Vantage
Medicare Advantage

2019

CONTACT MEMBER SERVICES

Phone:

(318) 998-4434

Toll-Free:

(844) 536-7103

(888) 823-1910

TTY:

(318) 361-2131

TTY Toll-Free:

(866) 524-5144

ANNUAL NOTICE OF CHANGES

Your Medicare Health Benefits and Service and Prescription Drug Coverage as a Member of Vantage Health Plan, Inc.

Vantage Medicare Advantage STANDARD (HMO-POS)

January 1, 2019 - December 31, 2019

This booklet gives the details about your Medicare healthcare and prescription drug coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Call seven days a week
8:00 A.M. - 8:00 P.M. CST

After March 31, 2019,
Monday - Friday
8:00 A.M. - 8:00 P.M. CST
An answering service will operate on weekends and holidays.

VANTAGE HEALTH PLAN

MedicareRx Prescription Drug Coverage

VHP2268 050418

Thank you for your membership in Vantage Medicare Advantage offered through Office of Group Benefits.

We are providing important information about the Medicare Advantage medical care and prescription drug coverage we will offer next year. Your benefits, cost share, and premiums are changing in 2019.

This **Annual Notice of Changes for 2019** gives you a summary of those changes which will take effect on January 1, 2019.

Please review this notice within a few days of receiving it to see how the changes might affect you. The benefits and cost share changes can be found in Sections 1.2 and 1.5.

If you decide to stay with Vantage Medicare Advantage for 2019, you do not have to tell us or fill out any paperwork. You will automatically stay enrolled as a member of Vantage Medicare Advantage.

If you decide to leave Vantage Medicare Advantage, please contact your Human Resources Department at Office of Group Benefits for more information about disenrollment periods.

An **"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider)** may also be included *for those who qualify*. Medicare beneficiaries who receive extra help paying for their Medicare prescription drug coverage will receive the LIS Rider. If you do not have this insert and believe that you should receive it, please call Member Services.

Other important documents will be available on our website, www.vhp-stategroup.com, beginning October 15, 2018. Please see the following pages for detailed instructions on how to find them on our website. You may also call our Member Services department at the numbers below and request a copy be mailed to you.

- The **Evidence of Coverage** is the legal, detailed description of your benefits and cost share for 2019 if you stay enrolled as a member of the Vantage Medicare Advantage plan. It also explains your rights and the rules you need to follow when using your coverage for medical care and prescription drugs. Please look through this document so you know what is in it.

- The **2019 Comprehensive Formulary (List of Covered Drugs)**, which is effective January 1, 2019. This drug list tells you what Part D prescription drugs are covered by the plan. It also lets you know if there are any rules that restrict coverage for a drug.

- The **Pharmacy Directory**. This directory lists the pharmacy providers currently contracted with Vantage Medicare Advantage to provide prescription drug services to you.

- The **Provider Directory**. This directory lists the medical providers currently contracted with Vantage Medicare Advantage to provide health care services to you. Affinity Health Network (AHN) providers are listed in the first section of the Provider Directory. Your cost share will be lower when you receive certain services from AHN providers.

If you have questions, we are here to help. Please call Member Services at (866) 704-0109 (TTY for the hearing impaired is (866) 524-5144). Hours are seven (7) days a week from 8:00 a.m. – 8:00 p.m. CST from October 1, 2018 through March 31, 2019. For all other dates, Member Services may be reached from 8:00 a.m. – 8:00 p.m., Monday – Friday. Calls to these numbers are free. Member Services also has free language interpreter services available for non-English speakers. You can also visit our website, www.vhp-stategroup.com.

We value your membership and hope to continue to serve you next year.

Sincerely,

P. Gary Jones, MD
President

Vantage Health Plan, Inc. is a health plan with a Medicare contract. Enrollment in Vantage Health Plan, Inc. depends on contract renewal. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-823-1910 (TTY: 1-866-524-5144).ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-823-1910 (ATS : 1-866-524-5144).

ONLINE DOCUMENTS MADE EASY

Vantage makes it easy to look up essential documents and information, including the Evidence of Coverage, plan formulary, and our provider and pharmacy directories.

Go to: www.VHP-StateGroup.com

1 Step One

Click the "OGB MEDICARE ADVANTAGE" button.

2 Step Two

Click the "Documents & Forms" link.

3 Step Three

Choose your plan.

4 Step Four

Click the PDF links to view or download your document.

- Evidence of Coverage
- Formulary
- Pharmacy Directory
- Provider Directory

If you need additional help finding and using the website, or to request a paper copy of these documents, call Vantage's Member Services toll-free at **1-844-536-7103** or TTY **1-866-524-5144**.

Hours of Operation

October 1, 2018–March 31, 2019:

Seven (7) Days a Week
8:00 a.m. – 8:00 p.m.

All other dates:

Monday through Friday
8:00 a.m. – 8:00 p.m.

122 St. John Street, Monroe, LA 71201 • 844-536-7103 or TTY 866-524-5144 • *www.VHP-StateGroup.com*

The pharmacy or provider network may change at any time. You will receive notice when necessary. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-704-0109 (TTY: 1-866-524-5144). ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-704-0109 (ATS: 1-866-524-5144).

Vantage Medicare Advantage STANDARD (HMO-POS) offered by Vantage Health Plan, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of *Vantage Medicare Advantage STANDARD (HMO-POS)*. 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. Enrollment forms must be received by OGB by December 7, 2018 to ensure proper deduction of plan premiums from your January retirement check.**

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 1.2 and 1.5 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 2019 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. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price

information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 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 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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

- If you want to **keep** *Vantage Medicare Advantage STANDARD (HMO-POS)*, you do not need to do anything. You will stay in *Vantage Medicare Advantage STANDARD (HMO-POS)*.
- To change to a **different plan** that may better meet your needs, you can switch plans until November 15, 2018 for OGB-sponsored standard plans and between October 15, 2018 and December 7, 2018 for OGB-sponsored Medicare Advantage plans.

4. ENROLL: To change plans, join a plan by November 15, 2018 for OGB-sponsored standard plans and between **October 15**, **2018** and **December 7, 2018** for OGB-sponsored Medicare Advantage plans

- Enrollment forms must be received by OGB by December 7, 2018 to ensure proper deduction of plan premiums from your January retirement check.
- If you **do not join another plan by December 7, 2018**, you will stay in *Vantage Medicare Advantage STANDARD (HMO-POS)*.

- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Member Services number at (844) 536-7103 for additional information. (TTY users should call (866) 524-5144.) Hours are seven days a week, 8:00 a.m. – 8:00 p.m. CST from October 1, 2018 – March 31, 2019. After March 31, 2019, Member Services will operate five days a week Monday – Friday, 8:00 a.m. – 8:00 p.m.
- You may choose to access your Vantage plan documents, including this *Annual Notice of Changes*, via the Vantage website instead of traditional paper booklets. You can view Vantage documents at *www.VantageMedicare.com*, or download them from the website. You may also request copies of your documents by contacting Member Services at the phone number on the back cover of this booklet.
- In addition to the digital format, we can also give you this information in large print, languages other than English, and other accessible formats.
- **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 *Vantage Medicare Advantage STANDARD (HMO-POS)*

- *Vantage Health Plan, Inc. (Vantage) is an HMO with a Medicare contract. Enrollment in Vantage depends on contract renewal.*
- When this booklet says "we," "us," or "our," it means *Vantage Health Plan, Inc*. When it says "plan" or "our plan," it means *Vantage Medicare Advantage STANDARD (HMO-POS)*.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for *Vantage Medicare Advantage STANDARD (HMO-POS)* in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* at www.vhp-stategroup.com or www.VantageMedicare.com to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	Please contact OGB for information about your plan premium.	Please contact OGB for information about your plan premium.
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.)	$3,000	$3,000
Doctor office visits	Medical home – primary care visits: $0 per visit for **Affinity Health Network (AHN)** providers. Standard network medical home – primary care visits: $10 per visit Specialist visits: $30 per visit for **Affinity Health Network (AHN)** providers. Standard network specialist visits: $40 per visit	Medical home - primary care visits: $0 per visit for **Affinity Health Network (AHN)** providers. Standard network medical home – primary care visits: $10 per visit Specialist visits: $30 per visit for **Affinity Health Network (AHN)** providers. Standard network specialist visits: $40 per visit

Cost	2018 (this year)	2019 (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.	**Affinity Health Network (AHN)** providers: Days 1-5: $225 copayment per day Days 6-90: $0 copayment per day Standard network: Days 1-5: $325 copayment per day Days 6-90: $0 copayment per day	**Affinity Health Network (AHN)** providers: Days 1-7: $170 copayment per day Days 6-90: $0 copayment per day Standard network: Days 1-7: $270 copayment per day Days 8-90: $0 copayment per day

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 deductible on all drug tiers Copayment/Coinsurance during the Initial Coverage Stage: <u>RETAIL:</u> • Drug Tier 1: $4 copayment • Drug Tier 2: $10 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: $100 copayment • Drug Tier 5: 33% coinsurance <u>MAIL ORDER (90-day supply):</u> • Drug Tier 1: $0 copayment for preferred mail order pharmacy (Saint John Pharmacy); $12 copayment for any other authorized mail order pharmacy • Drug Tier 2: $30 copayment • Drug Tier 3: $141 copayment • Drug Tier 4: $300 copayment • Drug Tier 5: 33% coinsurance (31-day supply)	Deductible: $250 deductible on Tiers 4 and 5 Copayment/Coinsurance during the Initial Coverage Stage: <u>RETAIL:</u> • Drug Tier 1: $4 copayment • Drug Tier 2: $12 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: 25% coinsurance • Drug Tier 5: 28% coinsurance <u>MAIL ORDER (90-day supply):</u> • Drug Tier 1: $0 copayment for preferred mail order pharmacy (Saint John Pharmacy); $12 copayment for any other authorized mail order pharmacy • Drug Tier 2: $36 copayment • Drug Tier 3: $141 copayment • Drug Tier 4: 25% coinsurance • Drug Tier 5: 28% coinsurance (31-day supply)

Annual Notice of Changes for 2019
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Please contact OGB for information about your plan premium.	Please contact OGB for information about your plan premium.

- For single coverage
- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) 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.	$3,000 Once you have paid $3,000 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.	$3,000 Once you have paid $3,000 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. There is no maximum out-of-pocket change for the upcoming benefit year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory, which includes the Affinity Health Network, is located on our websites at *www.vhp-stategroup.com* or *www.VantageMedicare.com*. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see if your providers (medical home - 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 websites at *www.vhp-stategroup.com* or *www.VantageMedicare.com*. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Air ambulance	You pay a $250 copayment for Medicare-covered air ambulance.	You pay 20% coinsurance for Medicare-covered air ambulance.
Cardiac rehabilitation services	You pay 20% of the total cost for Medicare-covered cardiac rehabilitation service.	You pay a $40 copay for Medicare-covered cardiac rehabilitation service.

Cost	2018 (this year)	2019 (next year)
Dental services		
Preventive	You pay 0% of the total cost with a $300 benefit maximum every six months for preventive dental and x-rays. Cost is defined as the Vantage allowable.	You pay 0% of the total cost with a $500 benefit maximum every six months for preventive dental and x-rays. Cost is defined as the Vantage allowable.
Comprehensive	You pay 0% of the total cost with a $300 benefit maximum every year for limited comprehensive dental coverage. Cost is defined as the Vantage allowable.	You pay 0% of the total cost with a $400 benefit maximum every year for limited comprehensive dental coverage. Cost is defined as the Vantage allowable.
Emergency care	You pay an $80 copayment for emergency care.	You pay an $90 copayment for emergency care.
Inpatient hospital care	You pay a $225 copayment per day for **Affinity Health Network (AHN)** providers for Days 1-5 and a $0 copayment for days 6-90 per benefit period. You pay a $325 copayment per day for standard network providers for Days 1-5 and a $0 copayment for days 6-90 per benefit period.	You pay a $170 copayment per day for **Affinity Health Network (AHN)** providers for Days 1-7 and a $0 copayment for days 8-90 per admit. You pay a $270 copayment per day for standard network providers for Days 1-7 and a $0 copayment for days 8-90 per admit.
Inpatient mental health care	You pay a $405 copayment for Days 1-4 per benefit period.	You pay a $415 copayment for Days 1-4 per admit.

Cost	2018 (this year)	2019 (next year)
Medicare Part B prescription drugs	You pay 0%-20% of the cost, depending on the drug: You pay 0% of the cost for drugs given in the MH-PCP office, except specialty drugs. You pay 20% of the cost for all other Part B drugs and specialty drugs.	You pay 20% of the cost in all settings, except emergency room.
Outpatient diagnostic tests and therapeutic services and supplies		
X-rays and Diagnostic procedures/tests	You pay a $25 **Affinity Health Network (AHN)** copayment per day for Medicare-covered x-rays and diagnostic procedures/tests. You pay a $75 copayment per day for Medicare-covered standard network x-rays and diagnostic procedures/tests.	You pay a $150 **Affinity Health Network (AHN)** copayment per day for Medicare-covered x-rays and diagnostic procedures/tests. You pay a $250 copayment per day for Medicare-covered standard network x-rays and diagnostic procedures/tests.
Diagnostic radiology	You pay a $350 **Affinity Health Network (AHN)** copayment per day for Medicare-covered diagnostic radiology. You pay a $400 copayment per day for Medicare-covered standard network diagnostic radiology.	You pay a $150 **Affinity Health Network (AHN)** copayment per day for Medicare-covered diagnostic radiology. You pay a $250 copayment per day for Medicare-covered standard network diagnostic radiology.

Cost	2018 (this year)	2019 (next year)
Outpatient hospital observation	You pay a $350 copayment for **Affinity Health Network (AHN)** providers per Medicare-covered outpatient hospital observation stay. You pay a $450 copayment per Medicare-covered standard network outpatient hospital observation stay.	You pay a $270 copayment per Medicare-covered outpatient hospital observation stay.
Outpatient hospital services	You pay a $350 copayment per day for Medicare-covered **Affinity Health Network (AHN)** outpatient hospital services. You pay a $400 copayment per day for Medicare-covered standard network outpatient hospital services.	You pay a $150 copayment per day for Medicare-covered **Affinity Health Network (AHN)** outpatient hospital services. You pay a $250 copayment per day for Medicare-covered standard network outpatient hospital services.
Outpatient lab services	You pay a $0 copayment per day for Medicare-covered outpatient lab services.	You pay a $0 copayment per day for all Medicare-covered **Affinity Health Network (AHN)** outpatient lab services. You pay a $40 copayment per day for Medicare-covered standard network outpatient facility lab services. You pay a $0 copayment for all other Medicare-covered standard network outpatient lab services.

Cost	2018 (this year)	2019 (next year)
Outpatient surgery (facility)	You pay a $350 copayment for Medicare-covered **Affinity Health Network (AHN)** outpatient surgery. You pay a $400 copayment for Medicare-covered standard network outpatient surgery.	You pay a $150 copayment for Medicare-covered **Affinity Health Network (AHN)** outpatient surgery. You pay a $250 copayment for Medicare-covered standard network outpatient surgery.
Over-the-Counter (OTC) items	You pay a $0 copayment for 30 credits per quarter of select OTC items with any unused credits to rollover to the next quarter up to a maximum benefit of 60 credits per quarter.	You pay a $0 copayment for 60 credits per quarter of select OTC items. Unused credits do not rollover to the next quarter.
Pulmonary rehabilitation services	You pay 20% of the total cost for each Medicare-covered pulmonary rehabilitation service.	You pay a $30 copayment for Medicare-covered pulmonary rehabilitation service.
Skilled Nursing Facility	You pay a $0 copayment per day for days 1-20 and a $167 copayment per day for days 21-100.	You pay a $0 copayment per day for days 1-20 and a $172 copayment per day for days 21-100.
Transportation	You pay a $0 copayment for 12 one-way non-emergent trips per year.	You pay a $0 copayment for 24 one-way (12 round trip) non-emergent trips per year.
Vision care **Eyewear**	You pay 50% of the cost for supplemental eyewear up to a maximum benefit of $100 per year.	You pay 50% of the cost for supplemental eyewear up to a maximum benefit of $200 per year.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call 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.

If you received approval for a formulary or tiering exception request during 2018, coverage for the drug approved under that exception will continue until the end of 2018.

You will need to submit a new formulary or tiering exception request to continue coverage for the drug for the 2019 plan year when the previously approved exception ends.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 31-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or

making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We 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 did not receive this insert with this packet, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* provided electronically at www.VantageMedicare.com.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 4 and 5 drugs until you have reached the yearly deductible.	Because we have no deductible, this payment stage does not apply to you.	The deductible is $250. During, this stage, you pay a $4, $12, and $47 cost-sharing for drugs on Tiers 1, 2, and 3, respectively, and the full cost of drugs on Tiers 4 and 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	2018 (this year)	2019 (next year)
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 (31-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*. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: ***Preferred Generic drugs*:** You pay $4 per prescription. ***Generic drugs*:** You pay $10 per prescription. ***Preferred Brand drugs*:** You pay $47 per prescription. ***Non-Preferred Brand drugs*:** You pay $100 per prescription. ***Specialty drugs*:** You pay 33% of the total cost. Once your total drug costs have reached $5,000, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: ***Preferred Generic drugs*:** You pay $4 per prescription. ***Generic drugs*:** You pay $12 per prescription. ***Preferred Brand drugs*:** You pay $47 per prescription. ***Non-Preferred Brand drugs*:** You pay 25% of the total cost. ***Specialty drugs*:** You pay 28% of the total cost. Once your total drug costs have reached $5,100, you will move to the next stage (the Catastrophic Coverage 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 Administrative Changes

Cost	2018 (this year)	2019 (next year)
Cost Share for Inpatient Hospital Care	Additional cost share did not apply for a subsequent inpatient hospital admission until you had not received any hospital care for 60 days in a row.	The inpatient cost share is applied per admission into an inpatient facility.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Vantage Medicare Advantage STANDARD (HMO-POS)*

To stay in our plan, you do not need to do anything. If you do not sign up for a different OGB-sponsored plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Please check with the OGB benefits administrator *before you change your plan*. This is important because you may lose benefits you currently receive under OGB if you switch to a non-OGB-sponsored Medicare Advantage plan.

Section 3.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different OGB-sponsored Medicare Advantage plan or one of the OGB-sponsored standard plans,
- *OR*-- You can cancel your OGB enrollment and change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

NOTE: Please check with the OGB before you change your plan. This is important because you may lose benefits you currently receive under OGB if you switch to a non-OGB-sponsored Medicare Advantage plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

As a reminder, *Vantage Health Plan, Inc.* 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 *Vantage Medicare Advantage STANDARD (HMO-POS)*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Vantage Medicare Advantage STANDARD (HMO-POS)*.
- 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, 2019. If you are switching to another OGB-sponsored Medicare Advantage plan, enrollment forms must be received by OGB by December 7, 2018 to ensure proper deductions of plan premiums from your January retirement check.

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

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

change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

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

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 Louisiana, the SHIP is called Senior Health Insurance Information Program.

Senior Health Insurance Information Program 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. Senior Health Insurance Information Program 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 Senior Health Insurance Information Program at (800) 259-5300. You can learn more about Senior Health Insurance Information Program by visiting their website (*http://www.ldi.la.gov/SHIIP*).

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 do not even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Louisiana has a program called Louisiana SenioRx that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with

HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Louisiana AIDS Drug Assistance Program (L-ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (504) 568-7474.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Vantage Medicare Advantage STANDARD (HMO-POS)*

Questions? We are here to help. Please call Member Services at (844) 536-7103. (TTY only, call (866) 524-5144). We are available for phone calls seven days a week, 8:00 a.m. – 8:00 p.m. CST from October 1, 2018 – March 31, 2019. After March 31, 2019, Member Services will operate five days a week Monday-Friday, 8:00 a.m. – 8:00 p.m. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for *Vantage Medicare Advantage STANDARD (HMO-POS).* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* will be provided electronically.

Visit our Website

You can also visit our websites at *www.vhp-stategroup.com* or *www.VantageMedicare.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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you do not 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.

Vantage Health Plan is required by federal law to provide the following information.

Nondiscrimination Notice

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic. Vantage does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic.

Vantage provides free aids and services to people with disabilities to communicate effectively with us. Those services include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

For people whose primary language is not English, Vantage provides free language translation services. Those services include qualified interpreters and information written in other languages. You can use Vantage's free language translation services by calling the "Members" phone number on the back of your Member ID card. For Members who are deaf or hard of hearing, please call for teletypewriter (TTY) services at (866) 524-5144.

If you believe that Vantage has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic, you can file a grievance with Vantage or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

If you would like to file a complaint directly with Vantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

Vantage Health Plan, Inc.
Attention: Civil Rights Coordinator
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: (318) 998-2887, TTY (866) 524-5144
Fax: (318) 361-2165
Email: *civilrightscoordinator@vhpla.com*

If you would like to file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights, you can contact them by mail, by phone, or by email at the addresses below:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Online Complaint Portal: *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*

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

If you need help filing a grievance, our Civil Rights Coordinator is available to help at *civilrightscoordinator@vhpla.com* or by phone at (318) 998-2887.

Vantage has adopted internal grievance procedures for providing prompt and equitable resolution of complaints alleging discrimination on the basis of race, color, national origin, sex, age, or disability. Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability, may file a grievance under Vantage's grievance procedure. It is against the law for Vantage to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Depending on the type of grievance, a 60 day filing limit may apply. To learn more about Vantage's grievance procedure, you can call or email our Civil Rights Coordinator at the addresses above or you can visit our website at *www.vantagehealthplan.com/vhpnondiscriminationgrievanceprocedure*.

Vantage Health Plan is required by federal law to provide the following information.

Language Assistance

If you, or someone you're helping, have questions about Vantage Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Member Services, 888-823-1910 (TTY 866-524-5144).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-823-1910 (TTY: 866-524-5144).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-823-1910 (ATS: 866-524-5144).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-823-1910 (TTY: 866-524-5144).

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 888-823-1910 (TTY 866-524-5144)。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية **تتوافر لك بالمجان. اتصل برقم** 888-823-1910(رقم هاتف **الصم والبكم**:866-524-5144).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-823-1910 (TTY: 866-524-5144).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-823-1910 (TTY: 866-524-5144) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 888-823-1910 (TTY: 866-524-5144).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 888-823-1910 (TTY: 866-524-5144).

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。888-823-1910 (TTY: 866-524-5144）まで、お電話にてご連絡ください。

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 888-823-1910 (TTY: 866-524-5144)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો 888-823-1910 (TTY: 866-524-5144).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-823-1910 (TTY: 866-524-5144)

توجه: اگر به **زبان** فارسی **گفتگو** می کنید، تسهیلات زبانی **بصورت** رایگان برای**شما** فراهم می **باشد. با** 888-823-1910(TTY: 866-524-5144) **تماس** بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-823-1910 (телетайп: 866-524-5144).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 888-823-1910 (TTY: 866-524-5144).

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VANTAGE HEALTH PLAN

Vantage Locations

Monroe
130 Desiard Street, Suite 300
Monroe, LA 71201

Shreveport
855 Pierremont Road, Suite 109
Shreveport, LA 71106

Baton Rouge
5778 Essen Lane, Suite B
Baton Rouge, LA 70810

Hammond
219 West Thomas Street
Hammond, LA 70401

For Information On Other Locations:
- ***www.vantagehealthplan.com/locations***

Hours of Operation

October 1, 2018 through March 31, 2019:

Seven (7) Days a Week 8:00 a.m. – 8:00 p.m

All other dates:

Monday through Friday 8:00 a.m. – 8:00 p.m.

Contact

Phone Numbers:

(844) 536-7103 or TTY (866) 524-5144
(for the hearing impaired)

Website:

www.vhp-stategroup.com