Community HealthFirst™
Medicare Advantage Plans
Offered by COMMUNITY HEALTH PLAN of Washington™

<LetterGenerationDate>

<MemberName>
<MemberAddressLine1>
<MemberAddressLine2>
<MemberCity>, <MemberState> <MemberZipCode>

Member ID: <MemberID>

Effective Date: <EffectiveDateofLISElgiblity> - <EndDateOfLISElgiblity>

## Evidence of Coverage Rider
## for People Who Get Extra Help Paying for Prescription Drugs
## (also called a Low Income Subsidy Rider or LIS Rider)

Please keep this notice - it is part of Community HealthFirst™ MA <PlanName>'s Evidence of Coverage.

Our records show that you qualify for extra help paying for your prescription drug coverage. This means that you will get help paying your monthly premium and prescription drug cost sharing.

As a member of our Plan, you will receive the same coverage as someone who is not getting extra help. Your membership in our Plan will not be affected by the extra help. This also means that you must follow all the rules and procedures in the Evidence of Coverage.

Please see the chart below for a description of your prescription drug coverage:

| Your monthly plan premium is | Your yearly deductible is | Your cost sharing amount for generic/preferred multi-source drugs is no more than | Your cost sharing amount for all other drugs is no more than |
|---|---|---|---|
| $<LISMonthlyPremium>* | $0 | <$0/$1.25/$3.35/15%> (each prescription) | <$0/$3.70/ $8.35/15%> (each prescription) |

* The monthly plan premium does not include any Medicare Part B premium that you may still need to pay. The plan premium you pay has been calculated based on the Plan's premium and the amount of extra help you get.

H5826_OP_EN_030_2018_v_01_Notice_of_LIS Accepted

Please refer to your Evidence of Coverage for more information on paying your plan premium.

You must continue to pay your Medicare Part B premium.

<Insert this statement for LIS members who qualify for the 15% co-insurance amount (LIS Level 4)>
If your co-insurance is 15% or less, the amount you pay per prescription may vary each time you fill a prescription. In addition, if the co-payment amount listed in the Evidence of Coverage is less than the amount listed above, you will pay the co-payment amount listed in the Evidence of Coverage. For example, if the 15% co-insurance for a generic drug is $7.50 and the Evidence of Coverage states the co-payment for a generic drug is $5, you will pay $5 for your generic drugs.

Once the amount both you **and** Medicare pay (as the extra help) reaches $5,000 in a year, your co-payment amount(s) will go down to <$0 per prescription/$3.35 for generic and preferred brand drugs that are multi-source, or $8.35 for all others>.

<Insert this statement for LIS members who have an increased cost (decrease level) in their cost-sharing and premium>
The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you filled prescriptions since this date, you may have been charged less than you should have paid as a member of our plan. In addition, if your premium has increased, you may not have paid enough. If you do owe us money, we will let you know how much. We will send you a bill for the amount due.

<Insert this statement for LIS members who have been LIS eligible and now have a decrease in their cost-sharing and premium (increase level), or for those newly LIS eligible with a retroactive effective date>
The changes to your prescription drug costs begin as of the effective date at the top of this letter. This date may have already passed when you get this letter. If you filled prescriptions or paid premiums since this date, you may have been charged more than you should have paid as a member of our plan. If we owe you money, we will send you a separate letter to let you know how much. We will mail you a check for the amount we owe you.

Medicare or Social Security will periodically review your eligibility to make sure that you still qualify for extra help with your Medicare prescription drug plan costs. Your eligibility for extra help might change if there is a change in your income or resources, if you get married or become single, or you lose Medicaid.

If you have any questions about this notice, please contact the Community HealthFirst™ Customer Service Department at 1-800-942-0247 (TTY Relay: Dial 7-1-1), 8 a.m. to 8 p.m., 7 days a week, or at healthfirst.chpw.org.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-942-0247 (TTY: 7-1-1).

Thank you.

Community Health Plan of Washington is an HMO Plan with a Medicare contract and a contract with the Washington State Medicaid Program. Enrollment in Community Health Plan of Washington depends on contract renewal.

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# 1557 Non Discrimination Notice

Community Health Plan of Washington complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Plan of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Community Health Plan of Washington:

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

If you need these services, contact the Appeals and Grievances Department

If you believe that Community Health Plan of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Appeals and Grievances Department, by mail at 1111 Third Avenue, Suite 400, Seattle WA 98101, by phone at 1-800-942-0247, by fax at 206-613-8984, or by email at appealsgrievances@chpw.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

# 1557 Non Discrimination Notice

Community Health Plan of Washington cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Community Health Plan of Washington no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Community Health Plan of Washington:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
    - Intérpretes de lenguaje de señas capacitados.
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
    - Intérpretes capacitados.
    - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Appeals and Grievances Department (Departamento de reclamos y apelaciones.

Si considera que Community Health Plan of Washington no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Appeals and Grievances Department, por correo en 1111 Third Avenue, Suite 400, Seattle WA 98101, por teléfono al 1-800-942-0247, por fax al 206-613-8984, o por correo electrónico en appealsgrievances@chpw.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Appeals and Grievances Department está a su disposición para brindársela. También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:
U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

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# Multi-Language Insert 2017

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-942-0247 (TTY: 7-1-1).

**Español (Spanish)** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-942-0247 (TTY: 7-1-1).

**繁體中文 (Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-942-0247（TTY：7-1-1）。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-942-0247 (TTY: 7-1-1).

**한국어 (Korean)** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-942-0247 (TTY: 7-1-1) 번으로 전화해 주십시오.

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-942-0247 (телетайп: 7-1-1).

**Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-942-0247 (TTY: 7-1-1).

**Українська (Ukrainian)** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-942-0247 (телетайп: 7-1-1).

**ខ្មែរ (Cambodian)** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-942-0247 (TTY: 7-1-1)។

**日本語 (Japanese)** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-942-0247（TTY: 7-1-1）まで、お電話にてご連絡ください。

**አማርኛ (Amharic)** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-942-0247 (መስማት ለተሳናቸው: 7-1-1).

**Oroomiffa (Oromo/Cushite)** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-942-0247 (TTY: 7-1-1).

**(Arabic)** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-249-0247 (رقم هاتف الصم والبكم: 7-1-1).

**ਪੰਜਾਬੀ (Punjabi)** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-942-0247 (TTY: 7-1-1) 'ਤੇ ਕਾਲ ਕਰੋ।

**Deutsch (German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-942-0247 (TTY: 7-1-1).

**ພາສາລາວ (Lao/Laotian)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-942-0247 (TTY: 7-1-1).