Wellcare Dual Select (HMO D-SNP) *offered by* Trillium Community Health Plan, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Wellcare Dual Select (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.wellcare.com/trilliumOR. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* 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 don't join another plan by December 7, 2022, you will stay in Wellcare Dual Select (HMO D-SNP).

- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Wellcare Dual Select (HMO D-SNP).
- Look in Section 2.2, page 19 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1-844-867-1156 for additional information. (TTY users should call 711.) Hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
- We must provide information in a way that works for you (in languages other than English, in braille, in audio, in large print, or other alternate formats, etc.). Please call Member Services if you need plan information in another format.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Wellcare Dual Select (HMO D-SNP)

- Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.
- The plan also has a written agreement with the Oregon Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Trillium Community Health Plan, Inc. When it says "plan" or "our plan," it means Wellcare Dual Select (HMO D-SNP).

OMB Approval 0938-1051 (Expires: February 29, 2024)

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Wellcare Dual Select (HMO D-SNP) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 or $40.50	$0 or $30.80
Deductible	$0 or $233	$0 or The Part B deductible was $233. This is the 2022 Medicare-defined amount and may change for 2023. Please contact Member Services for more information.
Doctor office visits	Primary care visits: $0 or 20% of the total cost per visit Specialist visits: $0 or 20% of the total cost per visit	Primary care visits: $0 or 20% of the total cost per visit Specialist visits: $0 or 20% of the total cost per visit
Inpatient hospital stays	For covered admissions, per admission: $0 or $1,800 copay for each covered hospital stay.	For covered admissions, per admission: $0 or $1,625 copay for each covered hospital stay.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $480 (applies to Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier)) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 - Preferred Generic Drugs: You pay a $0 copay for a one-month (30-day) supply. • Drug Tier 2 - Generic Drugs: You pay a $5 copay for a one-month (30-day) supply. • Drug Tier 3 - Preferred Brand Drugs: You pay a $29 copay for a one-month (30-day) supply. • Drug Tier 4 - Non-Preferred Drugs: You pay 50% of the total cost for a one-month (30-day) supply. • Drug Tier 5 - Specialty Tier: You pay 25% of the total cost for a one-month (30-day) supply. • Drug Tier 6 - Select Care Drugs: You pay a $0 copay for a one-month (30-day)	Deductible: $0 Copayment during the Initial Coverage Stage: You pay a $0 copay for all covered Part D drugs.

Cost	2022 (this year)	2023 (next year)
	supply.	
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.)	$3,450 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$8,300 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or $40.50	$0 or $30.80

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (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.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,450	$8,300 Once you have paid $8,300 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 and Pharmacy Networks

Updated directories are also located on our website at www.wellcare.com/trilliumOR. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Deductible	The following benefits do not apply to your deductible: Physician/Practitioner services, including doctor's office visits - additional telehealth services.	The following benefits apply to your deductible: Physician/Practitioner services, including doctor's office visits - additional telehealth services.
Referrals	The following in-network benefits have a change in referral requirements. • Hearing aids do(es) not require a referral. • Hearing exams do(es) not require a referral. • Eyewear do(es) not require a referral. • Eye exams do(es) not require a referral.	 • Hearing aids may require a referral. • Hearing exams may require a referral. • Eyewear may require a referral. • Eye exams may require a referral.

Cost	2022 (this year)	2023 (next year)
Dental services - Comprehensive dental services	Your plan has up to a $1,000 allowance for all in-network covered preventive and comprehensive dental services every year.	Your plan has up to a $5,000 allowance for all in-network covered comprehensive dental services every year.
Dental services - Comprehensive dental services - Non-routine services	Limited to 1 non-routine service(s) every day to 24 months depending on type of service.	Limited to 1 non-routine service(s) every date of service to 60 months depending on type of service.
Dental services - Comprehensive dental services - Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	Prosthodontics - every 12 to 84 months depending on type of service. Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service. Other Services are not covered.	Prosthodontics - every 12 to 84 months depending on type of service. Oral/maxillofacial surgery - every 12 to 60 months or per lifetime depending on type of service. Other services - every 6 to 60 months depending on type of service.
Dental services - Preventive dental services	Your plan has up to a $1,000 allowance for all in-network covered preventive and comprehensive dental services every year.	Your plan has no maximum allowance for in-network covered preventive dental services every year.
Emergency services	You pay a $0 or $120 copay for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. Copayment is waived if you are admitted to a hospital within 24 hours.	You pay a $0 or $95 copay for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. Copayment is waived if you are admitted to a hospital within 24 hours.

Cost	2022 (this year)	2023 (next year)
Emergency care - Worldwide emergency coverage	You pay a $120 copay for each covered service. Copayment is not waived if you are admitted to a hospital.	You pay a $95 copay for each covered service. Copayment is not waived if you are admitted to a hospital.
Flex Card	You receive $200 on your Flex Card. The debit card is prepaid by the plan for covered dental, vision, or hearing services. Please refer to your Evidence of Coverage for more information.	You receive $750 on your Flex Card. The debit card is prepaid by the plan for covered dental, vision, or hearing services. Up to $250 may be used for vision-related services only. Your remaining benefit dollars may be spent between dental and hearing as you see fit. Please refer to your Evidence of Coverage for more information.
Healthy Foods Card **Medicare approved Wellcare to provide these benefits as part of the Value-Based Insurance Design (VBID) program. This program lets Medicare try new ways to improve Medicare Advantage plans.** **For more information about VBID benefits, please contact Member Services.**	The Healthy Foods Card is not covered.	You receive an allowance of $25 every month to spend on eligible grocery products at participating retailers. This allowance does not carry over to the next month.
Hearing services - Hearing aids	Up to a $1,500 allowance for both ears combined every year for hearing aids.	Up to a $1,000 allowance per ear every year for hearing aids.

Cost	2022 (this year)	2023 (next year)
Home health agency care	You pay $0 or 20% of the total cost for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $0 copay for each Medicare-covered service.
Inpatient hospital care	For covered admissions, per admission: You pay a $0 or $1,800 copay for each covered hospital stay. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	For covered admissions, per admission: You pay a $0 or $1,625 copay for each covered hospital stay. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Inpatient services in a psychiatric hospital	For Medicare-covered admissions, per admission: You pay a $0 or $2,175 copay for each covered hospital stay. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	For Medicare-covered admissions, per admission: You pay a $0 or $1,800 copay for each covered hospital stay. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Cost	2022 (this year)	2023 (next year)
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic procedures and tests	You pay $0 or 20% of the total cost for each Medicare-covered service. If you are eligible for full Medicare cost sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $0 copay for each Medicare-covered spirometry test for members with a diagnosis of COPD. You pay a $0 copay for the removal of abnormal tissue and/or polyps during a colonoscopy performed as a preventive screening for colorectal cancer. You pay $0 or 20% of the total cost for all other Medicare-covered diagnostic procedures and tests. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital observation	You pay a $0 or $120 copay for outpatient observation services when you enter observation status through an emergency room. You pay $0 or 20% of the total cost for outpatient observation services when you enter observation status through an outpatient facility. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay $0 or 20% of the total cost for outpatient observation services when you enter observation status through an emergency room. You pay $0 or 20% of the total cost for outpatient observation services when you enter observation status through an outpatient facility. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Cost	2022 (this year)	2023 (next year)
Services to treat kidney disease and conditions - Kidney disease education services	You pay $0 or 20% of the total cost for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $0 copay for each Medicare-covered service.
Skilled nursing facility (SNF) care	For Medicare-covered admission per benefit period: You pay a $0 or $0 copay per day, for days 1 to 20 and $184 copay per day, for days 21 to 100 for Medicare-covered skilled nursing facility care. Beyond day 100: You are responsible for all costs. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	For Medicare-covered admission per admission: You pay a $0 or $0 copay per day, for days 1 to 20 and $196 copay per day, for days 21 to 100 for Medicare-covered skilled nursing facility care. Beyond day 100: You are responsible for all costs. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.
Special Supplemental Benefits for Chronically Ill (SSBCI) - Assistive Devices Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify. You must meet eligibility guidelines for the following plan benefits.	Assistive devices are <u>not</u> covered.	Assistive Devices: You pay a $0 copay. If eligible, you may receive up to $125 each calendar quarter to purchase items on a plan approved list of assistive devices. At the end of each calendar quarter, unused benefit dollars do not roll over to the next period.

Cost	2022 (this year)	2023 (next year)
Special Supplemental Benefits for Chronically Ill (SSBCI) - Grocery Delivery **Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify.**	Grocery Delivery: You pay a $0 copay. If eligible, you may receive a pre-paid membership to the plan's contracted grocery delivery service vendor and up to $50 a month to use on plan-approved grocery items. There is a minimum order limit of $35 per delivery. At the end of the month, any unused benefit dollars will not carry over.	Grocery Delivery is not covered.
Special Supplemental Benefits for Chronically Ill (SSBCI) - Helper Bees Care Concierge Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify. You must meet eligibility guidelines for the following plan benefits.	Helper Bees Care Concierge is not covered.	Helper Bees Care Concierge: You pay a $0 copay. If eligible, your plan provides a monthly allowance of 100 credits for plan-approved services through the plan's contracted vendor. Any unused credits will expire at the end of each month.
Special Supplemental Benefits for Chronically Ill (SSBCI) - Utility Flex Card Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify. You must meet eligibility guidelines for the following plan benefits.	Utility Flex Card is not offered.	Utility Flex Card: You pay a $0 copay. If eligible, the plan offers a prepaid Visa debit card with a limit of $100 per month to help cover the cost of utilities for your home. Any unused Utility Flex Card benefit dollars will expire at the end of each month. The approved utility services for this benefit include: - Electric, gas, sanitary, and water utilities - Landline telephone service - Cable TV service - Certain petroleum expenses

Cost	2022 (this year)	2023 (next year)
Urgently needed services	You pay a $0 or $65 copay for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. Copayment is waived if you are admitted to a hospital within 24 hours.	You pay a $0 or $60 copay for each Medicare-covered service. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. Copayment is waived if you are admitted to a hospital within 24 hours.
Urgently needed services - Worldwide urgent care coverage	You pay a $120 copay for each covered service. Copayment is not waived if you are admitted to a hospital.	You pay a $95 copay for each covered service. Copayment is not waived if you are admitted to a hospital.
"Welcome to Medicare" preventive visit - Medicare-covered EKG following Welcome Visit Preventive Services	You pay $0 or 20% of the total cost for each Medicare-covered EKG. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.	You pay a $0 copay for each Medicare-covered EKG.
Prior Authorizations	The following in-network benefits have a change in prior authorization requirements. • Outpatient mental health care - Non-psychiatric services do(es) not require prior authorization. • Opioid treatment program services do(es) not require prior authorization.	 • Outpatient mental health care - Non-psychiatric services may require prior authorization. • Opioid treatment program services may require prior authorization.

Cost	2022 (this year)	2023 (next year)
	• Physician/Practitioner services, including doctor's office visits- Other healthcare professionals do(es) not require prior authorization. • Physician/Practitioner services, including doctor's office visits - Specialist do(es) not require prior authorization. • Podiatry services do(es) not require prior authorization. • Outpatient mental health care - Psychiatric services do(es) not require prior authorization.	• Physician/Practitioner services, including doctor's office visits- Other healthcare professionals may require prior authorization. • Physician/Practitioner services, including doctor's office visits - Specialist may require prior authorization. • Podiatry services may require prior authorization. • Outpatient mental health care - Psychiatric services may require prior authorization.

Section 1.5 – 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 provided electronically.

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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	The deductible is $480. During this stage, you pay $0 cost sharing for drugs on Tier 1: Preferred Generic Drugs and $0 cost sharing for drugs on Tier 6: Select Care Drugs and the full cost of drugs on Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs, Tier 4: Non-Preferred Drugs, and Tier 5: Specialty Tier until you have reached the yearly deductible. Your deductible amount is either $0 or $99, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Drug Tier 1 - Preferred Generic Drugs:** You pay a $0 copay per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: You pay a $0 copay per prescription for all covered Part D drugs.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)		
	Drug Tier 2 - Generic Drugs: You pay a $5 copay per prescription. **Drug Tier 3 - Preferred Brand Drugs:** You pay a $29 copay per prescription. **Drug Tier 4 - Non-Preferred Drugs:** You pay 50% of the total cost. **Drug Tier 5 - Specialty Tier:** You pay 25% of the total cost. **Drug Tier 6 - Select Care Drugs:** You pay a $0 copay per prescription.	
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 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 drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Changes to your VBID Part D Benefit

Medicare approved Wellcare to provide lower copayments/co-insurance as part of the Value-Based

Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans. For more information about VBID benefits, please contact Member Services.

Description	2022 (this year)	2023 (next year)
Part D Cost-sharing Elimination	Part D cost-sharing elimination is not offered.	Because you qualify for Part D cost-sharing elimination, you pay nothing for all covered Part D drugs.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Wellcare Dual Select (HMO D-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 by December 7, you will automatically be enrolled in our Wellcare Dual Select (HMO D-SNP).

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 plans for 2023 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.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Wellcare Dual Select (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Wellcare Dual Select (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.

- – *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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), 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 and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Oregon, the SHIP is called Oregon Senior Health Insurance Benefits Assistance (SHIBA).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Oregon Senior Health Insurance Benefits Assistance (SHIBA) 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 Oregon Senior Health Insurance Benefits Assistance (SHIBA) at 1-800-722-4134 (TTY users should call 711). You can learn more about Oregon Senior Health Insurance Benefits Assistance (SHIBA) by visiting their website (http://www.oregon.gov/DCBS/SHIBA/pages/index.aspx).

For questions about your Oregon Health Plan (Medicaid) benefits, contact Oregon Health Plan (Medicaid) at 1-800-699-9075 (TTY 711) 8 a.m. - 5 p.m. PT, Monday - Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Oregon Health Plan (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help", also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; 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 Oregon's AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Oregon's AIDS Drug Assistance Program (ADAP), at 1-971-673-0144 (TTY 711) from 8 a.m. - 5 p.m. local time, Monday - Friday.

SECTION 6 Questions?

Section 6.1 – Getting Help from Wellcare Dual Select (HMO D-SNP)

Questions? We're here to help. Please call Member Services at 1-844-867-1156. (TTY only, call 711). We are available for phone calls. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Wellcare Dual Select (HMO D-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 located on our website at www.wellcare.com/trilliumOR. You may also call Member Services to ask us to

mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.wellcare.com/trilliumOR. As a reminder, our website has the most up-to-date information about our provider network (*Provider & 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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 Oregon Health Plan (Medicaid) at 1-800-699-9075. TTY users should call 711 from 8 a.m. - 5 p.m. PT, Monday - Friday.

Do you think Trillium Community Health Plan (Trillium) has treated you unfairly?
Trillium must follow state and federal civil rights laws. It cannot treat people unfairly in any of its programs or activities because of a person's:

- Age
- Gender identity
- Race
- Sexual orientation
- Color
- Marital status
- Religion
- Disability
- Health Status
- National Origin
- Sex

You have a right to enter, exit, and use buildings and services. You have the right to get information in a way you understand. Trillium will make reasonable changes to policies, practices, and procedures by talking with you about your needs.

To report concerns or to get more information, please contact Member Services at **1-541-485-2155**; Toll Free: **1-877-600-5472**; TTY: **1-877-600-5473**, Monday through Friday, 8:00 a.m. to 5:00 p.m. You can leave a message at other times, including weekends and federal holidays. We will return your call the next business day. The call is free.

If you believe you have been discriminated against, you may also contact:

Emily Farrell, *Non-Discrimination Coordinator*
555 International Way, Building B
Springfield, OR 97477
Phone: **1-541-214-3948**
Toll-free: **1-844-867-1156** (TTY **711**)
Email: **emilyann.farrell@TrilliumCHP.com**
Web: **https://wellcare.trilliumadvantage.com/legal/nondiscrimination-notice.html**

You have a right to file a civil rights complaint with these organizations:

U.S. Department of Health and Human Services Office for Civil Rights (OCR)
Web: **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**
Phone: **1-800-368-1019**, **1-800-537-7697** (TDD)
Email: **OCRComplaint@hhs.gov**
Mail: Office for Civil Rights, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

Oregon Health Authority (OHA) Civil Rights
Web: **www.oregon.gov/OHA/OEI**
Phone: **1-844-882-7889**, (TTY **711**)
Email: **OHA.PublicCivilRights@odhsoha.oregon.gov**
Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204

Bureau of Labor and Industries Civil Rights Division
Phone: **1-971-673-0764**
Email: **crdemail@boli.state.or.us**
Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St.,Suite 1045, Portland, OR 97232

You can get this letter in another language, large print, or another way that is best for you. You can also have a language interpreter. Call **1-844-867-1156** (TTY/TDD **711**).

Puede obtener esta carta en otro idioma, en letra grande o en otro formato que sea más conveniente para usted. También puede solicitar servicios de interpretación de idiomas. Llame al **1-844-867-1156** (TTY/TDD **711**).

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-844-867-1156**; TTY: **1-877-600-5473**

Español (Spanish)
ATENCIÓN: Si no habla Inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-867-1156**; TTY: **1-877-600-5473**

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị không nói tiếng Anh, có các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-844-867-1156**; TTY: **1-877-600-5473**

繁體中文 (Chinese)
注意：如果您不會講英語，我們有提供免費的語言協助服務。
請致電 **1-844-867-1156**；TTY：**1-877-600-5473**

Русский (Russian)
ВНИМАНИЕ! Если вы не говорите по-английски, вы можете бесплатно получить помощь переводчика. Позвоните по номеру **1-844-867-1156**; TTY: **1-877-600-5473**

한국어 (Korean)
주의: 영어 외 다른 언어를 사용하시는 분은 무료로 언어 지원 서비스를 이용할 수 있습니다. 전화: **1-844-867-1156**; TTY: **1-877-600-5473**

Українська (Ukrainian)
УВАГА: якщо ви не володієте англійською мовою, вам доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером **1-844-867-1156**; TTY: **1-877-600-5473**

日本語 (Japanese)
注意：英語を話さない方は、無料で言語支援サービスを利用できます。
1-844-867-1156（TTY: **1-877-600-5473**）までお電話ください。

العربية (Arabic):
ملاحظة: إذا كنت لا تجيد التحدث باللغة الإنجليزية، فنحن نوفر لك خدمات مساعدة لغوية مجانية. اتصل بالرقم **1-844-867-1156**؛
الهاتف النصي: **1-877-600-5473**

Română (Romanian)
ATENȚIE: Dacă nu vorbiți limba engleză, aveți la dispoziție gratuit servicii de asistență lingvistică. Apelați numărul de telefon **1-844-867-1156**; TTY: **1-877-600-5473**

ខ្មែរ (Cambodian)
ចំណាំ៖ បុរសិនបើអ្នកមិននិយាយភាសាអង់គ្លេសទេ នោះមានសេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ សម្រាប់អ្នក។ សូមទូរសព្ទទៅលេខ **1-844-867-1156; TTY: **1-877-600-5473**

Afaan Oromoo (Oromo)
XIYYEEFFANNO: Afaan Ingiliffaa hin dubbattu taanan, gargaarsi tajaajiloota afaanii, kan kaffaltii irraa bilisaa siif jira. **1-844-867-1156** irratti bilbila; TTY: **1-877-600-5473**

Deutsch (German)
ACHTUNG: Wenn Sie kein Englisch sprechen, stehen Ihnen kostenlos Sprachdienstleistungen zur Verfügung. Rufen Sie dazu folgende Nummer an: **++1-844-867-1156**; TTY: **++1-877-600-5473**

فارسی(Farsi)
توجه: اگر به زبان انگلیسی صحبت نمی‌کنید، خدمات کمک‌زبانی به صورت رایگان در اختیار شما قرار می‌گیرد. با شماره **1-844-867-1156** تماس بگیرید؛ شماره برای ناشنوایان: **1-877-600-5473**

Français (French)
ATTENTION : si vous ne parlez pas anglais, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le **1-844-867-1156** ; TTY : **1-877-600-5473**.

ภาษาไทย (Thai)
หมายเหตุ: หากคุณใช้ภาษาอังกฤษไม่ได้ เรามีความช่วยเหลือด้านภาษาฟรีพร้อมให้บริการแก่คุณ โทร **1-844-867-1156**; TTY: **1-877-600-5473**