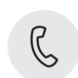
2018 ANNUAL NOTICE OF CHANGES

Important changes to your plan

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): San Francisco Health Service System
Group Number: 13694



Toll-Free **1-877-259-0493,** TTY **711**
8 a.m. - 8 p.m. local time, Monday - Friday

www.welcometouhc.com/sfhss

Do we have the right address for you?
If not, please let us know so we can keep you informed about your plan.

Y0066_H2001_828_2018

UnitedHealthcare® Group Medicare Advantage (PPO) offered by UnitedHealthcare

Annual Notice of Changes for the 2018 Plan Year

You are currently enrolled as a member of UnitedHealthcare® Group Medicare Advantage (PPO).

Next plan year, there will be some changes to the plan's costs and benefits. **This booklet tells about the changes.**

Members enrolled in our plan through a former employer, union group or trust administrator (plan sponsor) can make plan changes at times designated by your plan sponsor.

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 plan year.
- Do the changes affect the services you use?
- Look in Section 1 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?

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Form CMS 10260-ANOC/EOC
(Approved 05/2017) OMB Approval 0938-1051 (Expires: May 31, 2020)

- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.
- Because you are a member of the UnitedHealthcare® Group Medicare Advantage (PPO) plan, you can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded from Medicare.

☐ 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 (if applicable)?

☐ Think about whether you are happy with our plan.

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

- If you want to **keep** UnitedHealthcare® Group Medicare Advantage (PPO), you don't need to do anything. You will stay in UnitedHealthcare® Group Medicare Advantage (PPO).
- Members enrolled in our plan through a plan sponsor can make plan changes at times designated by your plan sponsor.
- You should consult with your plan sponsor regarding the availability of other coverage before you enroll in a plan not offered by your plan sponsor, or before ending your membership in our plan outside of your plan sponsor's open enrollment period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

Additional Resources

- This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number at 1-877-259-0493, TTY: 711, 8 a.m. - 8 p.m. local time, Monday - Friday, for additional information.
- **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.

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Form CMS 10260-ANOC/EOC
(Approved 05/2017) OMB Approval 0938-1051 (Expires: May 31, 2020)

About UnitedHealthcare® Group Medicare Advantage (PPO)

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.
- When this booklet says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means UnitedHealthcare® Group Medicare Advantage (PPO).

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OMB Approval 0938-1051 (Expires: May 31, 2020)

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for UnitedHealthcare® Group Medicare Advantage (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 plan year)	2018 (next plan year)
Maximum out-of-pocket amounts 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.)	From in-network and out-of-network providers combined: $3,750	From in-network and out-of-network providers combined: $3,750
Doctor Office Visits	Primary care visits: You pay a $5 copayment per visit (in-network). You pay a $5 copayment per visit (out-of-network). Specialist visits: You pay a $15 copayment per visit (in-network). You pay a $15 copayment per visit (out-of-network).	Primary care visits: You pay a $5 copayment per visit (in-network). You pay a $5 copayment per visit (out-of-network). Specialist visits: You pay a $15 copayment per visit (in-network). You pay a $15 copayment per visit (out-of-network).
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.	You pay a $150 copayment for each hospital stay for unlimited days (in-network). You pay a $150 copayment for each hospital stay for unlimited days (out-of-network).	You pay a $150 copayment for each hospital stay for unlimited days (in-network). You pay a $150 copayment for each hospital stay for unlimited days (out-of-network).
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: Because we have no deductible, this	Deductible: Because we have no deductible, this

Cost	**2017** (this plan year)	**2018** (next plan year)
	payment stage does not apply to you. Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: • Drug Tier 1: Standard retail cost-sharing (in-network) $5 copayment • Drug Tier 2: Standard retail cost-sharing (in-network) $20 copayment • Drug Tier 3: Standard retail cost-sharing (in-network) $45 copayment	payment stage does not apply to you. Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: • Drug Tier 1: Standard retail cost-sharing (in-network) $5 copayment • Drug Tier 2: Standard retail cost-sharing (in-network) $20 copayment • Drug Tier 3: Standard retail cost-sharing (in-network) $45 copayment

Annual Notice of Changes for 2018

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Section 1: Changes to Benefits and Costs for Next Plan Year

SECTION 1.1: Changes to the Monthly Premium

Your plan sponsor will notify you of any changes to your plan premium amount, if applicable.

SECTION 1.2: Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." 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 plan year)	**2018** (next plan year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	Once you have paid $3,750 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the plan year You do not have a separate in-network out-of-pocket maximum.	Once you have paid $3,750 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the plan year You do not have a separate in-network out-of-pocket maximum.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined	$3,750 Once you have paid $3,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered	$3,750 Once you have paid $3,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered

Cost	2017 (this plan year)	2018 (next plan year)
maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	Part A and Part B services from in-network or out-of-network providers for the rest of the plan year.	Part A and Part B services from in-network or out-of-network providers for the rest of the plan year.

SECTION 1.3: Changes to the Provider Network

Because you are a member of the UnitedHealthcare Group Medicare Advantage (PPO) plan, **you can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded from Medicare.**

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.welcometouhc.com/sfhss. You may also call Customer Service 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 our network of hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your network provider might leave your plan. If this happens, you may continue to see the provider as long as he/she continues to participate in Medicare and the care you receive is a covered service and is medically necessary. 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. When possible we will provide you with at least 30 days' notice that your network provider is leaving our plan. You may call Customer Service at the number listed in Chapter 2 of this booklet if you have questions.

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 mail order 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 plan year. An updated Pharmacy Directory is located on our website at www.welcometouhc.com/sfhss. You may also call Customer Service 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 plan year)	2018 (next plan year)
Plan Year Benefits	The plan's coverage begins January 1, 2017.	The plan's coverage begins January 1, 2018. Please see your Evidence of Coverage for information on Benefits and Costs for Medical Services.
Transgender Services	Surgical benefits have a $75,000 lifetime maximum through this additional benefit.	No lifetime limit.

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 booklet. The Drug List we included in this booklet includes many **– but not all –** of the drugs that we will cover next plan year. If you don’t see your drug on this list, it might still be covered. **You can get the complete Drug List** by calling Customer Service (1-877-259-0493) or visiting our website (www.welcometouhc.com/sfhss).

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 plan 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 Service.
- **Work with your doctor (or other prescriber) to 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 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 have obtained approval for a formulary exception this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. After the date of expiration on your approval letter, you will need to obtain a new approval in order for the plan to continue to cover the drug, if the drug still requires an exception and you and your doctor feel it is needed. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage or call Customer Service.

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, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service 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 plan year)	2018 (next plan 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

Your cost-sharing in the initial coverage stage may be changing from a copayment to coinsurance or a coinsurance to copayment. Please see the following chart for the changes from 2017 to 2018.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, **Types of out-of-pocket costs you may pay for covered drugs** in your **Evidence of Coverage.**

Stage	2017 (this plan year)	2018 (next plan 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.** Your cost-sharing in the initial coverage stage may be changing from a copayment to coinsurance or a coinsurance to copayment. Please see the columns to the right for the changes from 2017 to 2018. 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 mail-order prescriptions, look in	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 – Generic Drugs**: You pay $5 per prescription. **Tier 2 - Preferred Brand Drugs:** You pay $20 per prescription. **Tier 3 - Non-Preferred Brand Drugs:** You pay $45 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 – Generic Drugs:** You pay $5 per prescription. **Tier 2 - Preferred Brand Drugs:** You pay $20 per prescription. **Tier 3 - Non-preferred Drugs:** You pay $45 per prescription.

Stage	2017 (this plan year)	2018 (next plan year)
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.	Once your total drugs costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	Once your total drugs costs have reached $3,750, 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: Deciding Which Plan to Choose

SECTION 2.1: If You Want to Stay in UnitedHealthcare® Group Medicare Advantage (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, you will automatically stay enrolled as a member for the 2018 plan year.

SECTION 2.2: If You Want to Change Plans

You should consult with your plan sponsor regarding the availability of other coverage before you enroll in a plan not offered by your plan sponsor, or before ending your membership in our plan outside of your plan sponsor's open enrollment period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our 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).

Section 3: Deadline for Changing Plans

Because you are enrolled in our plan through your plan sponsor, you are only allowed to make plan changes at times designated by your plan sponsor.

Important Note: You may join or leave a plan only at certain times designated by your plan sponsor. If you choose to enroll in a Medicare health plan or Medicare prescription drug plan that is not offered by your plan sponsor, you may lose the option to enroll in a plan offered by your plan sponsor in the future. You could also lose coverage for other retirement benefits you may currently have through your plan sponsor. Once enrolled in our plan, if you choose to end your membership outside of your plan sponsor's open enrollment period, re-enrollment in any plan your plan sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

You should consult with your plan sponsor regarding the availability of other coverage before you enroll in a plan not offered by your plan sponsor, or before ending your membership in our plan outside of your plan sponsor's open enrollment period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

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.

State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can find your SHIP number and address in Chapter 2, Section 3 of the **Evidence of Coverage.**

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 a.m. and 7 p.m., 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.** State Pharmaceutical Assistance Program 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 Chapter 2, Section 3 of your **Evidence of Coverage**).
- **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 ADAP in your State. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP in your State. You can find your State's ADAP contact information in Chapter 2 of the **Evidence of Coverage.**

Section 6: Questions?

SECTION 6.1: Getting Help from UnitedHealthcare® Group Medicare Advantage (PPO)

Questions? We're here to help. Please call Customer Service at 1-877-259-0493. (TTY only, call 711.) We are available for phone calls 8 a.m. - 8 p.m. local time, Monday - Friday. Calls to these numbers are free.

Read your 2018 Evidence of Coverage (it has details about next plan 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 UnitedHealthcare® Group Medicare Advantage (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 booklet.

Visit our Website

You can also visit our website at www.welcometouhc.com/sfhss. 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.