***Easy Choice Freedom Plan (HMO SNP) offered by* Easy Choice Health Plan, Inc.**

Annual Notice of Changes for 2017

You are currently enrolled as a member of *Easy Choice Freedom Plan (HMO SNP)*. Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

Additional Resources

- This information is available for free in other languages.
- Please contact our Customer Service number at 1-866-999-3945 for additional information. (TTY users should call 1-800-735-2929). Hours are Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.
- Customer Service also has free language interpreter services available for non-English speakers.
- Esta información se encuentra disponible en otros idiomas gratis.
- Por favor comuníquese con nuestro Servicio al Cliente llamando al 1-866-999-3945, para información adicional. (Los usuarios de TTY deben llamar al 1-800-735-2929). El horario es de lunes a viernes de 8 a.m. a 8 p.m. Entre el 1 de Octubre y el 14 de Febrero, los representantes están disponibles de lunes a domingo de 8 a.m. a 8 p.m.
- Servicio al cliente también tiene servicios disponibles de interpretación a otros idiomas gratis para personas que no hablan inglés.
- 이 정보는 다른 언어로도 무료로 제공됩니다.
- 추가 정보를 원하시면 1-866-999-3945번으로 고객 서비스에

연락해 주십시오. (TTY 사용자의 경우 1-800-735-2929번으로 전화하셔야 합니다.) 업무 시간은 월요일-금요일, 오전 8시부터 오후 8시까지입니다. 10월 1일과 2월 14일 사이에는 월요일-일요일, 오전 8시부터 오후 8시까지 담당자와 통화가 가능합니다.

- 고객 서비스에서는 영어를 사용하지 않는 사람을 위한 무료 통역 서비스도 제공합니다.

- Thông tin này được cung cấp miễn phí bằng các ngôn ngữ khác.
- Vui lòng liên hệ với Dịch vụ Chăm sóc Khách hàng của chúng tôi qua số 1-866-999-3945 để biết thêm chi tiết. (Người dùng TTY gọi số 1-800-735-2929). Thời gian làm việc từ Thứ Hai đến Thứ Sáu, 8 giờ sáng đến 8 giờ tối. Từ ngày 1 tháng 10 đến ngày 14 tháng 2, nhân viên chăm sóc khách hàng làm việc từ Thứ Hai-Chủ Nhật, 8 giờ sáng đến 8 giờ tối.
- Dịch vụ Chăm sóc Khách hàng cũng có dịch vụ thông dịch viên ngôn ngữ miễn phí dành cho những người không nói tiếng Anh.

- This booklet is also available in different formats, including Braille, large print and audio compact disc (CD). Please call Customer Service if you need plan information in another format (phone numbers are printed on the back cover of this booklet).

- Minimum essential coverage (MEC): 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 on the individual requirement for MEC.

About Easy Choice Freedom Plan (HMO SNP)

- Easy Choice Health Plan (HMO SNP), a WellCare company, is a Medicare Advantage organization with a Medicare contract and a contract with the California Medicaid program. Enrollment in Easy Choice Health Plan (HMO) depends on contract renewal.

- When this booklet says "we," "us," or "our," it means Easy Choice Health Plan, Inc.. When it says "plan" or "our plan," it means Easy Choice Freedom Plan (HMO SNP).

Think about Your Medicare Coverage for Next Year

Medicare allows you to change your Medicare health and drug coverage. It's important to review your coverage each fall 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 Sections 1.1, 1.2 and 1.5 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 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 year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with *Easy Choice Freedom Plan (HMO SNP)*:

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, 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 at any time. If you enroll in a new plan, your new coverage will begin on the first day of the month after you request the change. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for *Easy Choice Freedom Plan (HMO SNP)* 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	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0.00	$0.00
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $0 per visit

Cost	2016 (this year)	2017 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $0 co-pay up to 90 days per admission Cost share applies Per admission.	You pay a $0 co-pay up to 90 days per admission Cost share applies Per admission.

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	If you receive Extra Help, you pay one of the following amounts:	
	Deductible: $0 or $74 on Tier 2 to 5	Deductible: $0 or $82 on Tiers 2 to 5
	For generic drugs (including brand drugs treated as generic): • $0 co-pay or • $1.20 co-pay or • $2.95 co-pay or • 15% of the total cost of the drug	For generic drugs (including brand drugs treated as generic): • $0 co-pay or • $1.20 co-pay or • $3.30 co-pay or • 15% of the total cost of the drug
	For all other covered drugs: • $0 co-pay or • $3.60 co-pay or • $7.40 co-pay or • 15% of the total cost of the drug	For all other covered drugs: • $0 co-pay or • $3.70 co-pay or • $8.25 co-pay or • 15% of the total cost of the drug

Cost	2016 (this year)	2017 (next year)
	If you do not qualify for Extra Help from Medicare, you will pay the following for your prescription drug costs:	
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $360 on Tiers 2 to 5 Co-payment/ coinsurance during the Initial Coverage Stage: ● Drug Tier 1: $0.00 ● Drug Tier 2: $20.00 ● Drug Tier 3: $47.00 ● Drug Tier 4: 50% ● Drug Tier 5: 25%	Deductible: $400 on Tiers 2 to 5 Co-payment/ coinsurance during the Initial Coverage Stage: ● Drug Tier 1: $0.00 ● Drug Tier 2: $20.00 ● Drug Tier 3: $47.00 ● Drug Tier 4: 50% ● Drug Tier 5: 25%
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400	$3,400

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0.00	$0.00

- 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 ever lose your low income subsidy ("Extra Help"), you must maintain your Part D coverage or you could be subject to a late enrollment penalty if you ever chose to enroll in Part D in the future. If you have a higher income as reported on your last tax return ($85,000 or more), you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as co-pays) 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 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 www.easychoicehealthplan.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2017 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 specialist (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.

- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes a mail service pharmacy with preferred cost-sharing, which may offer you lower cost- sharing than the standard cost-sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year. An updated Provider and Pharmacy Directory is located on our website at www.easychoicehealthplan.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider and Pharmacy Directory. **Please review the 2017 Provider and Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

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, *Benefits Chart (what is covered)*, in your *2017 Evidence of Coverage.* A copy of the *Evidence of Coverage* was included in this envelope.

Cost	2016 (this year)	2017 (next year)
ADDITIONAL SERVICES		
Dental Services		
Routine Dental (limitations and exclusions apply)	The maximum benefit amount of $1,500 every year applies to all covered routine services.	The maximum benefit amount of $2,000 every year applies to all covered routine services. Please refer to your Evidence of Coverage for covered services.
Hearing Services		
Routine Hearing	The maximum benefit amount for hearing aid is $350 every year .	The maximum benefit amount for hearing aid is $1,000 every year.
Vision Services		
Routine Vision (limitations and exclusions apply)	The maximum benefit amount for routine eyewear is $300 every year.	The maximum benefit amount for routine eyewear is $350 every year. Please see your Evidence of Coverage for additional details.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or 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 in the first 90 days of coverage of the plan year or coverage. (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.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

Perhaps you can find a different drug covered by the plan that might work just as well for you. You can check the formulary on our website or call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You and your doctor can also ask the plan to make an exception for you and continue to cover the drug. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. There are certain requirements that must be met so to learn what you must do to ask for an exception, see Chapter 9 of the Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) If you received a favorable formulary exception during 2016 you may not need to obtain a new formulary exception in 2017. At the time of the approval, we would have indicated in the approval notice how long the authorization is valid.

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 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 get "Extra Help" and haven't received this insert by October 15, 2016 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tiers 2 to 5 drugs until you have reached the yearly deductible.	The deductible is $360 on Tiers 2 to 5 During this stage, you pay $0.00 cost-sharing for drugs on Tier 1 and the full cost of drugs on Tier 2 to 5 until you have reached the yearly deductible.	The deductible is $400 on Tiers 2 to 5 During this stage, you pay $0.00 cost-sharing for drugs on Tier 1 and the full cost of drugs on Tiers 2 to 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how co-payments 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.*

Most of our members get "Extra Help" with their prescription drug costs. If you receive "Extra Help," your co-payment amount depends on the level of "Extra Help" you receive - you will either:

- Pay a $0 (generic and brand) co-payment
- -- Pay a $1.20 (generic) or $3.70 (brand) co-payment
- --or-- Pay a $3.30 (generic) or $8.25 (brand) co-payment
- --or-- Pay a 15% (generic and brand) coinsurance
- If the co-payments in the chart below are less than the co-payment you receive through your "Extra Help", you will pay the plan's co-payment. Please note - the plan's co-payment may be lower at a network mail service pharmacy that offers preferred cost-sharing.

Look at the separate insert (the "LIS Rider") for information about your deductible amount.

Stage	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:
Once you pay the yearly deductible, you move to the 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.**	**Tier 1 (Preferred Generic Drugs):** You pay $0.00 per prescription.	**Tier 1 (Preferred Generic Drugs):** You pay $0.00 per prescription.

Stage	2016 (this year)	2017 (next year)
	Tier 2 (Generic Drugs): You pay $20.00 per prescription.	**Tier 2 (Generic Drugs):** You pay $20.00 per prescription.
	Tier 3 (Preferred Brand Drugs): You pay $47.00 per prescription.	**Tier 3 (Preferred Brand Drugs):** You pay $47.00 per prescription.
	Tier 4 (Non-Preferred Brand Drugs): You pay 50% of the total cost.	**Tier 4 (Non-Preferred Drugs):** You pay 50% of the total cost.
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Tier 5 (Specialty Tier Drugs):** You pay 25% of the total cost.	**Tier 5 (Specialty Tier Drugs):** You pay 25% of the total cost.
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 $3,310, you will move to the next stage (the Coverage Gap Stage).	Once your total drugs costs have reached $3,700, 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 your *Summary of Benefits* or 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 *Easy Choice Freedom Plan (HMO SNP)*

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 of our plan for 2017.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 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 2017*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from ***Easy Choice Freedom Plan (HMO SNP)***.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from ***Easy Choice Freedom Plan (HMO SNP)***.
- 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 6.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

Because you are eligible for both Medicare and Medicaid you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling & Advocacy Program (HICAP).

Health Insurance Counseling & Advocacy Program (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. Health Insurance Counseling & Advocacy Program (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 Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222. You can learn more about Health Insurance Counseling &

Advocacy Program (HICAP) by visiting their website (http://www.aging.ca.gov/hicap).

SECTION 5 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 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).

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 California Department of Public Health Office of AIDS. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call California Department of Public Health Office of AIDS at 1-916-449-5900. (TTY users should call 711.)

SECTION 6 Questions?

Section 6.1 – Getting Help from Easy Choice Freedom Plan (HMO SNP)

Questions? We're here to help. Please call Customer Service at 1-866-999-3945. (TTY only, call 1-800-735-2929.) We are available for

phone calls Monday–Friday, 8 a.m. to 8 p.m. Between October 1 and February 14, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for ***Easy Choice Freedom Plan (HMO SNP)***. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our website

You can also visit our website at www.easychoicehealthplan.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 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 (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 website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans.”)

Read *Medicare & You 2017*

You can read *Medicare & You 2017* 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 (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.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid, you can call Medi-Cal at 1-800-541-5555. TTY users should call 711.