CAPITAL HEALTH PLAN
ADVANTAGE PLUS (HMO)

2022 Annual Notice of Changes

H5938_DP1711_M2021

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

Annual Notice of Changes for 2022

You are currently enrolled as a member of Capital Health Plan Advantage Plus. 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.**

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 2.1 and 2.5 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?

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

- 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 2022 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. and click the "dashboards" link in the middle of the second note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including specialist you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 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/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 4.2 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 don't join another plan by December 7, 2021 you will be enrolled in Capital Health Plan Advantage Plus.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

    - If you **don't join another plan by December 7, 2021**, you will be enrolled in Capital Health Plan Advantage Plus.

    - If you **join another plan by December 7, 2021**, your new coverage will start on **January 1, 2022.** You will be automatically disenrolled from your current plan.

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.

- 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 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Capital Health Plan Advantage Plus

- 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 Advantage Plus.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Capital Health Plan Advantage Plus in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.capitalhealth.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Benefit	2021 (this year)	2022 (next year)
Monthly plan premium* See Section 1.1 for details.	$35.00	$31.00
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.)	$3,400	$3,400
Doctor office visits	Primary care visits: $10 per visit Specialist visits: $40 per visit	Primary care visits: $10 per visit Specialist visits: $40 per visit

Benefit	2021 (this year)	2022 (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.	You pay $250 per day for days 1 through 5 You pay nothing per day for days 6 and beyond $1,250 out-of-pocket limit every stay.	You pay $250 per day for days 1 through 5 You pay nothing per day for days 6 and beyond $1,250 out-of-pocket limit every stay.

Benefit	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: There is no deductible Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $3 for a one month (30-day) supply • Drug Tier 2: $7 for a one month (30-day) supply • Drug Tier 3: $45 for a one month (30-day) supply • Drug Tier 4: $95 for a one month (30-day) supply • Drug Tier 5: 30% coinsurance for a one-month (30-day) supply • Select Care Drugs $0	Deductible: There is no deductible Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $3 for a one month (30-day) supply • Drug Tier 2: $7 for a one month (30-day) supply • Drug Tier 3: $45 for a one month (30-day) supply • Drug Tier 4: $95 for a one month (30-day) supply • Drug Tier 5: 33% coinsurance for a one-month (30-day) supply • Select Care Drugs $0

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Advantage Plus in 2022

If you do nothing to change your Medicare coverage by December 7, 2021 we will automatically enroll you in our Capital Health Plan Advantage Plus plan. This means starting January 1, 2022, you will be getting your medical and prescription drug coverage through Capital Health Plan Advantage Plus plan. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between January 1 and March 31. You can also change plans between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Capital Health Plan Advantage Plus and the benefits you will have on January 1, 2022 as a member of Capital Health Plan Advantage Plus.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	**2021 (this year)**	**2022 (next year)**
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$35.00	$31.00

- 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.

	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your	$3,400	No change for upcoming benefit year Once you have paid $3,400 out-of-pocket for covered Part A and Part B

	2021 (this year)	2022 (next year)
maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – 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 2022 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, we must 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 2.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated 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 2022 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Medical Benefit	**2021 (this year)**	**2022 (next year)**
Your Choice Card	N/A	A supplemental spend debit card in the amount of $400 per year to help pay towards Dental Expenses, Over the Counter Items, and Hearing Aids
Diabetic Supplies	You pay $0 for preferred manufacturer supplies such as Ascensia and Lifescan and 20% for Dexcom and Freestyle continuous glucose monitors	You pay $0 for preferred manufacturer supplies such as Ascensia and Lifescan and 20% for Dexcom and Freestyle continuous glucose monitors

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessment

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” You may request a copy of our Drug list or visit our website www.capitalhealth.com/Medicare. **You can get a *complete* Drug List** by calling Member Services (see the back cover).

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 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.

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.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month’s supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To

learn more about changes we may make to the Drug List, see Chapter 5, section 6 of the Evidence of Coverage.)

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 receive "Extra Help" and haven't received this insert by September 30, 2021, 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 more information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*, which is located on our website at www.capitalhealth.com/Medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.)

Changes to the Deductible Stage

	2021 (this year)	2022 (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*.

	2021 (this year)	2022 (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 cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1:** You pay $3 per prescription **Tier 2:** You pay $7 per prescription	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1:** You pay $3 per prescription **Tier 2:** You pay $7 per prescription

	2021 (this year)	2022 (next year)
your prescription at a network pharmacy that provides standard cost-sharing. For more 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*.	**Tier 3:** You pay $45 per prescription **Tier 4:** You pay $95 per prescription **Tier 5:** You pay 30% of the total cost	**Tier 3:** You pay $45 per prescription **Tier 4:** You pay $95 per prescription **Tier 5:** You pay 33% of the total cost
Mail Order- 90 Day supply when you fill your prescriptions using a mail order pharmacy.	**Tier 1**: You pay $0 **Tier 2:** You pay $17.50 **Tier 3:** You pay $112.50 **Tier 4:** You pay $237.50 **Tier 5:** Not available	**Tier 1**: You pay $0 **Tier 2:** You pay $17.50 **Tier 3:** You pay $112.50 **Tier 4:** You pay $237.50 **Tier 5:** Not available

	2021 (this year)	2022 (next year)
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.	**Select Care Drugs** **100 Day Supply $0** Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**Select Care Drugs** **100 Day Supply $0** Once your total drug costs have reached $4,430, 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*.

Stage 3: Coverage Gap Stage	**2021 (this year)**	**2022 (next year)**
During this stage, the plan pays its share of the cost of your drugs and you	Tier 1: You pay $3 Tier 2: You pay $7 **Select Care Drugs $0**	Tier 1: You pay $3 Tier 2: You pay $7 **Select Care Drugs $0**

Stage 3: Coverage Gap Stage	2021 (this year)	2022 (next year)
pay your share of the cost.	You pay 25% of the cost of all other generic and brand name drugs	You pay 25% of the cost of all other generic and brand name drugs

SECTION 3 Administrative Changes

Services	2021 (this year)	2022 (next year)
The following services explain changes for prior authorizations (authorization from the plan) in 2022. Therapeutic Radiological Services Ambulatory Surgical Center	Prior Authorization was required.	Prior Authorization is not required

Section 4 – Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Capital Health Plan Advantage Plus

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 2022.

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 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- --*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. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2022*, call your State Health Insurance Assistance Program SHIP (see Section 5), 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 https://www.medicare.gov/plan-compare. **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 Advantage Plus.
- 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 Advantage Plus.
- 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 7.1 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, 2022.

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, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

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

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at

1-800-963-5337 (TTY 1-800-955-8770). You can learn more about SHINE by visiting their website (www.floridashine.org).

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 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 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 local County Health Department. 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 8 Questions?

Section 8.1 – Getting Help from Capital Health Plan Advantage Plus

- 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.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Capital Health Plan Advantage Plus. 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.capitalhealth.com/Medicare. 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.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 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 (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 2022*

You can read the *Medicare & You 2022* 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.

Nondiscrimination and Accessibility Notice (ACA §1557)

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

Capital Health 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 Member Services at one of the numbers listed below.

If you believe that Capital Health 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:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: **memberservices@chp.org**. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services 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
800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Have a disability? Speak a language other than English? Call to get help for free. 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite.

1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية. أو 1-877-870-8943، 850-383-3534 (TDD/TTY) جهاز الاتصال الهاتفي للصم/الهاتف النصي، 1-877-247-6512

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos Unterstützung zu erhalten. 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

ناتوانی خاصی دارید؟ به زبانی بجز انگل سی صحبت می کن د؟ برای دریافت کمک رایگان با این شماره ها تماس بگ رید. 1-877-247-6512 یا DDT/YTT به شماره 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશ કરતાં અન્ય ભાષા બોલો છો? નિ શુલ્ક મદદ

મેળવવા કૉલ કરો. 1-877-247-6512, TTY/TDD 850-383-3534

અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis? 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 1-877-247-6512, TTY/TDD 850-383-3534 lub 1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：1-877-247-6512； TTY/TDD（**听障人士**）：850-383-3534 **或** 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。1-877-247-6512，**聽障者請使用** TTY/TDD 850-383-3534 **或** 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า?

โทรเพื่อขอความช่วยเหลือฟรี 1-877-247-6512, TTY/TDD

850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí. 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8:00 am – 5:00 pm at 850-383-3311 or 1-877-247-6512. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

Capital Health Plan contact information is located on our website:
https://capitalhealth.com/contact

Approved by Compliance Committee: 8/23/2016; Revised 5/3/17; Revised 11/14/17; Revised 8/21/18;
Revised 7/17/19