Vibra Health Plan Enhanced Coverage (PPO) *offered by* Vibra Health Plan, Inc.

Annual Notice of Changes for 2018

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

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 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 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ 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 2.1 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** Vibra Health Plan Enhanced Coverage PPO, you don't need to do anything. You will stay in Vibra Health Plan Enhanced Coverage PPO.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Vibra Health Plan Enhanced Coverage PPO.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in English.
- Please contact our Member Services number at 1-844-388-8268 for additional information. (TTY users should call 711). Hours are Monday through Friday, 8 am to 8 pm, with extended hours October 1 through February 14. After these hours, you may leave a message on our secure voice messaging system.
- This information may be available in different formats, including CD. Please call Member Services at the number printed on the back cover of this booklet if you need plan information in another format.
- **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 Vibra Health Plan Enhanced Coverage PPO

- Vibra Health Plan Enhanced Coverage PPO is offered by Vibra Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in Vibra Health Plan Enhanced Coverage PPO depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Vibra Health Plan, Inc., When it says "plan" or "our plan," it means Vibra Health Plan Enhanced Coverage PPO.

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Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Vibra Health Plan Enhanced Coverage PPO 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.	$49.50	$55
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.)	$4,800	$4,800
Doctor office visits	**In-Network:** Primary care visits: $5 copayment per visit **Out-of-Network:** Primary care visits: $25 copayment per visit **In-Network:** Specialist visits: $40 copayment per visit **Out-of-Network:** Specialist visits: $60 copayment per visit	**In-Network:** Primary care visits: $5 copayment per visit **Out-of-Network:** Primary care visits: 30% coinsurance per visit **In-Network:** Specialist visits: $35 copayment per visit **Out-of-Network:** Specialist visits: 30% coinsurance per visit

Cost	2017 (this year)	2018 (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.	$195 Copayment per day for days 1-8 for Medicare-covered inpatient hospital stays. $0 copayment for days 9 and beyond. Our plan covers an unlimited number of days for an inpatient hospital stay. Cost-sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.** **Out-of-Network:** 25% coinsurance for Medicare-covered Inpatient stay.	$195 Copayment per day for days 1-8 for Medicare-covered inpatient hospital stays. $0 copayment for days 9 and beyond. Our plan covers an unlimited number of days for an inpatient hospital stay. Cost-sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.** **Out-of-Network:** 25% coinsurance for Medicare-covered Inpatient stay.

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment and Coinsurance during the Initial Coverage Stage: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $10 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $15 copayment per prescription *Preferred cost-sharing:* You pay $10 copayment per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $40 copayment per prescription *Preferred cost-sharing:* You pay $35 copayment per prescription **Drug Tier 4 – Non Preferred Brand:** *Standard cost-sharing:* You pay $95 copayment per prescription *Preferred cost-sharing:* You pay $90 copayment per prescription	Deductible: $0 Copayment and Coinsurance during the Initial Coverage Stage: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $10 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $15 copayment per prescription *Preferred cost-sharing:* You pay $10 copayment per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $40 copayment per prescription *Preferred cost-sharing:* You pay $35 copayment per prescription **Drug Tier 4 – Non Preferred Brand:** *Standard cost-sharing:* You pay $95 copayment per prescription *Preferred cost-sharing:* You pay $90 copayment per prescription

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage continued	**Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost **Drug Tier 6 – Select Care** *Standard cost-sharing:* You pay $5 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription	**Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost **Drug Tier 6 – Select Care** *Standard cost-sharing:* You pay $5 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

- Your monthly plan premiums 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 enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each moth directly to the government for your Medicare prescription drug coverage.
- You monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$49.50	$55

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 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.	$4,800	$4,800 Once you have paid $4,800 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 listing is located on our website at VibraHealthPlan.com. You may also call Member Services 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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy listing is located on our website at VibraHealthPlan.com. You may also call Member Services 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

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.*

Cost	2017 (this year)	2018 (next year)
Ambulance Service	**In-Network:** $150 copayment per Medicare-covered Ambulance service trip **Out-of-Network:** 25% coinsurance per Medicare-covered Ambulance service trip **Prior authorization required for non-emergency transports.**	**In-and-Out-of-Network:** $150 copayment per Medicare-covered Ambulance service trip **Prior authorization required for non-emergency transports.**
Cardiac and Intensive Cardiac Rehabilitation Services	**In-Network:** $40 copayment for Medicare-covered services **Out-of-Network:** $60 copayment for Medicare-covered services	**In-Network:** $15 copayment for Medicare-covered services **Out-of-Network:** 30% coinsurance for Medicare-covered services **Prior authorization required.**
Pulmonary Rehabilitation Services	**In-Network:** $30 copayment for Medicare-covered services **Out-of-Network:** $60 copayment for Medicare-covered services **Prior authorization required.**	**In-Network:** $15 copayment for Medicare-covered services **Out-of-Network:** 30% coinsurance for Medicare-covered services **Prior authorization required.**

Cost	2017 (this year)	2018 (next year)
Chiropractic Care	**In-Network:** $20 copayment for Medicare-covered services **Out-of-Network:** $35 copayment for Medicare-covered services **Prior authorization required.**	**In-Network:** $20 copayment for Medicare-covered services **Out-of-Network:** 30% coinsurance for Medicare-covered services **Prior authorization required.**
Diabetes self-management training, diabetic services and supplies	**In-Network:** 20% Coinsurance for Diabetic Supplies and Services and Therapeutic shoes or inserts. $0 copayment for diabetes self-management training. **Out-of-Network:** 25% coinsurance for Medicare-covered diabetes monitoring, supplies, therapeutic shoes and inserts. 25% coinsurance for Medicare-covered diabetes self-management training. **Prior authorization required.**	**In-Network:** 20% Coinsurance for Diabetic Supplies and Services and Therapeutic shoes or inserts. $0 copayment for diabetes self-management training. **Out-of-Network:** 30% coinsurance for Medicare-covered diabetes monitoring, supplies, therapeutic shoes and inserts. 30% coinsurance for Medicare-covered diabetes self-management training.
Durable medical equipment and related supplies	**In-Network:** 20% Coinsurance for Medicare-covered items. **Out of Network:** 25% Coinsurance for Medicare-covered items. **Prior authorization may apply.**	**In-Network:** 20% Coinsurance for Medicare-covered items. **Out of Network:** 35% Coinsurance for Medicare-covered items. **Prior authorization may apply.**

Cost	2017 (this year)	2018 (next year)
Prosthetic devices and related supplies	**In-Network:** 20% Coinsurance for Medicare-covered prosthetic devices and related supplies. **Out of Network:** 25% Coinsurance for Medicare-covered prosthetic devices and related supplies. **Prior authorization may apply.**	**In-Network:** 20% Coinsurance for Medicare-covered prosthetic devices and related supplies. **Out of Network:** 35% Coinsurance for Medicare-covered prosthetic devices and related supplies. **Prior authorization may apply.**
Dental Services	**In-Network:** $45 - $300 Copayment for Medicare-covered dental services depending on the services. ($45 copayment is relative to a specialist visit, and $300 copayment is relative to outpatient surgery, when obtained in-network.) $20 Copayment per visit – 2 cleanings and exams per calendar year (which equates to 2 visits per year) **Out of Network:** $60 Copayment – 25% Coinsurance for Medicare-covered dental services depending on the services.	**In-Network:** $35 - $300 Copayment for Medicare-covered dental services depending on the services. ($35 copayment is relative to a specialist visit, and $300 copayment is relative to outpatient surgery, when obtained in-network.) $20 Copayment per visit – 2 cleanings and exams per calendar year (which equates to 2 visits per year) **Out of Network:** 30% Coinsurance for Medicare-covered dental services depending on the services. $20 Copayment per visit – 2 cleanings and exams per calendar year (which equates to 2 visits per year)

Cost	2017 (this year)	2018 (next year)
Emergency Care	**In-and-Out-of-Network (any emergency room in the U.S.):** $75 copayment	**In-and-Out-of-Network (any emergency room in the U.S.):** $80 copayment
Urgently Needed Care	**In-and-Out-of-Network (any urgent care center in the U.S.):** $50 copayment	**In-and-Out-of-Network (any urgent care center in the U.S.):** $50 copayment
Worldwide Coverage – Emergency and Urgently Needed Care (outside the U.S)	**Emergency Care Worldwide:** $75 copayment **Urgently Needed Care Worldwide:** $75 copayment $5,000 annual maximum allowance for emergency care services or urgently needed care received worldwide. Annual maximum allowance is combined for both Emergency and Urgently Needed Care received outside the U.S. **Emergency transportation covered if authorized by first responders only.**	**Emergency Care Worldwide:** $80 copayment **Urgently Needed Care Worldwide:** $65 copayment $5,000 annual maximum allowance for emergency care services or urgently needed care received worldwide. Annual maximum allowance is combined for both Emergency and Urgently Needed Care received outside the U.S. **Emergency transportation not covered.**
Home Health services	**In-Network:** $0 copayment for Medicare-covered services **Out-of-Network** $0 copayment for Medicare-covered services **Prior authorization required.**	**In-Network:** $0 copayment for Medicare-covered services **Out-of-Network** 30% coinsurance for Medicare-covered services **Prior authorization required.**

Cost	2017 (this year)	2018 (next year)
Partial Hospitalization	**In-Network:** $55 copayment for Medicare-covered services **Out-of-Network** 25% coinsurance for Medicare-covered services	**In-Network:** $55 copayment for Medicare-covered services **Out-of-Network** 30% coinsurance for Medicare-covered services **Prior authorization required.**
Primary Care Visit	**In-Network:** $5 copayment for Medicare-covered services Primary Care visit **Out-of-Network:** $25 copayment for Medicare-covered services Primary Care visit	**In-Network:** $5 copayment for Medicare-covered services Primary Care visit **Out-of-Network:** 30% coinsurance for Medicare-covered Primary Care visit
Specialist Visits	**In-Network:** $40 copayment for Medicare-covered Specialist visit **Out-of-Network:** $60 copayment for Medicare-covered Specialist visit	**In-Network:** $35 copayment for Medicare-covered Specialist visit **Out-of-Network:** 30% coinsurance for Medicare-covered Specialist visit
Podiatry Services	**In-Network:** $40 copayment for Medicare-covered Specialist visit **Out-of-Network:** $60 copayment for Medicare-covered Specialist visit	**In-Network:** $40 copayment for Medicare-covered Specialist visit **Out-of-Network:** 30% coinsurance for Medicare-covered Specialist visit

Cost	2017 (this year)	2018 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	**Diagnostic radiology services (such as MRI, CT Scan, PET Scan):** $225 Copayment for Medicare-covered services **Diagnostic tests and procedures:** 10% Coinsurance for Medicare-covered services **Lab Services:** 10% Coinsurance for Medicare-covered services **Outpatient X-rays:** $30 Copayment for Medicare-covered services **Therapeutic radiology (such as radiation treatment for cancer):** 20% Coinsurance for Medicare-covered services **Blood:** 10% Coinsurance for Medicare-covered services **Prior authorization may apply.**	**Diagnostic radiology services (such as MRI, CT Scan, PET Scan):** $225 Copayment for Medicare-covered services **Diagnostic tests and procedures:** $15 copayment for Medicare-covered services **Lab Services:** $15 copayment for Medicare-covered lab services **Outpatient X-rays:** $30 Copayment for Medicare-covered services **Therapeutic radiology (such as radiation treatment for cancer):** 20% coinsurance for Medicare-covered services **Blood:** 10% Coinsurance for Medicare-covered services If a physician provides you services in addition to outpatient diagnostic procedures, tests, lab services and/ or therapeutic radiology services, additional cost-sharing may apply. Multiple copayments apply for multiple services performed on the same day. **Prior authorization may apply.**

Cost	2017 (this year)	2018 (next year)
Outpatient diagnostic tests and therapeutic services and supplies continued	**Out of Network** 25% Coinsurance for Medicare covered diagnostic radiological services, X-ray services and therapeutic radiology. 20% Coinsurance for Medicare covered diagnostic tests and procedures, lab services and blood services.	**Out of Network** 30% Coinsurance for Medicare covered diagnostic radiological services, X-ray services and therapeutic radiology. 30% Coinsurance for Medicare covered diagnostic tests and procedures, lab services and blood services.
Inpatient mental hospital stays Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	$195 Copayment per day for days 1-8 for Medicare-covered inpatient hospital stays. $0 copayment days 9 and beyond. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.** **Out-of-Network:** 25% coinsurance for Medicare-covered Inpatient Mental Hospital stay	$200 Copayment per day for days 1-8 for Medicare-covered inpatient hospital stays. $0 copayment days 9 and beyond. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.** **Out-of-Network:** 25% coinsurance for Medicare-covered Inpatient Mental Hospital stay

Cost	2017 (this year)	2018 (next year)
Outpatient Mental Health Services	**In-Network:** $40 Copayment for each Medicare-covered individual or group session **Out of Network:** $60 Copayment to 25% coinsurance for each Medicare-covered individual or group session depending on where service is rendered	**In-Network:** $40 Copayment for each Medicare-covered individual or group session **Out of Network:** 30% coinsurance for each Medicare-covered individual or group session
Outpatient rehabilitation services	**In-Network:** $40 Copayment for each Medicare-covered outpatient rehabilitation service **Out of Network:** $60 Copayment for each Medicare-covered outpatient rehabilitation service **Prior authorization required after 12 visits.**	**In-Network:** $40 Copayment for each Medicare-covered outpatient rehabilitation service **Out of Network:** 30% coinsurance for each Medicare-covered outpatient rehabilitation service **Prior authorization required after 12 visits.**
Outpatient Substance Abuse services	**In-Network:** $45 Copayment for each Medicare-covered individual or group session **Out of Network:** $60 Copayment for each Medicare-covered individual or group session	**In-Network:** $45 Copayment for each Medicare-covered individual or group session **Out of Network:** 30% coinsurance for each Medicare-covered individual or group session

Cost	2017 (this year)	2018 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network:** $225 Copayment for each Medicare-covered outpatient surgery service obtained at an ambulatory surgery center. $300 Copayment for each Medicare-covered outpatient surgery service obtained at an outpatient hospital department. **Out of Network:** 25% coinsurance for each Medicare-covered outpatient surgery service obtained at an ambulatory surgery center. 25% coinsurance for each Medicare-covered outpatient surgery service obtained at an outpatient hospital department. **Prior authorization required.**	**In-Network:** $225 Copayment for each Medicare-covered outpatient surgery service obtained at an ambulatory surgery center. $300 Copayment for each Medicare-covered outpatient surgery service obtained at an outpatient hospital department. **Out of Network:** 30% coinsurance for each Medicare-covered outpatient surgery service obtained at an ambulatory surgery center. 30% coinsurance for each Medicare-covered outpatient surgery service obtained at an outpatient hospital department. **Prior authorization required.**

Cost	2017 (this year)	2018 (next year)
Services to treat kidney disease and conditions	**In-Network:** 20% Coinsurance for Medicare-covered kidney dialysis and other ESRD care and treatment. $0 copayment for kidney disease education. **Out of Network:** 35% Coinsurance for Medicare-covered kidney dialysis services. $30 copayment for kidney disease education services.	**In-Network:** 20% Coinsurance for Medicare-covered kidney dialysis and other ESRD care and treatment. $0 copayment for kidney disease education. **Out of Network:** 35% Coinsurance for Medicare-covered kidney dialysis services. 30% coinsurance for kidney disease education services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	Not covered.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network:** 30% coinsurance for Medicare-covered Diabetes Prevention Program (MDPP)

Cost	2017 (this year)	2018 (next year)
Skilled Nursing Facility (SNF)	Days 1–20: $0 copayment per day Days 21-100: $164.50 copayment per day **Benefit Period:** A benefit period starts the day you are admitted to a Medicare certified skilled nursing facility (SNF). It ends when you haven't been an inpatient at any SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Prior authorization required.** **Out-of-Network:** 25% coinsurance for Medicare-covered skilled nursing facility services.	Days 1–20: $0 copayment per day Days 21-100: $165.00 copayment per day **Benefit Period:** A benefit period starts the day you are admitted to a Medicare certified skilled nursing facility (SNF). It ends when you haven't been an inpatient at any SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Prior authorization required.** **Out-of-Network:** 25% coinsurance for Medicare-covered skilled nursing facility services.
Medicare Covered Preventive Services	For Medicare Preventive Services covered at $0 cost (check EOC for applicable services) **In-Network:** There is no coinsurance, copayment, or deductible **Out-of-Network:** 25% coinsurance $25 copayment for Annual Physical Exam.	For Medicare Preventive Services covered at $0 cost (check EOC for applicable services) **In-Network:** There is no coinsurance, copayment, or deductible **Out-of-Network:** 30% coinsurance 30% coinsurance for Annual Physical Exam.

Cost	2017 (this year)	2018 (next year)
Hearing Services	**In-Network:** $45 copayment for Medicare-covered diagnostic hearing services. $45 copayment for hearing aid fitting/evaluation **Out of Network** $60 copayment for Medicare-covered diagnostic hearing exams. $60 copayment for one routine hearing exam every year. $60 copayment for hearing aid fitting/evaluation.	**In-Network:** **Medicare-covered exams to diagnose and treat hearing and balance issues:** • $35 copayment **Contact EPIC Hearing Healthcare for Routine hearing exam (for up to 1 every year):** • $0 copayment **Hearing aid fitting/evaluation (for up to 1 every three years):** • $0 copayment **Hearing aid:** Our plan pays up to $300 every three years for hearing aids. Contact EPIC Hearing Healthcare to schedule your routine hearing exam and hearing aid fitting evaluation exam at **1-888-805-0345, TTY: 711. Monday – Friday, 9:00 a.m. to 9 p.m. EST.** **Out of Network** 30% coinsurance for Medicare-covered diagnostic hearing services. 30% coinsurance for routine hearing exam every year. 30% coinsurance for hearing aid fitting exam/evaluation **Hearing aid:** Our plan pays up to $300 every three years for hearing aids.

Cost	2017 (this year)	2018 (next year)
Vision Care	**In-Network:** $5 Copayment for Medicare-covered primary care eye exams to diagnose and treat diseases and conditions of the eye. $40 Copayment for Medicare-covered specialist eye exams to diagnose and treat diseases and conditions of the eye. $0 Copayment for Medicare-covered preventive glaucoma screening. $0 Copayment for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $45 Copayment for one routine eye exam per calendar year. $125 allowance for one pair of supplemental eyeglasses or contact lenses every other calendar year.	**In-Network:** $5 Primary Care Physician copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. $40 copayment for Medicare-covered specialist exams to diagnose and treat diseases and conditions of the eye. $0 copayment for Medicare-covered glaucoma screening. $0 copayment for one pair of standard eyeglass lenses, frames, or contact lenses after cataract surgery. $20 copayment for one routine eye exam per calendar year. Our plan pays up to $40 every two years for contact lenses or eyeglass frames. Eyeglass Lenses covered at 100% by plan for standard lenses. Coverage for lenses is provided every two years.

Cost	2017 (this year)	2018 (next year)
Vision Care continued	**Out of Network** $25 Copayment for Medicare-covered primary care eye exams to diagnose and treat diseases and conditions of the eye. $60 Copayment for Medicare-covered specialist eye exams to diagnose and treat diseases and conditions of the eye. 25% Coinsurance for Medicare-covered preventive glaucoma screening. 25% Coinsurance for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $45 Copayment for one routine eye exam per calendar year. $125 allowance for one pair of supplemental eyeglasses or contact lenses every other calendar year	**Out of Network** 30% coinsurance for Medicare-covered primary care eye exams to diagnose and treat diseases and conditions of the eye. 30% Coinsurance for Medicare-covered preventive glaucoma screening. 30% Coinsurance for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. 30% coinsurance for one routine eye exam per calendar year. Our plan pays up to $40 every two years for contact lenses or eyeglass frames. Plan pays up to the following for standard lenses: • $36 for single vision lenses • $48 for bi-focal lenses • $58 for tri-focal lenses

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 in this envelope.

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

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

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

In some situations, we are required to cover a **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 are a current member of the plan, and one of your drugs will no longer be covered, you should work with your doctor (or other prescriber) to find an appropriate alternative therapy on our new formulary. If there is no appropriate alternative therapy available, you can request a formulary exception beginning December 1, 2017. For more information, please see Chapter 9 of your *Evidence of Coverage* or call Member Services.

If you currently have a formulary exception in place, the plan will allow you to continue to receive your drug for the length of time indicated in your formulary exception approval letter. Please be aware that you may be responsible for a different cost share than you were paying last year.

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. If you receive "Extra Help" and haven't received this insert by September 30, 2017, 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 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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

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*.

	2017 (this year)	2018 (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 (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs 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 at a network pharmacy: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $10 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $15 copayment per prescription *Preferred cost-sharing:* You pay $10 copayment per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $40 copayment per prescription *Preferred cost-sharing:* You pay $35 copayment per prescription **Drug Tier 4 – Non Preferred Brand:** *Standard cost-sharing:* You pay $95 copayment per prescription *Preferred cost-sharing:* You pay $90 copayment per prescription	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $10 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $15 copayment per prescription *Preferred cost-sharing:* You pay $10 copayment per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $40 copayment per prescription *Preferred cost-sharing:* You pay $35 copayment per prescription **Drug Tier 4 – Non Preferred Brand:** *Standard cost-sharing:* You pay $95 copayment per prescription *Preferred cost-sharing:* You pay $90 copayment per prescription

	2017 (this year)	2018 (next year)
	Drug Tier 5 – Specialty Drugs: You pay 33% of the cost **Drug Tier 6 – Select Care** *Standard cost-sharing:* You pay $5 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription _____ Once you have paid $4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost **Drug Tier 6 – Select Care** *Standard cost-sharing:* You pay $5 copayment per prescription *Preferred cost-sharing:* You pay $0 copayment per prescription _____ Once you have paid $5,000 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 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 Vibra Health Plan Enhanced Coverage PPO

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically 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,
- *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.

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, Vibra 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 Vibra Health Plan Enhanced Coverage PPO.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Vibra Health Plan Enhanced Coverage PPO.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 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.

SECTION 3 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, 2018.

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 are allowed to make a change at

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

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 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 Pennsylvania, the SHIP is called APPRISE.

APPRISE 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. APPRISE 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 APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (www.aging.pa.gov).

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. People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 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.** Pennsylvania has a program called PACE 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 4 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

Pennsylvania Department of ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Pennsylvania Department of Health at 1-977-PA-HEALTH (1-877-724-3258).

SECTION 6 Questions?

Section 6.1 – Getting Help from Vibra Health Plan Enhanced Coverage PPO

Questions? We're here to help. Please call Member Services at 1-844-388-8268. (TTY only, call 711). We are available for phone calls Monday through Friday, 8 am to 8 pm with extended hours October 1 through February 14. After these hours, you may leave a message on our secure voice messaging system. 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 Vibra Health Plan Enhanced Coverage PPO. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at VibraHealthPlan.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.

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

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

Vibra Health Plan provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓Qualified sign language interpreters
- ✓Written information in other formats (large print, audio, accessible electronic format, other formats)
- ✓Qualified interpreters, and information written in other languages

If you need these services, call 1-844-388-8268 (TTY: 711).

If you believe that Vibra Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person; or you can file a grievance by mail, phone, fax, or email at:

Vibra Health Plan
P.O. Box 60250 Harrisburg, PA 17106-0250
1-717-510-6203 (TTY: 711), fax, 1-844-744-5585
CRC@vibrahealthplan.com

If you need help filing a grievance, our Civil Rights Coordinator 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
Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 1-844-388-8268 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 1-844-388-8268 (TTY: 711).
欲免费用本国语言洽询传译员，请拨电话 1-844-388-8268 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 1-844-388-8268 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 1-844-388-8268 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 1-844-388-8268 uff (TTY: 711).
무료 전화 통역 서비스 1-844-388-8268 (TTY: 711).
Per parlare con un interpete nella vostra lingua gratis, chiami 1-844-388-8268 (TTY: 711).
للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 1-844-388-8268
(الهاتف النصي: 711)
Pour parler à un interpréter dans votre langue sans charges, téléphoner à 1-844-388-8268 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-388-8268 an (TTY: 711).
ક્ુભાષીયા જોડે વાત કરવા, 1-844-388-8268 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 1-844-388-8268 (TTY: 711).
Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 1-844-388-8268 (TTY: 711).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 1-844-388-8268 (TTY: 711).
Para falar com um intérprete em seu idioma de graça, ligue para 1-844-388-8268 (TTY: 711).