Employer Group Plus A Plan (HMO)

offered by Health First Health Plans

You are currently enrolled as a member of the Employer Group Plus A Plan (HMO). Next year, there will be some changes to the plan’s costs and benefits. This booklet tells about the changes.

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

Additional Resources

- This information is available for free in other languages. Please contact our Customer Service number at 1-800-716-7737 for additional information. (TTY users should call 1-800-955-8771). Hours are October 1 – February 14, Seven days per week from 8 a.m. to 8 p.m. February 15 – September 30, Monday through Friday from 8 a.m. to 8 p.m., Saturday from 8 a.m. to Noon. From February 15 through September 30, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day. Customer Service also has free language interpreter services available for non-English speakers.

- Esta información está disponible gratuitamente en otros idiomas. Puede llamar a nuestro número de servicio al cliente 1-800-716-7737 (los usuarios de TTY deben llamar 1-800-955-8771). El horario es el 1 de Octubre - 14 de Febrero, siete días a la semana de 8 a.m. - 8 p.m. El 15 de Febrero - 30 de Septiembre, lunes a viernes de 8 a.m. - 8 p.m, y los sábados de 8 a.m.- 12 p.m. Desde el 15 de Febrero - 30 de Septiembre, recibirá un servicio de mensajes los fines de semana y festivos. Por favor deje un mensaje y su llamada será devuelta el siguiente día hábil. Servicios para el cliente también dispone de interpretación para idiomas no inglés.

- This information is available in a different format, including large print.

About the Employer Group Plus A Plan (HMO)

- Health First Health Plans is an HMO plan with a Medicare contract.

- When this booklet says “we,” “us,” or “our,” it means Health First Health Plans. When it says “plan” or “our plan,” it means the Employer Group Plus A Plan (HMO).
Think about Your Medicare Coverage for Next Year

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

Important things to do:

- **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 2.1 and 2.5 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 2.6 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 2.3 for information about our Provider/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.**

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**If you decide to stay with the Employer Group Plus A Plan (HMO):**

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

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**If you decide to change plans:**

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2014. Look in Section 4.2 to learn more about your choices.
## Summary of Important Costs for 2014

The table below compares the 2013 costs and 2014 costs for the Employer Group Plus A Plan (HMO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this Annual Notice of Changes** and review the enclosed Evidence of Coverage to see if other benefit or cost changes affect you.

<table>
<thead>
<tr>
<th></th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 2.1 for details.</td>
<td>Please contact the employer’s or union’s benefit administrator for information about your plan premium.</td>
<td>Please contact the employer’s or union’s benefit administrator for information about your plan premium.</td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $10 per visit</td>
<td></td>
<td>Primary care visits: $10 per visit</td>
</tr>
<tr>
<td>Specialist visits: $20 per visit</td>
<td></td>
<td>Specialist visits: $20 per visit</td>
</tr>
<tr>
<td><strong>In-patient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay $250 copayment for each Medicare-covered stay at a network hospital.</td>
<td>You pay $250 copayment for each Medicare-covered stay at a network hospital.</td>
<td></td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Deductible: Not applicable</td>
<td>Deductible: Not applicable</td>
</tr>
<tr>
<td>(See Section 2.6 for details.)</td>
<td>Copays during the Initial Coverage Stage:</td>
<td>Copays during the Initial Coverage Stage:</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 1: $2</td>
<td>• Drug Tier 1: $0</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 2: $10</td>
<td>• Drug Tier 2: $10</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 3: $25</td>
<td>• Drug Tier 3: $25</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 4: $45</td>
<td>• Drug Tier 4: $45</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 5: $90</td>
<td>• Drug Tier 5: $90</td>
</tr>
</tbody>
</table>
Annual Notice of Changes for 2014

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SECTION 1  Unless You Choose Another Plan, You Will Be Automatically Enrolled in the Employer Group Plus A Plan (HMO) in 2014

If you have not done anything to change your Medicare coverage by December 7, 2013, we will automatically enroll you in our Employer Group Plus A Plan (HMO). This means starting January 1, 2014, you will be getting your medical and prescription drug coverage through the Employer Group Plus A Plan (HMO). You have choices about how to get your Medicare coverage. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare.

The information in this document tells you about the differences between your current benefits in the Employer Group Plus A Plan (HMO) and the benefits you will have on January 1, 2014 as a member of the Employer Group Plus A Plan (HMO).

SECTION 2  Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Monthly premium</th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td>Please contact the employer’s or union’s benefit administrator for information about your plan premium.</td>
<td>Please contact the employer’s or union’s benefit administrator for information about your plan premium.</td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be more if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach the maximum out-of-pocket amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.
Section 2.3 – Changes to the Provider Network

There are changes to our network of doctors and other providers for next year.

An updated Provider/Pharmacy Directory is located on our Web site at www.HealthFirstHealthPlans.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. Please review the 2014 Provider/Pharmacy Directory to see if your providers are in our network.

Section 2.4 – 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/Pharmacy Directory is located on our Web site at www.HealthFirstHealthPlans.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. Please review the 2014 Provider/Pharmacy Directory to see which pharmacies are in our network.

Section 2.5 – 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 2014 Evidence of Coverage.

<table>
<thead>
<tr>
<th>Service</th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient hospital services and outpatient surgery</strong></td>
<td>You pay $150 for each Medicare covered visit to either an ambulatory surgical center or an outpatient hospital facility</td>
<td>You pay $125 for each Medicare covered visit to either an ambulatory surgical center or an outpatient hospital facility</td>
</tr>
<tr>
<td>Services to treat kidney disease and conditions</td>
<td>You pay $0 for outpatient covered renal dialysis received in a Medicare certified dialysis facility</td>
<td>You pay 20% of the total cost for outpatient covered renal dialysis received in a Medicare certified dialysis facility</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td>3 day inpatient hospital stay not required prior to SNF admission</td>
<td>3 day inpatient hospital stay is required prior to SNF admission</td>
</tr>
<tr>
<td>Dental services</td>
<td>You pay $0 to $45 copay for up to 1 cleaning every year. You pay $0 to $35 copay for up to 1 dental x-ray every year. Dental services are provided by DeltaCare® USA</td>
<td>You pay $0 copay for supplemental preventive dental benefits: • Oral exams • Cleanings • Dental x-rays DeltaCare® USA dental services are not covered. There is a $200 plan coverage limit for supplemental preventive dental benefits every year.</td>
</tr>
<tr>
<td>Continuous Glucose Monitoring (CGM)</td>
<td>Continuous Glucose Monitoring is not covered</td>
<td>You pay $0 copay for Continuous Glucose Monitoring</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>Extended Medical Nutrition Therapy is not covered</td>
<td>You pay $0 for Extended Medical Nutrition Therapy for the following conditions: • Heart Disease • Lipid Disorders (High Cholesterol/Triglycerides) • Malnutrition • Obesity</td>
</tr>
<tr>
<td>Annual pap smear and pelvic exam</td>
<td>You pay a $0 copay for one Medicare covered pap smear and pelvic exam every 12 months.</td>
<td>You pay a $0 copay for one Medicare covered pap smear and pelvic exam every 24 months.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>You pay a $50 copay for Medicare covered round trip.</td>
<td>You pay a $50 copay for Medicare covered one way trip.</td>
</tr>
</tbody>
</table>
Cost-sharing Tier 5 (Specialty) | You pay a $270 copay for a 90 day supply of Tier 5 drugs at retail. | 90 day supply of Tier 5 drugs is not covered at retail.
---|---|---
Cost-sharing Tier 5 (Specialty) | You pay a $180 copay for a 90 day supply of Tier 5 drugs at mail order. | 90 day supply of Tier 5 drugs is not covered at mail order.

**Section 2.6 – 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. **Current members** can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber’s supporting statement). If we approve your request, you’ll be able to get your drug at the start of the new plan year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Customer Service.
- **Find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

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

Prior authorizations for Part D drugs often expire at the end of the year. You should contact your doctor if you take a drug approved as an exception to the formulary. Your doctor should submit a request to continue the coverage of the drug before your authorization expires. Please call Customer Service if you are not sure when your authorization expires.

**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 coverage. If you get “Extra Help” and haven’t received this insert by September 30, 2013, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 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 enclosed Evidence of Coverage.)

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

### Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage 1: Yearly Deductible Stage</th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td></td>
</tr>
</tbody>
</table>
Changes to Your Copayments in the Initial Coverage Stage

<table>
<thead>
<tr>
<th>Stage 2: Initial Coverage Stage</th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Your cost for a one-month supply filled at a network pharmacy:</td>
<td>Your cost for a one-month supply filled at a network pharmacy:</td>
</tr>
<tr>
<td>Tier 1 Preferred Generic:</td>
<td>You pay $2 per prescription</td>
<td>Tier 1 Preferred Generic:</td>
</tr>
<tr>
<td>Tier 2 Non-Preferred Generic:</td>
<td>You pay $10 per prescription</td>
<td>You pay $0 per prescription</td>
</tr>
<tr>
<td>Tier 3 Preferred Brand:</td>
<td>You pay $25 per prescription</td>
<td>Tier 2 Non-Preferred Generic:</td>
</tr>
<tr>
<td>Tier 4 Non-Preferred Brand:</td>
<td>You pay $45 per prescription</td>
<td>You pay $25 per prescription</td>
</tr>
<tr>
<td>Tier 5 Specialty:</td>
<td>You pay $90 per prescription</td>
<td>Tier 3 Preferred Brand:</td>
</tr>
<tr>
<td></td>
<td>______________________</td>
<td>Tier 4 Non-Preferred Brand:</td>
</tr>
<tr>
<td></td>
<td>Once you have paid $4,750 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
<td>Once you have paid $4,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</td>
</tr>
</tbody>
</table>

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

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.
SECTION 3  Other Changes

<table>
<thead>
<tr>
<th></th>
<th>2013 (this year)</th>
<th>2014 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health First Fitness Program Vendor</td>
<td>Silver &amp; Fit® (Indian River County residents only)</td>
<td>SilverSneakers® (Brevard and Indian River County residents)</td>
</tr>
<tr>
<td></td>
<td>Parrish Health &amp; Fitness facility</td>
<td>Parrish Health &amp; Fitness is no longer a participating facility</td>
</tr>
</tbody>
</table>

SECTION 4  Deciding Which Plan to Choose

Section 4.1 – If you want to stay in the Employer Group Plus A Plan (HMO)

To stay in our plan you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2014.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2014 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2014, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare Web site. Go to http://www.medicare.gov and click “Compare Drug and Health Plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.

As a reminder, Health First Health Plans offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.
Step 2: Change your coverage

☐ To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from the Employer Group Plus A Plan (HMO).

☐ To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from the Employer Group Plus A Plan (HMO).

☐ To change to Original Medicare without a prescription drug plan, you must either:
  o 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 8.1 of this booklet).
  o – 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 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from October 15 until December 7. The change will take effect on January 1, 2014.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

If you enrolled in a Medicare Advantage plan for January 1, 2014, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2014. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 6 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 Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

SHINE 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. SHINE 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 SHINE at 1-800-963-5337 (TDD/TTY call 1-800-955-8770). You can learn more about SHINE by visiting their Web site (www.floridashine.org).

SECTION 7 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
seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office.

**SECTION 8  Questions?**

**Section 8.1 – Getting Help from the Employer Group Plus A Plan (HMO)**

Questions? We’re here to help. Please call Customer Service at 1-800-716-7737. (TTY only, call 1-800-955-8771). We are available for phone calls October 1 – February 14, Seven days per week from 8 a.m. to 8 p.m. February 15 – September 30, Monday through Friday from 8 a.m. to 8 p.m., Saturday from 8 a.m. to Noon. From February 15 through September 30, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day. Calls to these numbers are free.

**Read your 2014 Evidence of Coverage (it has details about next year’s benefits and costs)**

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2014. For details, look in the 2014 *Evidence of Coverage* for the Employer Group Plus A Plan (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* was included in this envelope.

**Visit our Web site**

You can also visit our Web site at www.HealthFirstHealthPlans.org. As a reminder, our Web site has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our list of covered drugs (*Formulary/Drug List*).

**Section 8.2 – Getting Help from Medicare**

To get information directly from Medicare:

**Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Visit the Medicare Web site**

You can visit the Medicare Web site (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the
Medicare Web site. (To view the information about plans, go to http://www.medicare.gov and click on “Compare Drug and Health Plans.”)

**Read Medicare & You 2014**

You can read *Medicare & You 2014* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare Web site (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.