# Care N' Care Classic (HMO)
# offered by Care N' Care Insurance Company, Inc.

# Annual Notice of Changes for 2019

You are currently enrolled as a member of Care N' Care Classic (HMO). 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.**

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## 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.
- 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 https://go.medicare.gov/drugprices. 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.

OMB Approval 0938-1051 (Pending OMB Approval)

☐ 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 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 want to **keep** Care N' Care Classic (HMO), you don't need to do anything. You will stay in Care N' Care Classic (HMO).
- 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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Care N' Care Classic (HMO).
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

## Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-877-374-7993 for additional information. (TTY users should call 711). Hours are October 1 - March 31, 8AM – 8PM Central, 7 days a week; April 1 - September 30, 8AM – 8PM Central, Monday through Friday.
- This information is available in a different format, including large print and Spanish. Please call your Healthcare Concierge at the number listed above if you need plan information in another format or language.
- **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 Care N' Care Classic (HMO)

- Care N' Care Insurance is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Care N' Care Insurance Company, Inc. When it says "plan" or "our plan," it means Care N' Care Classic (HMO).

## Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Care N' Care Classic (HMO) 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 separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Monthly plan premium*** <br><br> * Your premium may be higher or lower than this amount. See Section 1.1 for details. | $0 | $0 |
| **Maximum out-of-pocket amounts** <br><br> 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.) | $4,300 | $3,400 |
| **Doctor office visits** | **Primary care visits:** <br> $0 copay per visit <br><br> **Specialist visits:** <br> $25 copay per visit | **Primary care visits:** <br> $0 copay per visit <br><br> **Specialist visits:** <br> $15 copay per visit |
| **Inpatient hospital stays** <br><br> 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**.** | Day 1: $225 per day <br> Days 2-5: $75 per day <br> Days 6-90: $0 per day | Day 1: $225 per day <br> Days 2-5: $75 per day <br> Days 6-90: $0 per day |
| **Part D prescription drug coverage** <br><br> (See Section 1.6 for details.) | Deductible: $0 <br><br> Copayment for a 30-day supply during the Initial Coverage Stage: <br><br> • Drug Tier 1: $0 copay <br> • Drug Tier 2: $10 copay <br> • Drug Tier 3: $43 copay <br> • Drug Tier 4: $95 copay <br> • Drug Tier 5: 33% coinsurance | Deductible: $0 <br><br> Copayment for a 30-day supply during the Initial Coverage Stage: <br><br> • Drug Tier 1: $0 copay <br> • Drug Tier 2: $10 copay <br> • Drug Tier 3: $40 copay <br> • Drug Tier 4: $95 copay <br> • Drug Tier 5: 33% coinsurance |

# *Annual Notice of Changes* for 2019

## Table of Contents

# 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**<br>(You must also continue to pay your Medicare Part B premium.) | $0 | $0 |

- 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 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

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**<br>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. | $4,300 | $3,400<br>Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. |

## Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at https://www.cnchealthplan.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 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 specialist (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 https://www.cnchealthplan.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 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. 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 *2019 Evidence of Coverage.*

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Physician Specialist** | You pay a $25 copay per visit | You pay a $15 copay per visit |
| **Outpatient Diagnostic Procedures, Tests and Lab Services** | You pay a $5 copay for laboratory tests at a provider office/laboratory facility<br><br>You pay a $5 copay for laboratory tests at a outpatient hospital facility<br><br>You pay a $5 copay for diagnostic procedures or tests at a provider office/ laboratory facility<br><br>You pay a $5 copay for diagnostic procedures or tests at a outpatient hospital facility<br><br>You pay a $5 copay for X-Rays | You pay a $0 copay for laboratory tests at a provider office/laboratory facility<br><br>You pay a $0 copay for laboratory tests at a outpatient hospital facility<br><br>You pay a $0 copay for diagnostic procedures or tests at a provider office/laboratory facility<br><br>You pay a $0 copay for diagnostic procedures or tests at a outpatient hospital facility<br><br>You pay a $0 copay for X-Rays |
| **Ambulance Services** | You pay $225 copay for Medicare-covered ground and air ambulance benefits per one-way trip.<br><br>Prior Authorization is required for Non-Emergency transportation | You Pay $225 copay for Medicare-covered ground ambulance benefits per one-way trip.<br><br>You Pay 20% of the cost for Air Transportation<br><br>Prior Authorization is required for Non-Emergency transportation |
| **Outpatient Diagnostic and Therapeutic Radiological Services** | You pay a $200 copay for Stress Echocardiography, Spec Scan, Treadmill Stress Test, Pulminary Function Test, or Sleep study. | You pay a $200 copay for Stress Echocardiography, or Spec Scan.<br><br>You pay a $100 copay for a Treadmill Stress Test, Pulmonary Function Test, or Sleep study. |
| **Meal Benefit** | Meal Benefit is not covered. | You pay $0 copay for two (2) deliveries of 15 meals.<br>This benefit is only eligible to members post discharge of an acute care hospital stay with prior authorization. |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Fitness Benefit** | There is no copay for an unlimited number of visits to a Siver&Fit participating fitness facility. You can switch fitness facilities once per month. | You pay $0 copay for your SilverSneakers® fitness benefit. SilverSneakers® can help you live a healthier, more active life. You have access to certified instructors who lead specially designed group exercise classes. At fitness locations* nationwide you can take classes plus use exercise equipment and other amenities. In addition to SilverSneakers classes offered in fitness classrooms, more than 50 SilverSneakers FLEX® options are available in settings outside traditional fitness locations. SilverSneakers BOOM™ classes, MIND, MUSCLE and MOVE, offer more intense workouts inside fitness locations. SilverSneakers also includes a support network and online resources such as daily exercise videos. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit, or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.<br><br>*At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.<br><br>Tivity Health, SilverSneakers, SilverSneakers FLEX and SilverSneakers BOOM are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018. All rights reserved. |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Dental Services** | **In-Network:** You pay a $0 Copay<br><br>We cover two oral exams (Choice of the following):<br>• Recall Exam - up to 2 per year (ADA Code: D0120)<br>• Comprehensive Exam - One every three years (ADA Code: D0150) | **In-Network:** You pay a $0 Copay for Oral Exams<br><br>We cover clinical oral evaluations (Choice of the following):<br>• Periodic Oral Evaluation- 1 every 6 months (ADA Code: D0120)<br>• Comprehensive Oral Evaluation - One every 36 months (ADA Code: D0150) |
| | **In-Network:** You pay a $0 Copay<br><br>Up to Two Cleanings Per Year:<br>• Routine Cleaning (ADA Code: D1110) | **In-Network:** You pay a $0 Copay for Cleanings<br><br>We Cover:<br>• Prophylaxis - 1 every 6 months (ADA Code: D1110)<br>• Periodontal Scaling and Root Planing, per quadrant - 1 every 12 months (ADA Code: D4341<br>• Periodontal Scaling and Root Planing, 1-3 teeth - 1 every 12 months (ADA Code: D4342) |
| | Denture Adjustments are not Covered | **In-Network:** You pay a $0 Copay<br><br>We cover:<br>• Adjust complete denture - maxillary (ADA Code: D5410)<br>• Adjust complete denture - mandibular (ADA Code: D5411)<br>• Adjust partial denture - maxillary (ADA Code: D5421)<br>• Adjust partial denture - mandibular (ADA Code: D5422) |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Dental Services (continued)** | **In-Network:** You pay a $0 Copay<br><br>One Set of X-Rays from the Choices Below:<br>• Bitewing X-Rays (ADA Codes: D0270/D0272/ D0273/D0274)<br>• Single X-Ray Film (ADA Code: D0220) and up to 3 additional (ADA Code D0230); a total of 4 films per year<br>• Full Mouth X-Rays - limited one every three years (ADA Code D0210) | **In-Network:** You pay a $0 Copay for dental x-rays and radiographs<br><br>We Cover:<br>• Intraoral, complete series (includes bitewings) - 1 every 36 months (ADA Code: D0210)<br>• Intraoral, periapical first film - 1 every 12 months (ADA Code: D0220)<br>• Bitewing, single film - 1 every 12 months (ADA Code: D0270)<br>• Bitewings, two films - 1 every 12 months (ADA Code: D0272)<br>• Bitewings - three films - 1 every 12 months (ADA Code: D0273)<br>• Bitewings, four films - 1 every 12 months (ADA Code: D0274) |
| **Coverage Gap Stage Drug Coverage** | You have no extra coverage for Prescription Drugs in the Coverage Gap Stage | You have coverage for Tier 1 drugs and select respiratory drugs used for the treatment of Chronic Obstructive Pulmonary Disease (COPD) drugs in the Coverage Gap Stage. |
| **Medicare Part B Prescription Drugs** | No step therapy requirements for any drug. | Some drugs may have step therapy requirements. |
| **Optional Supplemental Benefits** | **Dental Coverage:**<br>You can add additional dental coverage through Avesis for an extra $20 per month in premium | **Dental Coverage:**<br>You can add additional dental coverage through FCL Dental for an extra $18 per month in premium.<br><br>See Chapter 4,Section 2.2 in the Evidence of Coverage for full benefit information |

| Cost | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Optional Supplemental Benefits** | **Dental, Vision and Hearing Coverage:** You can add additional coverage for Dental, Vision and Hearing through Avesis for an extra $35 per month in premium | No Coverage Offered as an extra benefit. |
| **Routine Eye Exam** | You pay $25 copay | You pay $0 copay |
| **Routine Hearing Test** | Routine Hearing Test is not covered. | You pay $45 copay |
| **Hearing Aids** | Hearing Aids are not covered. | You pay a $599 copayment per aid for Advanced Aids<br>You pay a $899 copayment per aid for Premium Aids<br><br>Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Call 833-492-9866 to schedule an appointment (for TTY, dial 711).<br><br>Hearing aid purchase includes:<br>• 3 provider visits within first year of hearing aid purchase<br>• 45-day trial period<br>• 3-year extended warranty<br>• 48 batteries per aid<br><br>Benefit does not include or cover any of the following:<br>• Ear molds<br>• Hearing aid accessories<br>• Additional provider visits<br>• Extra batteries<br>• Hearing aids that are not TruHearing-branded hearing aids<br>• Costs associated with loss & damage warranty claims<br>Routine hearing exam and hearing aid copayments are not subject to the maximum out-of-pocket. |

## 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." A copy of our Drug List is provided electronically. The Drug List we provided electronically includes many – *but not all* – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling your Health Care Concierge (see the back cover) or visiting our website (https://www.cnchealthplan.com).

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

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31 days supply of medication rather than the amount provided in 2018 (91 to 98 days supply depending on the dispensing increment). (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.

Members who have an approved formulary exception through 2018 may have that formulary exception extended through 2019 by the plan. If the formulary exception is extended, you will receive advanced notice of the terms of the extension. If the formulary exception is not extended, you will need to resubmit a formulary exception request for 2019."

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 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

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 the 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, 2018, please call your Healthcare Concierge and ask for the "LIS Rider." Phone numbers for your Healthcare Concierge are in Section 6.1 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 separately mailed *Evidence of Coverage*.)

## Changes to the Deductible Stage

| 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*.

| Stage | 2018 (this year) | 2019 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br><br>During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**<br><br>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 long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.<br><br>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:<br><br>**Preferred Generics:**<br>You pay $0 per prescription<br><br>**Generics:**<br>You pay $10 per prescription<br><br>**Preferred Brands:**<br>You pay $43 per prescription<br><br>**Non-Preferred Drugs:**<br>You pay $95 per prescription<br><br>**Specialty Tier:**<br>You pay 33% of the total cost<br><br>Once your total drug costs have reached $3,750, 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:<br><br>**Preferred Generics:**<br>You pay $0 per prescription<br><br>**Generics:**<br>You pay $10 per prescription<br><br>**Preferred Brands:**<br>You pay $40 per prescription<br><br>**Non-Preferred Drugs:**<br>You pay $95 per prescription<br><br>**Specialty Tier:**<br>You pay 33% of the total cost<br><br>Once your total drug costs have reached $3,820, 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 Deciding Which Plan to Choose

## Section 2.1 – If you want to stay in Care N' Care Classic (HMO)

**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 2019.

## Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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 2019*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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, Care N' Care Insurance Company, Inc. 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 Care N' Care Classic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Care N' Care Classic (HMO).

- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact your Healthcare Concierge if you need more information on how to do this (phone numbers are in Section 6.1 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 3 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, 2019.

### 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, and those who move out of the service area may be 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, 2019, 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, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 4 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 Texas, the SHIP is called the Health Information Counseling and Advocacy Program (HICAP).

The Health Information Counseling and Advocacy Program (HICAP) 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. The Health Information Counseling and Advocacy Program (HICAP) 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 the Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about the Health Insurance Information Counseling and Advocacy Program (HICAP) by visiting their website (*http://www.tdi.texas.gov/consumer/hicap/*).

## SECTION 5 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.** Texas has a program called Texas Kidney Health Care Program (KHC) and the Texas HIV Medication 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 Section 4 of this booklet).

- **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 the ADAP qualify for prescription cost-sharing assistance through the Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090.

# SECTION 6 Questions?

## Section 6.1 – Getting Help from Care N' Care Classic (HMO)

Questions? We're here to help. Please call your Healthcare Concierge at 1-877-374-7993. (TTY only, call 711) We are available October 1 - March 31, 8AM – 8PM Central, 7 days a week; April 1 - September 30, 8AM – 8PM Central, Monday through Friday.

### 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 2019. For details, look in the 2019 *Evidence of Coverage* for Care N' Care Classic (HMO). 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 will be separately mailed to you

### Visit our Website

You can also visit our website at http:\\www.cnchealthplan.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 6.2 – Getting Help from Medicare

To get information directly from Medicare:

### Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Visit the Medicare Website

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 2019*

You can read *Medicare & You 2019* 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.

care@care
Insurance Company, Inc.

2019

# NOTICE OF HOW TO FIND OR REQUEST YOUR CARE N' CARE PPO OR HMO:

## Evidence of Coverage

If you have a question about what is covered by the plan, please call your Healthcare Concierge at 1-877-374-7993 (TTY 711), October 1 - March 31, 8am - 8pm, CST, seven days a week or April 1 - September 30, 8am - 8pm Monday through Friday, CST, or visit www.cnchealthplan.com/2019-plan-documents/ to access the online Evidence of Coverage.

The 2019 Evidence of Coverage will be available October 15, 2018. If you would like a copy mailed to you, you may call your Healthcare Concierge at the number above, request one online at www.cnchealthplan.com/members/ or email your Healthcare Concierge at concierge@cnchealthplan.com to request an electronic copy or hard copy.

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2019

# NOTICE OF HOW TO FIND OR REQUEST YOUR CARE N' CARE HMO OR PPO:

## Comprehensive Formulary (List of Covered Drugs)

If your plan includes prescription drug coverage and you have a question about covered drugs, please call your Healthcare Concierge at 1-877-374-7993 (TTY 711), October 1 - March 31, 8am - 8pm, CST, seven days a week or April 1 - September 30, 8am - 8pm Monday through Friday, CST, or visit www.cnchealthplan.com/2019-medication-look-up/ to access our on-line formulary.

The 2019 Comprehensive Formulary will be available October 15, 2018. If you would like a copy mailed to you, you may call your Healthcare Concierge at the number above, request one online at www.cnchealthplan.com/members/ or email your Healthcare Concierge at concierge@cnchealthplan.com to request an electronic or hard copy.

## Provider/Pharmacy Directory

If you need help finding a network provider, please call your Healthcare Concierge at 1-877-374-7993 (TTY 711), October 1 - March 31, 8am - 8pm, CST, seven days a week or April 1 - September 30, 8am - 8pm, CST, Monday through Friday, or visit www.cnchealthplan.com/seath to access our online searchable Provider/Pharmacy Directory.

The 2019 Provider/Pharmacy Directory will be available October 15, 2018. If you would like a copy mailed to you, you may call your Healthcare Concierge at the number above, request one online at www.cnchealthplan.com/members, or email your Healthcare Concierge at concierge@cnchealthplan.com to request an electronic or hard copy.