1 to September 30, Monday through Friday, 8 a.m. to 8 p.m., Hawaii time.

• This information is available in large print. Please contact Member Services for more information (phone numbers are in Section 6.1 of this booklet).
• 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 AlohaCare Advantage Plus

• AlohaCare Advantage Plus (HMO SNP) is an HMO SNP with a Medicare contract and a contract with the Hawaii Medicaid Program. Enrollment in AlohaCare Advantage Plus depends on contract renewal.

• When this booklet says “we,” “us,” or “our,” it means AlohaCare. When it says “plan” or “our plan,” it means AlohaCare Advantage Plus.
Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for AlohaCare Advantage Plus 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.AlohaCare.org. You may also call Member Services to ask us to mail you an Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong>*</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $0 copay per visit</td>
<td>Primary care visits: $0 copay per visit</td>
<td></td>
</tr>
<tr>
<td>Specialist visits: $0 copay per visit</td>
<td>Specialist visits: $0 copay per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Part D prescription drug coverage

(See Section 1.6 for details.)

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible:</strong> $0</td>
<td><strong>Deductible:</strong> $0</td>
<td></td>
</tr>
<tr>
<td><strong>Copayment during the Initial Coverage Stage:</strong></td>
<td><strong>Copayment during the Initial Coverage Stage:</strong></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 1: For Generic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1.25 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3.40 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For all other drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3.80 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$8.50 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug Tier 1: For Generic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1.30 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3.60 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For all other drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3.90 copay or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$8.95 copay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 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.)

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$6,700</strong></td>
<td><strong>$6,700</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Annual Notice of Changes for 2020

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SECTION 1   Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum out-of-pocket amount</td>
<td>$6,700</td>
<td>$6,700</td>
</tr>
<tr>
<td>Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider & Pharmacy Directory is located on our website at www.AlohaCare.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory.
Please review the 2020 Provider & Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, 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 and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Provider & Pharmacy Directory is located on our website at www.AlohaCare.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. Please review the 2020 Provider & 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 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, Benefits Chart (what is covered and what you pay), in your 2020 Evidence of Coverage. A copy
of the *Evidence of Coverage* is located on our website at www.AlohaCare.org. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Surgical Center Services</strong></td>
<td>Prior authorization is required.</td>
<td>Certain Ambulatory Surgical Center services are subject to prior authorization. Call Member Services to get more information.</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>Prior authorization is required.</td>
<td>Prior authorization is NOT required.</td>
</tr>
<tr>
<td>(Medicare-covered Hearing Exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opioid Treatment Services</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td></td>
<td>Medicare-covered opioid treatment services are not covered.</td>
<td>You pay 20% coinsurance for Medicare-covered opioid treatment services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior authorization IS required.</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Therapeutic and Radiology Services</strong></td>
<td>Prior authorization is NOT required.</td>
<td>Prior Authorization is required for certain diagnostic and therapeutic radiological services (e.g. MRI). Call Member Services to get more information.</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Specialty Services</strong></td>
<td>Prior authorization is required.</td>
<td>Prior authorization is required only for psychological and neuropsychological testing.</td>
</tr>
<tr>
<td><strong>Physician Specialist Services</strong></td>
<td>Prior authorization is required.</td>
<td>Prior authorization is NOT required.</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td>Prior authorization is required.</td>
<td>Prior authorization is required for surgeries only.</td>
</tr>
<tr>
<td>(Medicare-covered)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

For more information on the Drug List, please call us and request the Comprehensive Formulary (Drug List). You can view the Comprehensive Formulary (Drug List) at our website (https://www.alohacare.org/Medicare/MemberDocuments). Or, call us and we will send you a copy of the Comprehensive Formulary (Drug List).

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

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 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.

Current formulary exceptions will not be covered for the next year. You must request a new formulary exception for the next year. Contact the plan for more information. Phone numbers are in Section 6.1 of this booklet.
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 does not apply to you.* We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. Because you receive “Extra Help” and haven’t received this insert by September 30th, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services 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 in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the Evidence of Coverage.)

#### Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2019 (this year)</th>
<th>2020 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

#### 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 2: Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**

The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing.

For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost-sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.*

<table>
<thead>
<tr>
<th>Drug Tier 1: For Generic Drugs</th>
<th>Drug Tier 1: For Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay $0 copay or $1.25 copay or $3.40 copay per prescription.</td>
<td>You pay $0 copay or $1.30 copay or $3.60 copay per prescription.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For all other drugs: You pay $0 copay or $3.80 copay or $8.50 copay per prescription.</th>
<th>For all other drugs: You pay $0 copay or $3.90 copay or $8.95 copay per prescription.</th>
</tr>
</thead>
</table>

Once you have paid $5,100 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

### Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or 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 AlohaCare Advantage Plus

**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 2020.
**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 2020 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 2020*, 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.**

**Step 2: Change your coverage**

- To change to a **different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from AlohaCare Advantage Plus.
- To change to **Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from AlohaCare Advantage Plus.
- 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 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 Changing Plans**

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 7. The change will take effect on January 1, 2020.
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 QUEST Integration (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.

If you enrolled in a Medicare Advantage plan for January 1, 2020, 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, 2020. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

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 Hawaii, the SHIP is called Hawaii SHIP.

Hawaii 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. Hawaii 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 Hawaii SHIP at (808) 586-7299 or 1(888) 875-9229. You can learn more about Hawaii SHIP by visiting their website (www.hawaiiship.org).

For questions about your QUEST Integration (Medicaid) benefits, contact AlohaCare toll-free number 1-800-316-8005, TTY 1-877-447-5990, and October 1 to March 31, 8 a.m. to 8 p.m., 7 days a week, for April 1 to September 30, 8 a.m. to 8 p.m., Monday through Friday. Ask how joining another plan or returning to Original Medicare affects how you get your QUEST Integration (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“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).

**SECTION 6 Questions?**

**Section 6.1 – Getting Help from AlohaCare Advantage Plus**

Questions? We’re here to help. Please call Member Services at 973-6395. (TTY/TDD only, call 1-877-447-5990.) We are available for phone calls from October 1 to March 31, 7 days a week, 8 a.m. to 8 p.m., Hawaii time. From April 1 to September 30, Monday through Friday, 8 a.m. to 8 p.m., Hawaii time. Calls to these numbers are free.

**Read your 2020 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 2020. For details, look in the 2020 *Evidence of Coverage* for AlohaCare Advantage Plus. 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.AlohaCare.org. 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.AlohaCare.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

**Section 6.2 – Getting Help from Medicare**

To get information directly from Medicare:

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

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 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 2020**

You can read Medicare & You 2020 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 (QUEST Integration)**

To get information from QUEST Integration (Medicaid) you can call Med-QUEST Enrollment Services at 1-800-316-8005. TTY/TDD users should call 1-800-603-1201.
AlohaCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AlohaCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AlohaCare 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 AlohaCare’s Compliance Officer.

If you believe that AlohaCare 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:

AlohaCare
Attn: Grievance and Appeals Department
1357 Kapiolani Blvd., Ste. 1250
Honolulu, HI 96814
Phone: 973-0712
Toll-free: 1-877-973-0712
TTY/TDD: 1-877-447-5990
Fax: 973-2140
Email: Compliance@alohacare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, AlohaCare’s Grievance and Appeals 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, 800-537-7697 (TDD)