Today's Options Premier Plus 250A (PFFS) *offered by* American Progressive Life & Health Insurance Company of New York, Inc.

Annual Notice of Changes for 2017

You are currently enrolled as a member of Today's Options Premier Plus 150A (PFFS). 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

- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- We must provide information in a way that works for you (in languages other than English, Braille, and Large Print or other alternate formats, etc.).
- 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 Today's Options Premier Plus 250A (PFFS)

- Today's Options® PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PFFS depends on contract renewal.
- When this booklet says "we," "us," or "our," it means American Progressive Life & Health Insurance Company of New York, Inc.When it says "plan" or "our plan," it means Today's Options Premier Plus 250A (PFFS).

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 2.4 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 2.5 for information about changes to our drug coverage.
- □ **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 stay with Today's Options Premier Plus 250A (PFFS):

If you want to stay with us next year, it's easy - you don't need to do anything.

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, 2017. Look in Section 4.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Today's Options Premier Plus 250A (PFFS) 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 2.1 for details.	$95.00	$106.00
Combined Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services from in-network and out-of-network providers for the rest of the calendar year. (See Section 2.2 for details.)	$3,400.00	$3,400.00
Doctor office visits	Primary care visits: $0.00 per visit Specialist visits: $25.00 per visit	Primary care visits: $0.00 per visit Specialist visits: $25.00 per visit
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.	$350.00 copay for each Medicare-covered hospital stay.	$450.00 copay for each Medicare-covered hospital stay.

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (Standard Cost-Share for a 30-day supply) (See Section 2.5 for details.)	Copayment during the Initial Coverage Stage: Drug Tier 1: $5.00 Drug Tier 2: $10.00 Drug Tier 3: $45.00 Drug Tier 4: $85.00 Drug Tier 5: 33%	Copayment during the Initial Coverage Stage: Drug Tier 1: $5.00 Drug Tier 2: $10.00 Drug Tier 3: $45.00 Drug Tier 4: $85.00 Drug Tier 5: 33%
Part D prescription drug coverage (Preferred Cost-Share for a 30-day supply) (See Section 2.5 for details.)	Copayment during the Initial Coverage Stage: Drug Tier 1: $0.00 Drug Tier 2: $5.00 Drug Tier 3: $35.00 Drug Tier 4: $75.00 Drug Tier 5: 33%	Copayment during the Initial Coverage Stage: Drug Tier 1: $0.00 Drug Tier 2: $5.00 Drug Tier 3: $35.00 Drug Tier 4: $75.00 Drug Tier 5: 33%

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2017, our plan name will change from Today's Options Premier Plus 150A (PFFS) to Today's Options Premier Plus 250A (PFFS).

You shall receive a separate mailing that will contain your Member ID Card.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – 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.)	$95.00	$106.00

- 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 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 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)
Combined Maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers, count toward your combined maximum out-of-pocket amount. Your plan premium and your	$3,400.00	$3,400.00 Once you have paid $3,400.00 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part

Cost	2016 (this year)	2017 (next year)
costs for prescription drugs do not count toward your combined maximum out-of-pocket amount.		B services from in-network and out-of-network providers for the rest of the calendar year.

Section 2.3 – 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 pharmacies 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 Pharmacy Directory is located on our website at www.TodaysOptions.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2017 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.4 – 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 *2017 Evidence of Coverage.*

	2016 (this year)	2017 (next year)
Abdominal Aortic Aneurysm Screening	**Out-of-Network** 20% of the cost for Medicare-covered screening ultrasound for abdominal aortic aneurysm preventive screenings.	**Out-of-Network** 25% of the cost for Medicare-covered screening ultrasound for abdominal aortic aneurysm preventive screenings.
Annual Wellness Visit	**Out-of-Network** 20% of the cost for this preventative service.	**Out-of-Network** 25% of the cost for this preventative service.

	2016 (this year)	2017 (next year)
Bone Mass Measurement	**Out-of-Network** 20% of the cost for Medicare-covered bone mass measurement.	**Out-of-Network** 25% of the cost for Medicare-covered bone mass measurement.
Breast Cancer Screening	**Out-of-Network** 20% of the cost for Medicare-covered breast exams. 20% of the cost for Medicare-covered mammography screening.	**Out-of-Network** 25% of the cost for Medicare-covered breast exams. 25% of the cost for Medicare-covered mammography screening.
Cardiac Rehabilitation Services	**Out-of-Network** 20% of the cost for Medicare-covered Cardiac Rehabilitation Services.	**Out-of-Network** 25% of the cost for Medicare-covered Cardiac Rehabilitation Services.
Cardiovascular Disease Risk Reduction Visit	**Out-of-Network** 20% of the cost for Medicare-covered intensive therapy to reduce the risk of cardiovascular disease.	**Out-of-Network** 25% of the cost for Medicare-covered intensive therapy to reduce the risk of cardiovascular disease.
Cardiovascular Disease Testing	**Out-of-Network** 20% of the cost for Medicare-covered cardiovascular screening blood test.	**Out-of-Network** 25% of the cost for Medicare-covered cardiovascular screening blood test.
Cervical and Vaginal Cancer Screening	**Out-of-Network** 20% of the cost for Medicare-covered pap smears and pelvic exams.	**Out-of-Network** 25% of the cost for Medicare-covered pap smears and pelvic exams.
Chiropractic Services	**Out-of-Network** 20% of the cost for each Medicare-covered service.	**Out-of-Network** 25% of the cost for each Medicare-covered service.

	2016 (this year)	2017 (next year)
Colorectal Cancer Screening	**Out-of-Network** 20% of the cost for Medicare-covered colorectal screenings.	**Out-of-Network** 25% of the cost for Medicare-covered colorectal screenings.
Depression Screening	**Out-of-Network** 20% of the cost for Medicare-covered screening.	**Out-of-Network** 25% of the cost for Medicare-covered screening.
Diabetes Screening	**Out-of-Network** 20% of the cost for Medicare-covered Diabetes screenings.	**Out-of-Network** 25% of the cost for Medicare-covered Diabetes screenings.
Diabetes Self-Management Training, Diabetic Services and Supplies	**Out-of-Network** 20% of the cost for Medicare-covered Therapeutic shoes or inserts. 20% of the cost for Medicare-covered Diabetes monitoring supplies. 20% of the cost for Medicare-covered Diabetes self-management training.	**Out-of-Network** 25% of the cost for Medicare-covered Therapeutic shoes or inserts. 25% of the cost for Medicare-covered Diabetes monitoring supplies. 25% of the cost for Medicare-covered Diabetes self-management training.
Durable Medical Equipment and Related Supplies	**Out-of-Network** 20% of the cost for Medicare-covered durable medical equipment.	**Out-of-Network** 25% of the cost for Medicare-covered durable medical equipment.

	2016 (this year)	2017 (next year)
Health and Wellness Education Programs	**In-Network** Not Available	**In-Network** $0.00 copay for Enhanced Disease Management benefit.
	Out-of-Network Not Available	**Out-of-Network** 25% of the cost for Enhanced Disease Management benefit.
	20% of the cost for Nursing Hotline benefit.	25% of the cost for Nursing Hotline benefit.
Hearing Services	**Out-of-Network** 20% of the cost for annual hearing exam.	**Out-of-Network** 25% of the cost for annual hearing exam.
	20% of the cost for each Medicare-covered basic hearing and balance exam performed by a specialist, audiologist or other provider that is not a primary care doctor.	25% of the cost for each Medicare-covered basic hearing and balance exam performed by a specialist, audiologist or other provider that is not a primary care doctor.
HIV Screening	**Out-of-Network** 20% of the cost for Medicare-covered HIV screenings.	**Out-of-Network** 25% of the cost for Medicare-covered HIV screenings.
Home Health Agency Care	**Out-of-Network** 20% of the cost for each Medicare-covered home health visit.	**Out-of-Network** 25% of the cost for each Medicare-covered home health visit.
Immunizations	**Out-of-Network** 20% of the cost for Medicare-covered Flu, Hepatitis, Pneumonia, and other Medicare-covered vaccines/immunizations and their administration.	**Out-of-Network** 25% of the cost for Medicare-covered Flu, Hepatitis, Pneumonia, and other Medicare-covered vaccines/immunizations and their administration.

	2016 (this year)	2017 (next year)
Inpatient Hospital Care	**In-Network** $350.00 copay for each Medicare-covered hospital stay.	**In-Network** $450.00 copay for each Medicare-covered hospital stay.
Inpatient Mental Health Care	**In-Network** $350.00 copay for each Medicare-covered hospital stay.	**In-Network** $450.00 copay for each Medicare-covered hospital stay.
Medical Nutritional Therapy	**Out-of-Network** 20% of the cost for Medicare-covered medical nutritional therapy.	**Out-of-Network** 25% of the cost for Medicare-covered medical nutritional therapy.
Medicare Part B Prescription Drugs	**Out-of-Network** 20% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare). 20% of the cost for Part B-covered chemotherapy drugs.	**Out-of-Network** 25% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare). 25% of the cost for Part B-covered chemotherapy drugs.
Obesity Screening and Therapy to Promote Sustained Weight Loss	**Out-of-Network** 20% of the cost for Medicare-covered behavioral counseling to promote sustained weight loss.	**Out-of-Network** 25% of the cost for Medicare-covered behavioral counseling to promote sustained weight loss.
Outpatient Diagnostic Tests, Therapeutic Services and Supplies	**Out-of-Network** 20% of the cost for Medicare-covered Blood Services. 20% of the cost for Medicare-covered non-radiologic diagnostic procedures and tests. 20% of the cost for Medicare-covered diagnostic	**Out-of-Network** 25% of the cost for Medicare-covered Blood Services. 25% of the cost for Medicare-covered non-radiologic diagnostic procedures and tests. 25% of the cost for Medicare-covered diagnostic

	2016 (this year)	2017 (next year)
	radiology services (not including X-rays). 20% of the cost for Medicare-covered lab services. 20% of the cost for Medicare-covered medical supplies. 20% of the cost for Medicare-covered therapeutic radiology services. 20% of the cost for Medicare-covered X-rays.	radiology services (not including X-rays). 25% of the cost for Medicare-covered lab services. 25% of the cost for Medicare-covered medical supplies. 25% of the cost for Medicare-covered therapeutic radiology services. 25% of the cost for Medicare-covered X-rays.
Outpatient Mental Health Care	**Out-of-Network** 20% of the cost for each Medicare-covered individual therapy visit provided by a non-physician. 20% of the cost for each Medicare-covered group therapy visit provided by a non-physician. 20% of the cost for each Medicare-covered individual therapy visit with a psychiatrist. 20% of the cost for each Medicare-covered group therapy visit with a psychiatrist.	**Out-of-Network** 25% of the cost for each Medicare-covered individual therapy visit provided by a non-physician. 25% of the cost for each Medicare-covered group therapy visit provided by a non-physician. 25% of the cost for each Medicare-covered individual therapy visit with a psychiatrist. 25% of the cost for each Medicare-covered group therapy visit with a psychiatrist.
Outpatient Rehabilitation Services	**Out-of-Network** 20% of the cost for each Medicare-covered Occupational Therapy visit. 20% of the cost for each Medicare-covered Physical	**Out-of-Network** 25% of the cost for each Medicare-covered Occupational Therapy visit. 25% of the cost for each Medicare-covered Physical

	2016 (this year)	2017 (next year)
	and/or Speech and Language Therapy visit.	and/or Speech and Language Therapy visit.
Outpatient Substance Abuse Services	**Out-of-Network** 20% of the cost for Medicare-covered individual therapy visits. 20% of the cost for Medicare-covered group therapy visits.	**Out-of-Network** 25% of the cost for Medicare-covered individual therapy visits. 25% of the cost for Medicare-covered group therapy visits.
Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers	**Out-of-Network** 20% of the cost for each Medicare-covered ambulatory surgical center visit. 20% of the cost for each Medicare-covered outpatient hospital facility visit.	**Out-of-Network** 25% of the cost for each Medicare-covered ambulatory surgical center visit. 25% of the cost for each Medicare-covered outpatient hospital facility visit.
Partial Hospitalization Services	**Out-of-Network** 20% of the cost for Medicare-covered partial hospitalization program services.	**Out-of-Network** 25% of the cost for Medicare-covered partial hospitalization program services.
Podiatry Services	**Out-of-Network** 20% of the cost for each Medicare-covered visit.	**Out-of-Network** 25% of the cost for each Medicare-covered visit.
Prostate Cancer Screening Exams	**Out-of-Network** 20% of the cost for Medicare-covered prostate cancer screening exams.	**Out-of-Network** 25% of the cost for Medicare-covered prostate cancer screening exams.
Prosthetic Devices and Related Supplies	**Out-of-Network** 20% of the cost for each Medicare-covered prosthetic or orthotic device or supply, including replacement or repairs of such devices and	**Out-of-Network** 25% of the cost for each Medicare-covered prosthetic or orthotic device or supply, including replacement or repairs of such devices and

	2016 (this year)	2017 (next year)
	supplies, which includes parenteral /enteral nutrition.	supplies, which includes parenteral /enteral nutrition.
Pulmonary Rehabilitation Services	**Out-of-Network** 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services.	**Out-of-Network** 25% of the cost for Medicare-covered Pulmonary Rehabilitation Services.
Screening and Counseling to Reduce Alcohol Misuse	**Out-of-Network** 20% of the cost for Medicare-covered screening and counseling to reduce alcohol misuse.	**Out-of-Network** 25% of the cost for Medicare-covered screening and counseling to reduce alcohol misuse.
Screening for lung cancer with low dose computed tomography (LDCT)	**In-Network** Not Available	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.
	Out-of-Network Not Available	**Out-of-Network** 25% of the cost for medicare-covered screening.
Screening for Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs	**Out-of-Network** 20% of the cost for Medicare-covered screening for sexually transmitted infections (STIs) and counseling to prevent STIs.	**Out-of-Network** 25% of the cost for Medicare-covered screening for sexually transmitted infections (STIs) and counseling to prevent STIs.
Services to Treat Kidney Disease and End Stage Renal Disease	**Out-of-Network** 20% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.	**Out-of-Network** 25% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.

	2016 (this year)	2017 (next year)
	20% of the cost for Medicare-covered kidney disease education services.	25% of the cost for Medicare-covered kidney disease education services.
Smoking and Tobacco use Cessation	**Out-of-Network** 20% of the cost for Medicare-covered smoking cessation counseling services.	**Out-of-Network** 25% of the cost for Medicare-covered smoking cessation counseling services.
Vision Care	**Out-of-Network** 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. 20% of the cost for Medicare-covered vision exams. 20% of the cost for annual routine vision exam (refractions). 20% of the cost for Medicare-covered Glaucoma screening.	**Out-of-Network** 25% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. 25% of the cost for Medicare-covered vision exams. 25% of the cost for annual routine vision exam (refractions). 25% of the cost for Medicare-covered Glaucoma screening.
"Welcome to Medicare" Preventive Visit	**Out-of-Network** 20% of the cost for this preventative service.	**Out-of-Network** 25% of the cost for this preventative service.

Section 2.5 – 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 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 Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of 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.

If you received a formulary exception in 2016, depending on the drug, most of the formulary exceptions may be granted for a minimum of 1 year beginning on the date the formulary exception was originally approved.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by October 1, 2016 please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services 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*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2016 (this year)	2017 (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.** 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 for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: Tier 1: Standard cost-sharing: You pay $5.00 per prescription Preferred cost-sharing: You pay: $0.00 per prescription. Tier 2: Standard cost-sharing: You pay $10.00 per prescription Preferred cost-sharing: You pay: $5.00 per prescription. Tier 3: Standard cost-sharing: You pay $45.00 per prescription Preferred cost-sharing: You pay: $35.00 per prescription. Tier 4: Standard cost-sharing: You pay $85.00 per prescription Preferred cost-sharing: You pay: $75.00 per prescription.	Your cost for a one-month supply at a network pharmacy: Tier 1: Standard cost-sharing: You pay $5.00 per prescription Preferred cost-sharing: You pay: $0.00 per prescription. Tier 2: Standard cost-sharing: You pay $10.00 per prescription Preferred cost-sharing: You pay: $5.00 per prescription. Tier 3: Standard cost-sharing: You pay $45.00 per prescription Preferred cost-sharing: You pay: $35.00 per prescription. Tier 4: Standard cost-sharing: You pay $85.00 per prescription Preferred cost-sharing: You pay: $75.00 per prescription.

Stage	2016 (this year)	2017 (next year)
	Tier 5: Standard cost-sharing: You pay 33% per prescription Preferred cost-sharing: You pay: 33% per prescription. _____ Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	Tier 5: Standard cost-sharing: You pay 33% per prescription Preferred cost-sharing: You pay: 33% per prescription. _____ Once your total drug 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 Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Other Changes

Cost	2016 (this year)	2017 (next year)
Emergency Care	If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for the emergency room visit. If you have surgery as an outpatient within 24 hours for the same condition, the copayment is waived for the emergency room visit and the applicable outpatient surgical cost share applies. If you receive emergency care at an out-of-network hospital and need	If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for the emergency room visit. If you have surgery as an outpatient within 24 hours for the same condition, the copayment is waived for the emergency room visit and the applicable outpatient surgical cost share applies.

Cost	2016 (this year)	2017 (next year)
	inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized. Currently, Medicare and Medicare Advantage programs do not recognize Free Standing Emergency Rooms, which are distinct and separate from hospitals, as providers qualified to furnish emergency services. Services received at freestanding ERs will not be covered by Today's Options Premier Plus 250A (PFFS) and will be the financial responsibility of the member.
Urgently Needed Care	For both in and out of network benefits, in addition to the cost-share	In addition to the cost-share above, there will be a copay and/or

Cost	2016 (this year)	2017 (next year)
	above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, Part D outpatient prescription drugs, and Medicare Part B prescription drugs, as described in this Benefit Chart. If you are admitted to the inpatient acute level of care from an Urgent Care Center, the above cost shares are waived and the Inpatient Hospital care cost shares applies.	coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, Part D prescription drugs, and Medicare Part B prescription drugs, as described in this Benefit Chart. If you are admitted to the inpatient acute level of care from an Urgent Care Center, the above cost shares are waived and the Inpatient Hospital care cost shares applies. Urgently needed care may be received from both contracted and non-contracted urgent care centers, as long as the urgent care center accepts Medicare. Services received from an urgent care center that does not accept Medicare will be the financial responsibility of the member.
Ambulance Services	Prior Authorization (approval in advance) required for non-emergent	Prior Authorization not required.

Cost	2016 (this year)	2017 (next year)
	ambulance transports to be covered.	
Outpatient rehabilitation services	Not Available	For both in and out of network benefits, if these services are provided in your home, then the home health cost-share applies instead of the above. Outpatient Rehabilitation Services will take the Outpatient Rehabilitation Cost share, regardless of the specialty of the provider. There will also be a copayment and/or coinsurance for Medically Necessary Medicare-Covered Services for Durable Medical Equipment, prosthetic devices, certain medical supplies, Part D prescription drugs and Medicare Part B prescription drugs, where applicable.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Today's Options Premier Plus 250A (PFFS)

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 2017.

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 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 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 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.**

As a reminder, American Progressive Life & Health Insurance Company of New York, Inc. 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 Today's Options Premier Plus 250A (PFFS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Today's Options Premier Plus 250A (PFFS).
- 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 this (phone numbers are in Section 8.1 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 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, 2017.

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, those who have or are leaving employer coverage, 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, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. 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.

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. The name, phone number and Website for the State Health Insurance Assistance Program in your state are located in Appendix A of your *Evidence of Coverage*.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); Or
  - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Your state has a program called State Health Insurance Assistance Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Appendix A of your *Evidence of Coverage*).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through your state specific ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state specific ADAP (the name and phone numbers for this organization are located in Appendix A of your *Evidence of Coverage*).

SECTION 8 Questions?

Section 8.1 – Getting Help from Today's Options Premier Plus 250A (PFFS)

Questions? We're here to help. Please call Member Services at (866) 568-8921. (TTY only, call 711.) We are available for phone calls seven days a week from 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 Today's Options Premier Plus 250A (PFFS). 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.TodaysOptions.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 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 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.

Discrimination is Against the Law

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today's Options® PFFS, and Today's Options® PPO (hereinafter, the Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids 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 Civil Rights Coordinator.

If you believe that the Plan 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: Civil Rights Coordinator, Your Plan Name, P.O. Box 742608, Houston, Texas 77274, c/o Appeals and Grievances, 1-866-422-1690 (TTY users call 711), Fax: 1-800-817-3516, Email: AGMailbox@UniversalAmerican.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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, 1-800-537-7697 (TDD).

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

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711).

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 1-888-736-7442 (TTY: 711)。

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-736-7442 (телетайп: 711).

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-736-7442 (ATS: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-736-7442 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-736-7442 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-736-7442 (رقم هاتف الصم والبكم :711).

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-736-7442 (TTY: 711).

Yiddish:
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-888-736-7442 (TTY: 711).

Bengali:
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরষবা উপলব্ধ আছ। ফোন করুন ১-888-736-7442 (TTY: 711)।

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں 1-888-736-7442 (TTY: 711). کال کریں ۔

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-736-7442 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-736-7442 (TTY: 711).

Greek:
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-736-7442 (TTY: 711).

Albanian:
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-736-7442 (TTY: 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-736-7442 (TTY: 711) पर कॉल करें।