SHARP HEALTH PLAN
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2020 Sharp Direct Advantage® Annual Notice of Changes

Sharp Direct Advantage Gold Card (HMO) Plan

Sharp Direct Advantage Gold Card (HMO) offered by Sharp Health Plan

Annual Notice of Changes for 2020

You are currently enrolled as a member of Sharp Advantage. Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

- **You have from Oct. 15 until Dec. 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 1.1 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 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
   - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

- ▢ **Check to see if your doctors and other providers will be in our network next year.**
  - ° Are your doctors, including specialists you see regularly, in our network?
  - ° What about the hospitals or other providers you use?
  - ° Look in Sections 1.3 and 1.4 for information about our *Provider and Pharmacy Directory*.
- ▢ **Think about your overall health care costs.**
  - ° How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - ° How much will you spend on your premium and deductibles?
  - ° How do your total plan costs compare to other Medicare coverage options?
- ▢ **Think about whether you are happy with our plan.**

2. COMPARE: Learn about other plan choices

- ▢ **Check coverage and costs of plans in your area.**
  - ° Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
  - ° Review the list in the back of your *Medicare & You* handbook.
- ▢ **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** Sharp Advantage, you don't need to do anything. You will stay in our plan.
- ° To change to a **different plan** that may better meet your needs, you can switch plans between Oct. 15 and Dec. 7.

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

- ° If you **don't join by Dec. 7, 2019**, you will stay in our plan.
- ° If you **join by Dec. 7, 2019**, your new coverage will start on January 1, 2020.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at 1-855-562-8853 for additional information, (TTY/TDD users should call 711). Hours are: from Oct. 1 to March 31: 7 days per week 8:00 a.m. to 8:00 p.m., and from April 1 to Sep. 30: Monday through Friday, 8:00 a.m. to 8:00 p.m. and on weekends and holidays, your call will be handled by our voicemail system. A Customer Care Representative will return your phone call the next business day.
- Alguien que hable español le podrá ayudar. Este es un servicio gratuito.
- This information is available in large print.
- 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 irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Sharp Direct Advantage Gold Card (HMO)

- When this booklet says "we," "us," or "our," it means Sharp Health Plan. When it says "plan" or "our plan," it means Sharp Direct Advantage Gold Card.

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for our plan in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at sharpmedicareadvantage.com/members/forms-authorizations-resources. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0	$0
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:** $10 per visit **Specialist visits:** $35 per visit	**Primary care visits:** $5 per visit **Specialist visits:** $35 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$260 per day for days 1 through 7 $0 per day for days 8 through 90 $260 per day for days 91 through 97 $0 per day for days 98 and beyond	$250 per day for days 1 through 7 $0 per day for days 8 through 90 $0 per day for days 91 and beyond

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	**Deductible:** $0 Copayment/ Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1:** $4 for a 1-month supply at retail • **Drug Tier 2:** $8 for a 1-month supply at retail • **Drug Tier 3:** $47 for a 1-month supply at retail • **Drug Tier 4:** $100 for a 1-month supply at retail • **Drug Tier 5:** 33% of the cost for a 1-month supply at retail • **Drug Tier 6:** $0 for a 1-month supply at retail	**Deductible:** $0 Copayment/ Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1:** $4 for a 1-month supply at retail • **Drug Tier 2:** $8 for a 1-month supply at retail • **Drug Tier 3:** $47 for a 1-month supply at retail • **Drug Tier 4:** $100 for a 1-month supply at retail • **Drug Tier 5:** 33% of the cost for a 1-month supply at retail • **Drug Tier 6:** $0 for a 1-month supply at retail

Annual Notice of Changes for 2020

Table of Contents

SECTION 1
Change to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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 enroll in Medicare prescription drug coverage in the future.
- 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	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. 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 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 and Pharmacy Directory* is located on our website at sharpmedicareadvantage.com/members/forms-authorizations-resources. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory.* **Please review the 2020 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at sharpmedicareadvantage.com/members/forms-authorizations-resources. You may also call Customer Care for updated pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2020 *Provider and 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 *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Abdominal aortic aneurysm screening		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Ambulance services	$275 copayment for each one-way Medicare-covered trip. $275 copayment for worldwide emergency transportation.	$250 copayment for each one-way Medicare-covered trip. $250 copayment for worldwide emergency transportation. *Except in an emergency, prior authorization may be required from our plan.*
Bone mass measurement		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Breast cancer screening (mammograms)		*Referral may be required from your network provider.*
Cardiac rehabilitation services	*Referral may be required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Cardiovascular disease testing		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Cervical and vaginal cancer screening		*Referral may be required from your network provider.*
Chiropractic services	*Referral required from our plan for manual manipulation of the spine to correct subluxation by your network provider.* *No prior authorization or referral required for routine chiropractic care.*	*Referral from your network provider and prior authorization from our plan may be required for manual manipulation of the spine to correct subluxation.* *No prior authorization or referral required for supplemental chiropractic care.*
Colorectal cancer screening		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Dental Advantage by Delta Dental* *Supplemental dental benefit available for an extra monthly premium*	$11 additional monthly premium	$12 additional monthly premium
Comprehensive services include unlimited extractions	$35 to $150 copayment	$35 to $65 copayment Please see Chapter 4, Section 2.2 in your *Evidence of Coverage* for more information.

*Delta Dental refers to Delta Dental of California.

Cost	2019 (this year)	2020 (next year)
Dental services (Medicare covered)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Diabetes screening		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Diabetes self-management training, diabetic services and supplies	*Referral required from our plan for diabetes self-management training by your network provider.*	*Prior authorization may be required from our plan for therapeutic shoes, diabetic services and supplies.* *Referral by your network provider and prior authorization from our plan may be required for diabetes self-management training.*
Durable medical equipment (DME) and related supplies		*Prior authorization may be required from our plan.*

Cost	2019 (this year)	2020 (next year)
Hearing services	$35 copayment for exam to diagnose and treat hearing and balance issues. **Hearing aid:** Our Plan pays up to $2,500 every three years for a hearing aid. **Hearing aid fitting and examinations (up to 2 visits every year):** $35 copayment with network provider *Referral required from our plan for exam and treatment of hearing and balance issues by your network provider.* *Prior authorization from our plan by your network provider must be obtained for hearing aids.*	$10 copayment for exam to diagnose and treat hearing and balance issues. **Hearing aids:** Our Plan pays up to $3,000 every **two years** for hearing aids. **Hearing aid fitting and examinations (up to 2 visits every year):** $10 copayment with network provider. *Referral from your network provider and prior authorization by our plan may be required for exam and treatment of hearing and balance issues.* *Prior authorization from our plan must be obtained for hearing aids. Once authorized, you can see a provider of your choice for hearing aids.*
HIV screening		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Home health agency care	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Immunizations		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Inpatient hospital care	$260 per day for days 1 through 7 $0 per day for days 8 and beyond *Except in an emergency, prior authorization must be obtained from our plan by your network provider.*	$250 per day for days 1 through 7 $0 per day for days 8 through 90 $0 per day for days 91 and beyond *Except in an emergency, prior authorization may be required from our plan.* *Except in an emergency, referral may be required from your network provider.*
Inpatient mental health care	$260 per day for days 1 through 6 $0 per day for days 7 and beyond *Except in an emergency, prior authorization must be obtained from our plan by your network provider.*	$250 per day for days 1 through 7 $0 per day for days 8 through 90 $0 per day for days 91 and beyond *Except in an emergency, prior authorization may be required from our plan.*
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay	**Lab Services:** $5 copayment *Referral required from our plan by your network provider.*	**Lab Services:** $0 copayment *Prior authorization may be required from our plan.*
Medical nutrition therapy		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Medicare Diabetes Prevention Program (MDPP)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Obesity screening and therapy to promote sustained weight loss		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Opioid treatment program services	Not covered	$35 copayment per visit for covered opioid treatment services *Prior authorization may be required from our plan.*
Outpatient diagnostic tests and therapeutic services and supplies	**Lab tests:** $5 copayment *Referral required from our plan by your network provider.*	**Lab tests:** $0 copayment *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Outpatient hospital services	**Laboratory services:** $5 copayment *Referral required from our plan by your network provider.*	**Laboratory services:** $0 copayment *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Outpatient mental health care		*Prior authorization may be required from our plan.*
Outpatient rehabilitation services	*Referral required from our plan by your network provider for all therapy services and additional visits.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Outpatient substance abuse services	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.*

Cost	2019 (this year)	2020 (next year)
Over-the-Counter (OTC) items	Not covered	There is no coinsurance, copayment, or deductible for covered OTC items.
Physician/Practitioner services, including doctor's office visits	**Primary care physician visit:** $10 copayment	**Primary care physician visit:** $5 copayment *Prior authorization may be required from our plan for certain specialist services.* *Referral may be required from your network provider for certain specialist services.*
Prostate cancer screening exams		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Prosthetic devices and related supplies		*Prior authorization may be required from our plan.*
Pulmonary rehabilitation services	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Screening for lung cancer with low-dose computed tomography (LDCT)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Services to treat kidney disease	*Referral required from our plan by your network provider.*	*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Skilled nursing facility (SNF)	$0 per day for days 1 through 20 $160 per day for days 21 through 41 $0 per day for days 42 through 100 *Prior authorization required from our plan by your network provider.*	$0 per day for days 1 through 20 $155 per day for days 21 through 100 *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Supervised Exercise Therapy (SET)		*Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

Cost	2019 (this year)	2020 (next year)
Vision care	$20 copayment for Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye.	$10 copayment for Medicare-covered eye exams to diagnose and treat diseases and conditions of the eye. *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*
Routine eye exam: Supplemental vision coverage, including: One (1) routine eye exam per year. **Routine eye wear:** Pair of standard lenses and frames, limited to 1 pair of lenses and frames every 2 years OR contact lenses in lieu of lenses and frames every 2 years. Routine eye exam and eye wear provided by Vision Service Plan (VSP).	**Routine eye exam (up to 1 every year):** $20 copayment Our plan pays up to $95 every two years for eyeglass frames. Our plan pays up to $105 every two years for contact lenses in lieu of eyeglasses.	**Routine eye exam (up to 1 every year):** $10 copayment Our plan pays up to $200 every two years for eyeglasses (lenses and frames) or contact lenses. *Prior authorization may be required from our plan.* *Referral may be required from your network provider.*

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 located on our website at sharpmedicareadvantage.com/druglist. You can also get a copy of our Drug List mailed to you by calling Customer Care (phone numbers are printed on the back cover of this booklet).

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care 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 we make an exception and cover a drug that is not on our drug list, this coverage will expire at the end of your plan benefit year, unless you were otherwise informed at the time the exception was made. See Chapter 9 of your *Evidence of Coverage* for details on how to request an exception.

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 2020, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs 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 didn't receive this insert with this packet, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are in Section 8.1 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*, which is located on our website at sharpmedicareadvantage.com/members/forms-authorizations-resources. You may also contact Customer Care to ask us to mail you an *Evidence of Coverage*).

Changes to the Deductible Stage

Cost	2019 (this year)	2020 (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.*

Cost	2019 (this year)	2020 (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 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: ***Tier 1 – Preferred Generic Drugs:*** You pay $2 per prescription ***Tier 2 – Generic Drugs:*** You pay $6 per prescription ***Tier 3 – Preferred Brand Name Drugs:*** You pay $40 per prescription ***Tier 4 – Non-Preferred Drugs:*** You pay $90 per prescription ***Tier 5 – Specialty Drugs:*** You pay 33% of the cost ***Tier 6 – Select Care Drugs:*** You pay $0 per prescription _____ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: ***Tier 1 – Preferred Generic Drugs:*** You pay $2 per prescription ***Tier 2 – Generic Drugs:*** You pay $6 per prescription ***Tier 3 – Preferred Brand Name Drugs:*** You pay $40 per prescription ***Tier 4 – Non-Preferred Drugs:*** You pay $90 per prescription ***Tier 5 – Specialty Drugs:*** You pay 33% of the cost ***Tier 6 – Select Care Drugs:*** You pay $0 per prescription _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 2
Administrative Changes

We are partnering with a new pharmacy benefit manager (PBM) and mail order supplier in 2020 to help us improve your pharmacy experience. These new partnerships will bring some enhancements for you beginning January 1, 2020:

- A new, dedicated Medicare prescription helpline staffed by pharmacy experts who are available to assist you 24/7.
- An improved digital pharmacy experience that allows you to access medication, prescription and pharmacy network tools and information through our website and Sharp Connect member portal.
- Enhanced digital tools, like a free mobile app that lets you see your personalized pharmacy benefit information, refill or request new mail service prescriptions, track order status, view prescription history and much more.

To learn more, visit sharpmedicareadvantage.com/2020pharmacyinfo.

Changes	2019 (this year)	2020 (next year)
Pharmacy Benefit Manager (PBM)	MedImpact	CVS Caremark®
Mail Order Pharmacy	Postal Prescription Services® Mail Order	CVS Caremark Mail Service Pharmacy

SECTION 3
Deciding Which Plan to Choose

Section 3.1 If you want to stay in Sharp Direct Advantage Gold Card (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 Dec. 7, you will automatically stay enrolled as a member of our plan for 2020.

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 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call the California Health Insurance Counseling and Advocacy 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 http://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, Sharp Health Plan 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 Sharp Direct Advantage Gold Card (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Sharp Direct Advantage Gold Card (HMO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Care 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/TDD 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 **Oct. 15 until Dec. 7**. The change will take effect on January 1, 2020.

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

In certain situations, changes are also allowed at other times of the year. For example, people with 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're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 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 California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP).

HICAP 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. HICAP 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 HICAP at 1-800-434-0222. You can learn more about HICAP by visiting their website (www.aging.ca.gov/hicap).

SECTION 6
Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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 cost 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/TDD 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/TDD users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).

- **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 AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call ADAP at 1-844-421-7050.

SECTION 7
Questions?

Section 7.1 Getting Help from *Sharp Direct Advantage Gold Card (HMO)*

Questions? We're here to help. Please call Customer Care at 1-855-562-8853 (TTY/TDD only, call 711). We are available for phone calls from Oct. 1 to March 31, 7 days per week 8:00 a.m. to 8:00 p.m., and from April 1 to Sep. 30, Monday through Friday, 8:00 a.m. to 8:00 p.m. On weekends and holidays, your call will be handled by our voicemail system. A Customer Care Representative will return your phone call the next business day. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for your plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at sharpmedicareadvantage.com/members/forms-authorizations-resources. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at sharpmedicareadvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and 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/TDD users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (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 medicare.gov and click on "Find health & drug plans".)

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

Nondiscrimination Notice

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Sharp 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. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (such as large print, audio, accessible electronic formats, or other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Customer Care at 1-855-562-8853.

If you believe that Sharp 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 at:

- Address: Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 200 San Diego, CA 92123-1450
- Telephone: 1-855-562-8853 (TTY/TDD: 711) Fax: 1-619-740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. Please call our Customer Care team at 1-855-562-8853 if you need help filing a grievance. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Language Assistance Services

English
Attn:If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-562-8853 (TTY/TDD: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-562-8853 (TTY/TDD: 711).

繁體中文 (Chinese)
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 1-855-562-8853 (TTY/TDD: 711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-562-8853 (TTY/TDD: 711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-562-8853 (TTY/TDD: 711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-562-8853 (TTY/TDD: 711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-562-8853 (TTY/TDD (հեռատիպ)՝ 711).

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY/TDD: 711) 1-855-562-8853 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-562-8853 (телетайп: 711).

日本語 **(Japanese):**
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。1-855-562-8853 (TTY/TDD: 711) まで、お電話にてご連絡ください。

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-562-8853 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-855-562-8853 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Language Assistance Services

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-562-8853 (TTY/TDD: 711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-562-8853 (TTY/TDD: 711).

हिंदी **(Hindi):**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-562-8853 (TTY/TDD: 711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-562-8853 (TTY/TDD: 711).

SHARP HEALTH PLAN

Consider us your personal health care assistant®

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1-855-562-8853, TTY/TDD users call 711

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