EmblemHealth VIP (HMO) *offered by*
HIP Health Plan of New York (HIP)/EmblemHealth

Annual Notice of Changes for 2014

You are currently enrolled as a member of VIP (HMO).
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.**

Additional Resources

- This information is available for free in other languages. Please contact our Customer Service number at **1-877-344-7364** for additional information. (TTY users should call **711**). Hours are Monday to Sunday, 8:00 am to 8:00 pm. Customer Service also has free language interpreter services available for non-English speakers.
- Esta informacion esta disponsible gratis en othos idiomas. Comuniquese con nuestro departmento se Servicio al cliente al **1-877-344-7364** para obtener mas informacion. (Los usarios de TTY deben llamar al **711**). El horario es de lunes a domingo, de 8:00 am a 8:00 pm. Servicio a clientes tambien cuenta con servicios gratuitos de interpretacion a otros idiomas para las personas que no hablan el ingles.
- This information is also available in alternate formats such as large print and Braille. Please call Customer Service at the above numbers for more information.

About EmblemHealth VIP (HMO)

- HIP Health Plan of New York (HIP) is an HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.
- When this booklet says "we," "us," or "our," it means HIP/EmblemHealth. When it says "plan" or "our plan," it means EmblemHealth VIP (HMO).

THINK ABOUT YOUR MEDICARE COVERAGE FOR NEXT YEAR

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 2 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.4 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use?
- ☐ **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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to stay with EmblemHealth VIP (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything. If you don't make a change by December 7, you will automatically stay enrolled in our plan.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2014. Look in Section 3 to learn more about your choices.

SUMMARY OF IMPORTANT COSTS FOR 2014

The table below compares the 2013 costs and 2014 costs for EmblemHealth VIP (HMO) 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.

	2013 (this year)	**2014 (next year)**
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$141.50	$166.00
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 2.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: $15 per visit Specialist visits: $25 per visit	Primary care visits: $15 per visit Specialist visits: $25 per visit
In-patient hospital stays	$200/days 1 - 7	$200/days 1 - 7
Part D prescription drug coverage (See Section 2.4 for details.)	Deductible: Not Applicable Copays during the Initial Coverage Stage: • Drug Tier 1: $5 • Drug Tier 2: $35 • Drug Tier 3: 50% • Drug Tier 4: 25%	Deductible: Not Applicable Copays during the Initial Coverage Stage: • Drug Tier 1: $2 • Drug Tier 2: $10 • Drug Tier 3: $35 • Drug Tier 4: $95 • Drug Tier 5: 25%

Annual Notice of Changes for 2014

Table of Contents

SECTION 1
WE ARE CHANGING THE PLAN'S NAME

On January 1, 2014, our plan name will change from "VIP (HMO)" to "EmblemHealth VIP (HMO)."

You will receive other materials from us with the new plan name, including the enclosed *Evidence of Coverage* and other important plan materials we will send you in the future.

SECTION 2
CHANGES TO BENEFITS AND COSTS FOR NEXT YEAR

Section 2.1 – Changes to the Monthly Premium

	2013 (this year)	2014 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$141.50	$166.00

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- 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 2.2 – 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 the maximum out-of-pocket amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

	2013 (this year)	2014 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and coinsurance) 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.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – 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 *2014 Evidence of Coverage.*

	2013 (this year)	2014 (next year)
Outpatient Lab Services/Diagnostic Tests	You pay a $25 copay	You pay a $0 copay
Supplemental Annual Physical Exam	Not Covered	You pay a $0 copay
Supplemental Education/Health Management Programs: • **Health Education** • **Nursing Hotline** • **Enhanced Disease Management**	Not Covered	You pay a $0 copay
Routine Eyewear	You pay a $40 copay for one pair of eyeglasses per year	You pay a $40 copay for one pair of eyeglasses or contact lenses per year
Ambulance	You pay a $100 copay	You pay a $125 copay
Renal Dialysis	You pay a $0 copay	You pay a 20% coinsurance
Supplemental Preventive Dental Services	$5 Exam $10 Cleaning $19 - $23 Fluoride	Not Covered

Section 2.4 – 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. **Current members** can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, you'll be able to get your drug at the start of the new plan 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 Customer Service.
- **Find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

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

If you have a current formulary exception for 2013, you need to submit a new one for 2014. You may submit your request for a formulary exception for 2014 in advance of 2014, and if approved, your formulary exception will be effective in 2014.

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 send 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 coverage. If you get "Extra Help" and haven't received this insert by September 30, 2013, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service 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 enclosed *Evidence of Coverage*.)

In addition to the changes in costs described below, there is a change to daily cost sharing that might affect your costs in the Initial Coverage Stage. Starting in 2014, when your doctor first prescribes less than a full month's supply of certain drugs, you may no longer need to pay the copay for a full month. (For more information about daily cost sharing, look at Chapter 6, Section 5.3, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

	2013 (this year)	2014 (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 Copayments in the Initial Coverage Stage

	2013 (this year)	2014 (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 (90-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. 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: **Generic Drugs:** You pay $5 per prescription. **Preferred Brand Drugs:** You pay $35 per prescription. **Non-Preferred Brand Drugs:** You pay 50% of the total cost. **Specialty Drugs:** You pay 25% of the total cost. Once your total drugs costs have reached $2,970, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic Drugs:** You pay $2 per prescription. **Non-Preferred Generic Drugs:** You pay $10 per prescription. **Preferred Brand Drugs:** You pay $35 per prescription. **Non-Preferred Brand Drugs:** You pay $95 per prescription. **Specialty Drugs:** You pay 25% of the total cost. Once your total drugs costs have reached $2,850, you will move to the next stage (the Coverage Gap Stage).

There is another important change that might affect your costs in the Initial Coverage Stage. Generally, your copay has been the same whether you filled your prescription for a full month's supply or for fewer days. However, starting in 2014, your copay for some drugs will be based on the actual number of days' supply you receive rather than a set amount for a month. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when your doctor first prescribes a drug that is known to cause side effects). If your doctor prescribes less than a full month's supply of certain drugs, and you are required to pay a copay, you will no longer have to pay for a month's supply. Instead, you will pay a lower copay (a daily cost-sharing rate) based on the number of days of the drug that you receive.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3
DECIDING WHICH PLAN TO CHOOSE

Section 3.1 – If you want to stay in EmblemHealth VIP (HMO)

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 2014.

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 2014 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2014*, 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 Web site. Go to **http://www.medicare.gov** and click "Compare Drug and Health Plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, EmblemHealth offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from EmblemHealth VIP (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from EmblemHealth VIP (HMO).
    - To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 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, 2014.

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, 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, 2014, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2014. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5
PROGRAMS THAT OFFER FREE COUNSELING ABOUT MEDICARE

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York State, the SHIP is called the Health Insurance Information Counseling and Assistance Program (HIICAP).

HIICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HIICAP at **1-800-701-0501**.. You can learn more about HIICAP by visiting their Web site (**www.aging.ny.gov**).

SECTION 6
PROGRAMS THAT HELP PAY FOR PRESCRIPTION DRUGS

You may qualify for help paying for prescription drugs. There are two basic 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 seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
    - The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, **1-800-325-0778**; or
    - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmaceutical Insurance Coverage (EPIC) 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).

SECTION 7
QUESTIONS?

Section 7.1 – Getting Help from EmblemHealth VIP (HMO)

Questions? We're here to help. Please call Customer Service at **1-877-344-7364**. (TTY only, call **711)** We are available for phone calls from Monday to Sunday, 8:00 am to 8:00 pm. Calls to these numbers are free.

Read your 2014 *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 2014. For details, look in the 2014 *Evidence of Coverage* for EmblemHealth VIP (HMO). 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* was included in this envelope.

Visit our Web site

You can also visit our Web site at **www.emblemhealth.com/our-plans/medicare**. As a reminder, our Web site has the most up-to-date information about our provider network (*Provider/Pharmacy 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 Web site

You can visit the Medicare Web site (**http://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 Web site. (To view the information about plans, go to **http://www.medicare.gov** and click on "Compare Drug and Health Plans.")

Read *Medicare & You 2014*

You can read *Medicare & You 2014* 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 Web site (**http://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**.