Capital Health Plan℠

An Independent Licensee of the Blue Cross and Blue Shield Association

CAPITAL HEALTH PLAN **RETIREE ADVANTAGE** (HMO)

2019 Annual Notice of Changes

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Capital Health Plan Retiree Advantage (HMO) offered by Capital Health Plan

Annual Notice of Changes for 2019

You are currently enrolled as a member of Capital Health Plan Retiree Advantage. There will be some changes to the plan's costs and benefits for plan years beginning in 2019. *This booklet tells about the changes.*

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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?

- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ 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 want to **keep** Capital Health Plan Retiree Advantage, you don't need to do anything. You should check with your former employer's benefits administrator to see if they have other requirements.
- To change to a **different plan** that may better meet your needs, you may be able to switch plans between October 15 and March 31. Check with your former employer's benefits administrator to see when their open enrollment is scheduled.

Additional Resources

- Please contact our Member Services number at 850-523-7441 or 1-877-247-6512 for additional information. (TTY users should call 850-383-3534 or 1-877-870-8943.) Hours are 8:00 a.m. to 8:00 p.m., seven days a week between October 1 and March 31 and 8:00 a.m. to 8:00 p.m., Monday through Friday, between April 1 and September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. to 8:00 p.m,
- This document may be available in other formats such as Braille and large print. If you need plan information in another format please contact Member Services at the numbers above.
- Member Services has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).
- **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.

About Capital Health Plan Retiree Advantage

- Capital Health Plan Retiree Advantage is an HMO plan with a Medicare contract. Enrollment in Capital Health Plan Retiree Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Capital Health Plan. When it says "plan" or "our plan," it means Capital Health Plan Retiree Advantage.

Summary of Important Costs for 2019

The table below compares the costs for plan years beginning in 2018 and plan years beginning in 2019 for Capital Health Plan Retiree Advantage in several important areas. **Please note this is only a summary of changes**. You may request a written copy of the Evidence of Coverage to see if other benefit of cost changes affect you or visit our website www.capitalhealth/Medicare.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	Please contact your former employer's benefits administrator for information about your plan premium.	Please contact your former employer's benefits administrator for information about your plan premium.
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.)	Please see your group's Schedule of Copayments for your maximum out-of- pocket amount.	Please see your group's Schedule of Copayments for your maximum out-of- pocket amount.
Doctor office visits	Primary care visits: Please see your group's Schedule of Copayments for your primary care visit cost sharing. Specialist visits: Please see your group's Schedule of Copayments for your specialist visit cost sharing.	Primary care visits: Please see your group's Schedule of Copayments for your primary care visit cost sharing. Specialist visits: Please see your group's Schedule of Copayments for your specialist visit cost sharing.

Cost	2018 (this year)	2019 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Please see your group's Schedule of Copayments for your inpatient hospital stay cost sharing.	Please see your group's Schedule of Copayments for your inpatient hospital cost sharing.
Part D prescription drug coverage (See Section 1.6 for details.)	Please see your group's Schedule of Copayments for your Part D prescription drug cost sharing.	Please see your group's Schedule of Copayments for your Part D prescription drug cost sharing.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Please contact your former employer's benefits administrator for information about your plan premium.	Please contact your former employer's benefits administrator for information about your plan premium.

- 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 enroll in Medicare prescription drug coverage in the future.
- 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 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) 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.	Please see your group's Schedule of Copayments for your maximum out-of- pocket amount. Once you have paid your maximum out-of-pocket amount 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.	Please see your group's Schedule of Copayments for your maximum out-of- pocket amount. Once you have paid your maximum out-of-pocket amount 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 Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.capitalhealth.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.capitalhealth.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. For details about the coverage and costs please review your group's Schedule of Copayments and see Chapter 4, *Medical Benefits Chart (what is covered and what you pay),* in your *2019 Evidence of Coverage.*

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." You may request a copy of our Drug List or visit our website www.capitalhealth/Medicare.

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.
    - 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 the plan year or the first 90 days of membership to avoid a gap in

therapy. (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 requested and were granted a formulary exception this year, this exception is valid only through the end of the year. If you would like to receive a formulary exception again next year a new request will need to be submitted.

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. Because you receive "Extra Help" and haven't received this insert, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 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

	2018 (this year)	2019 (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*.

	2018 (this year)	2019 (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 that provides standard cost-sharing. 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 filled at a network pharmacy with standard cost-sharing: **See your group's Schedule of Copayments for prescription drug cost-sharing.** Once your total drug costs have reached $3,750 for plan years beginning in 2018, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **See your group's Schedule of Copayments for prescription drug cost-sharing.** Once your total drug costs have reached $3,820 for plan years beginning in 2019, 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 2 Administrative Changes

Cost	2018 (this year)	2019 (next year)
The following services did not require prior authorization (authorization from the plan) in 2018. These services will require prior authorization in 2019. Home Health Services, Therapeutic Radiological Services	Prior authorization was not required.	Prior authorization is required.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Capital Health Plan Retiree Advantage

To stay in our plan you don't need to do anything. You should check with your former employer's benefits administrator for their annual open enrollment procedures.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change 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, read *Medicare & You*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://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, Capital Health Plan offers other Medicare health 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 Capital Health Plan Retiree Advantage. **You must also contact your former employer's benefits administrator to disenroll.**
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Capital Health Plan Retiree Advantage. **You must also contact your former employer's benefits administrator to disenroll.**
- To **change to Original Medicare without a prescription drug plan**, you must:
    - Contact your former employer's benefits administrator to disenroll.

SECTION 4 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 March 31, or during your group's annual open enrollment period. **You should check with your former employer's benefits administrator for their annual open enrollment procedures and deadlines.**

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, and don't like your plan choice, you can switch to Original Medicare between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

You should check with your former employer's benefits administrator or Capital Health Plan Member Services for additional times during which you can make a change.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida, the SHIP is called SHINE (Serving Health Insurance Needs of Elders).

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance

counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 1-800-963-5337 (TTY 1-800-955-8770). You can learn more about SHINE by visiting their website (www.floridashine.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida Department of Health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your local County Health Department and speak with an ADAP staff member or call the Florida HIV/AIDS Hotline at 1-800-352-2437 (TTY 1-888-503-7118).

SECTION 7 Questions?

Section 7.1 – Getting Help from Capital Health Plan Retiree Advantage

- Questions? We're here to help. Please call Member Services at 850-523-7441 or 1-877-247-6512. (TTY only, call 850-383-3534 or 1-877-870-8943). We are available for phone calls 8:00 a.m. to 8:00 p.m., seven days a week between October 1 and March 31 and 8:00 a.m. to 8:00 p.m., Monday through Friday, between April 1 and September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. to 8:00 p.m.

Read your 2019 *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 plan years beginning in 2019. For details, look in the 2019 *Evidence of Coverage* for Capital Health Plan Retiree Advantage and your group's Schedule of Copayments. 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.capitalhealth.com/Medicare. 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 7.2 – 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 (https://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 https://www.medicare.gov and click on "Find health & drug plans").

Read *Medicare & You*

You can read the *Medicare & You* 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 (https://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.