CareNeeds (HMO SNP)
H1019-081

2019



ANNUAL NOTICE OF CHANGES

South Florida: Broward, Palm Beach

Broward and Palm Beach counties

CarePlus HEALTH PLANS



The information you need is just a click away

Thank you for being a CarePlus member. This booklet shows important changes to your health plan for 2019. We want to be sure you are aware of changes or added benefits and how we ensure your privacy.

Please spend some time reviewing this booklet. As you learn more, you can better understand how to get the most out of your plan.

You may notice this booklet is smaller than last year's mailing. That's because starting October 1, 2018, you can view or print these plan documents online at **https://www.careplushealthplans.com/members/forms-tools-resources** or request copies be mailed to you:

- **Evidence of Coverage:** Complete details of your CarePlus plan, including benefits and costs
- **Drug Guide:** Drugs covered in your plan
- **Provider Directory:** A list of doctors, pharmacies and other providers in your network

https://www.careplushealthplans.com/members/forms-tools-resources is your one-stop place to view or print these plan documents. If you have trouble using our online tools, please call the number on the back of your CarePlus ID card for support. We're here to help.

To get paper copies of any of these documents by mail, request them online at the website above. Or call **1-800-794-5907 (TTY: 711)**, from 8 a.m. to 8 p.m., 7 days a week. From April 1st to September 30th, we are open Monday – Friday from 8 a.m. to 8 p.m.

CareNeeds (HMO SNP) offered by CarePlus Health Plans, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of CareNeeds (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *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 Section 1 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 Guide 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.

☐ 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 2.2 to learn more about your choices.

OMB Approval 0938-1051 (Expires: December 31, 2021)

☐ 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** CareNeeds (HMO SNP), you don't need to do anything. You will stay in CareNeeds (HMO SNP).
   - If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in section 2.2 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between now and **December 31, 2018**

   - If you **don't join another plan by December 31, 2018**, you will stay in CareNeeds (HMO SNP).
   - If you **join another plan by December 31, 2018**, your new coverage will start on the first day of the following month.
   - Starting in 2019, there are new limits on how often you can change plans. Look in section 3 to learn more.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-794-5907 for additional information. (TTY users should call 711.) Hours are from 8 a.m. to 8 p.m. seven days a week from Oct. 1 - Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30.
- This information is available in a different format, including Braille, large print, and audio tapes. Please call Member Services at the number listed above if you need plan information in another format.
- **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 CareNeeds (HMO SNP)

- CareNeeds (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in this CarePlus plan depends on contract renewal.
- Sponsored by CarePlus Health Plans, Inc. and the State of Florida, Agency for Health Care Administration.
- When this booklet says "we," "us," or "our," it means CarePlus Health Plans, Inc. When it says "plan" or "our plan," it means CareNeeds (HMO SNP).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for CareNeeds (HMO SNP) 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 *Evidence of Coverage* we provided electronically to see if other benefit or cost changes affect you.

Based upon the level of assistance you get from Medicaid, you may pay nothing for your covered services as long as you follow the plan's rules for getting your care. (See Chapter 3 of the Evidence of Coverage for more information about the plan's rules for getting your care.) For more information about what your level of assistance is, contact your state Medicaid agency.

Cost	2018 (this year)	2019 (next year)
	In-Network	**In-Network**
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$0 or up to $16.70**	**$0 or up to $18.20**
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** If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$3,400** If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Doctor office visits	Primary care visits: **$0** at a primary care provider's office per visit	Primary care visits: **$0** at a primary care provider's office per visit
	Specialist visits: **$0** at a specialist's office per visit	Specialist visits: **$0** at a specialist's office per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**$0** copayment per stay	**$0** copayment per stay

Cost	2018 (this year)	2019 (next year)
	In-Network	**In-Network**
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: **$405** Copayment/Coinsurance during the Initial Coverage Stage: For a 30-day supply from a **retail pharmacy** with preferred cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$47** • Drug Tier 4: **$99** • Drug Tier 5: **25%**	Deductible: **$415** Copayment/Coinsurance during the Initial Coverage Stage: For a 30-day supply from a **retail pharmacy** with preferred cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$47** • Drug Tier 4: **$99** • Drug Tier 5: **25%**
	For a 30-day supply from a **retail pharmacy** with standard cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$47** • Drug Tier 4: **$100** • Drug Tier 5: **25%**	For a 30-day supply from a **retail pharmacy** with standard cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$47** • Drug Tier 4: **$100** • Drug Tier 5: **25%**
	For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$131** • Drug Tier 4: **$287** • Drug Tier 5: Not available	For a 90-day supply from a **mail-order pharmacy** with preferred cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$131** • Drug Tier 4: **$287** • Drug Tier 5: Not available

Cost	2018 (this year)	2019 (next year)
	In-Network	**In-Network**
	For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$141** • Drug Tier 4: **$300** • Drug Tier 5: Not available	For a 90-day supply from a **mail-order pharmacy** with standard cost-sharing • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$141** • Drug Tier 4: **$300** • Drug Tier 5: Not available

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SECTION 1 Changes to Medicare 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 unless it is paid for you by Medicaid.)	**$0 or up to $16.70** Because you qualify for extra help with your prescription drug expenses, you may not have to pay a plan premium, or may pay a reduced amount.	**$0 or up to $18.20** Because you qualify for extra help with your prescription drug expenses, you may not have to pay a plan premium, or may pay a reduced amount.

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)
	In-Network	**In-Network**
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.	**$3,400**	**$3,400** 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 **www.careplushealthplans.com/directories**. You may also call Member Services 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 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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Provider Directory is located on our website at **www.careplushealthplans.com/directories**. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 Provider Directory to see which pharmacies are in our network.**

Section 1.5 Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

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, *Benefits Chart* (*what is covered and what you pay*), in your *2019 Evidence of Coverage*.

Based upon the level of assistance you get from Medicaid, you may pay nothing for your covered services as long as you follow the plan's rules for getting your care. (See Chapter 3 of the Evidence of Coverage for

more information about the plan's rules for getting your care.) For more information about what your level of assistance is, contact your state Medicaid agency.

Cost	**2018** (this year)	**2019** (next year)
	In-Network	**In-Network**
Ambulance services • For each Medicare-covered emergency transportation by ground, you pay:	**$0 or $100** copayment per trip	**$0** copayment per trip
Emergency care • For each Medicare-covered emergency room visit, you pay:	**$0 or $100** copayment waived if admitted within 24 hours	**$0 or $120** copayment waived if admitted within 24 hours
Worldwide Coverage • For each emergency room visit, you pay:	**$0 or $100** copayment waived if admitted within 24 hours	**$0 or $120** copayment waived if admitted within 24 hours
Medicare Part B prescription drugs • Trying a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy".	Not required	May be required
Dental services • Routine dental services:	**$0** copayment for comprehensive oral exam up to 1 every 3 years. **$0** copayment for partial or complete dentures up to 1 set(s) every 5 years. **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant per year. **$0** copayment for bitewing x-rays up to 1 set(s) per year. **$0** copayment for denture reline, panoramic film up to 1 per year. **$0** copayment for amalgam and/or composite filling, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for simple or surgical extraction up to 3 per year. **$0** copayment for necessary anesthesia with covered service up to unlimited per year.	**$0** copayment for comprehensive oral exam, panoramic film up to 1 every 3 years. **$0** copayment for partial or complete dentures up to 1 set(s) every 5 years. **$0** copayment for scaling and root planing (deep cleaning) up to 1 per quadrant per year. **$0** copayment for bitewing x-rays up to 1 set(s) per year. **$0** copayment for crown, root canal up to 1 per year. **$0** copayment for periodic oral exam, prophylaxis (cleaning) up to 2 per year. **$0** copayment for amalgam and/or composite filling up to 4 per year. **$0** copayment for simple or surgical extraction up to 6 per year.

Cost	**2018** (this year)	**2019** (next year)
	In-Network	**In-Network**
		$0 copayment for necessary anesthesia with covered service up to unlimited per year.
Hearing services • Routine hearing services:	**$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year. **$500** maximum benefit coverage amount per ear per year for hearing aids (all types). Note: includes one month battery supply and two year warranty.	**$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year. **$1000** maximum benefit coverage amount per ear per year for hearing aids (all types). Note: Includes one month battery supply, 1 year warranty.
Vision care • Routine vision services:	**$0** copayment for routine exam, refraction up to 1 per year. **$115** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting) or 1 pair of select eyeglasses at no cost. Eyeglasses include ultraviolet protection and scratch resistant coating.	**$0** copayment for routine exam, refraction up to 1 per year. **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting) or 3 pairs of select eyeglasses at no cost. Eyeglasses will include ultraviolet protection and scratch resistant coating.
Well Dine Meal Program	**$0** copayment for 2 meals per day for 5 days, up to 10 meals delivered to member's home after an inpatient stay in a hospital or nursing facility. Limited to 4 times per year.	**$0** copayment for 2 meals per day for 5 days, up to 10 meals delivered to member's home after an inpatient stay in a hospital or nursing facility. Limited to 4 times per year. **$0** copayment for 2 meals per day for 10 days. Up to 20 meals delivered to member's home to assist in establishing a diet needed for

Cost	2018 (this year)	2019 (next year)
	In-Network	In-Network
		diabetes mellitus with physician approval. **$0** copayment for 2 meals per day for 10 days. Up to 20 meals delivered to member's home to assist in establishing a diet needed for chronic heart failure with physician approval. **$0** copayment for 2 meals per day for 10 days. Up to 20 meals delivered to member's home to assist in establishing a diet needed for cardiovascular disorders with physician approval.
Over-the-counter (OTC) items	**$50** maximum benefit coverage amount per month for select over-the-counter health and wellness products.	**$100** maximum benefit coverage amount per month for select over-the-counter health and wellness products.
Personal Home Care (Respite)	Not Covered	Covered
Wigs (related to chemotherapy treatment)	Wigs (for hair loss related to chemotherapy) up to a **$500** maximum benefit per year.	Wigs (for hair loss related to chemotherapy) up to an unlimited benefit per year.

Section 1.6 Changes to Part D Prescription Drug Coverage

Changes to Our Drug Guide

Our list of covered drugs is called a Formulary or "Drug Guide." A copy of our Drug Guide is provided electronically. The Drug Guide 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 Guide** by calling Member Services (see the back cover) or visiting our website (**www.careplushealthplans.com/medicare-plans/2019-prescription-drug-guides**).

We made changes to our Drug Guide, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug Guide 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 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 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. 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: 30 day supply of medication rather than the amount provided in 2018 (98 day supply of medication). (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.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.
- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. To learn what you must do to ask for an exception, see the Evidence of Coverage provided electronically. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.
- **If we approve your request for an exception**, our approval usually is valid until the end of the plan year. A new formulary exception will need to be submitted for the upcoming plan 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))*.

Most of the changes in the Drug Guide 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, we may immediately remove a brand name drug in our Drug Guide 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 in our Drug Guide, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill 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.

Also, starting in 2019, before we make other changes during the year to our Drug Guide that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we

make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug Guide 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 Guide as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug Guide, 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. Because you receive "Extra Help" and haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	**2018** (this year)	**2019** (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible.	The deductible is **$405**. During this stage, you pay **$0** cost-sharing for drugs on Tier 1, **$0** cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. Your deductible amount is either $0 or $83, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is **$415**. During this stage, you pay **$0** cost-sharing for drugs on Tier 1, **$0** cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. Your deductible amount is either $0 or $85, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

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 Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug Guide. To see if your drugs will be in a different tier, look them up on the Drug Guide.	Your cost for a one-month supply at a network pharmacy: **Preferred Generic:** *Standard cost-sharing*: You pay **$0** per prescription. *Preferred cost-sharing*: You pay **$0** per prescription. **Generic:** *Standard cost-sharing*: You pay **$0** per prescription. *Preferred cost-sharing*: You pay **$0** per prescription. **Preferred Brand:** *Standard cost-sharing*: You pay **$47** per prescription. *Preferred cost-sharing*: You pay **$47** per prescription. **Non-Preferred Drug:** *Standard cost-sharing*: You pay **$100** per prescription. *Preferred cost-sharing*: You pay **$99** per prescription. **Specialty Tier:** *Standard cost-sharing*: You pay **25%** per prescription. *Preferred cost-sharing:* You pay **25%** per prescription. Once your total drug costs have reached **$3750**, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Preferred Generic:** *Standard cost-sharing*: You pay **$0** per prescription. *Preferred cost-sharing*: You pay **$0** per prescription. **Generic:** *Standard cost-sharing*: You pay **$0** per prescription. *Preferred cost-sharing*: You pay **$0** per prescription. **Preferred Brand:** *Standard cost-sharing*: You pay **$47** per prescription. *Preferred cost-sharing*: You pay **$47** per prescription. **Non-Preferred Drug:** *Standard cost-sharing*: You pay **$100** per prescription. *Preferred cost-sharing*: You pay **$99** per prescription. **Specialty Tier:** *Standard cost-sharing*: You pay **25%** per prescription. *Preferred cost-sharing*: You pay **25%** per prescription. Once your total drug costs have reached **$3820**, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or 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 CareNeeds (HMO SNP)

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, 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.

Your new coverage will begin on the first day of the following month. 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.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from CareNeeds (HMO SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CareNeeds (HMO SNP).
- 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 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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from now until December 31. 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, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage*.

Note: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans.

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 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

A State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program (SHIP) 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 your State Health Insurance Assistance Program at the number listed in "Exhibit A" in the back of this booklet.

For questions about your Medicaid benefits, contact your state Medicaid agency. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage. You can call your state Medicaid agency at the number listed in "Exhibit A" in the back of this booklet.

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.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, 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 ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP program (the name and phone numbers for this organization are in "Exhibit A" in the back of this booklet).

SECTION 6 Questions?

Section 6.1 Getting Help from CareNeeds (HMO SNP)

Questions? We're here to help. Please call Member Services at 1-800-794-5907. (TTY only, call 711.) We are available for phone calls from 8 a.m. to 8 p.m., seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday-Friday from Apr. 1 - Sept. 30. Calls to these numbers are free.

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 CareNeeds (HMO SNP). 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. You can get the *Evidence of Coverage* by calling Member Services (see above) or visiting our website (**www.careplushealthplans.com**).

Visit our Website

You can also visit our website at **www.careplushealthplans.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 Guide).

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.

Section 6.3 Getting Help from Medicaid

To get information from Medicaid, you can call your state Medicaid agency at the numbers listed in "Exhibit A" in the back of this booklet.

State Agency Contact Information

This section provides the contact information for the state agencies referenced in Sections 4 and 5 within this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Member Services at the phone number on the back cover of this booklet.

Florida	
SHIP Name and Contact Information	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way Suite 270 Tallahassee,FL 32399-7000 1-800-963-5337 (toll free) 1-850-955-8771 (TTY) 1-850-414-2150 (fax) Monday through Friday, 8 a.m. - 5 p.m. http://www.floridaSHINE.org
Quality Improvement Organization	KEPRO 5201 W. Kennedy Blvd. Suite 900 Tampa,FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (Fax)
State Medicaid Office	Florida Agency for Health Care Administration 1317 Winewood Blvd. Building 1 Room 202 Tallahassee,FL 32399-0700 1-866-762-2237 (toll free) 1-850-487-1111 (local) 1-850-922-2993 (fax) Monday through Friday, 8 a.m. - 5 p.m. http://www.fdhc.state.fl.us/
AIDS Drug Assistance Program	Florida ADAP Program HIV/AIDS Section 4052 Bald Cypress Way Tallahassee,FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (Spanish) 1-800-2437-101 (1-800-AIDS-101) (Creole) 1-888-503-7118 (TTY) Monday through Friday, 8 a.m. - 4:30 p.m. http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

Notice of Privacy Practices for your personal health information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?
Personal and health information - from now on referred to as “information” - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term “information” in this notice includes any personal and health information created or received by a healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written, and oral information.

How do we protect your information?
In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How do we use and disclose your information?
We must use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law

We have the right to use and disclose your information:
- To a doctor, a hospital, or other healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you if you have not opted out as described below
- To your family and friends if you are unavailable to communicate, such as in an emergency

- To your family and friends or any other person you identify, provided the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities, and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director

Will we use your information for purposes not described in this notice?
In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:
- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?
Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner:
- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Adverse Underwriting Decision - You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application for insurance. *
- Alternate Communications - You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life threatening situation. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice - You have the right to receive a written copy of this notice any time you request.
- Restriction - You have the right to ask to restrict uses or disclosures of your information. We are not required to

agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

What types of communications can I opt out of that are made to me?
- Appointment reminders
- Treatment alternatives or other health-related benefits or services
- Fundraising activities

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:
- Contacting us at 1-866-861-2762 at any time
- Accessing our website at **Humana.com** and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

* This right applies only to our Massachusetts residents in accordance with state regulations.

Send completed request form to:

Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

What should I do if I believe my privacy has been violated?
If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater member protection.

What will happen if my private information is used or disclosed inappropriately?
You have a right to receive a notice that a breach has resulted in your unsecured private information being inappropriately used or disclosed. We will notify you in a timely manner if such a breach occurs.

The following affiliates and subsidiaries also adhere to our privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
Cariten Insurance Company
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.

CompBenefits of Georgia, Inc.
Corphealth Provider Link, Inc.
DentiCare, Inc.
Emphesys, Inc.
Emphesys Insurance Company
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Behavioral Health
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Kanawha Insurance Company*
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.
*These affiliates and subsidiaries are only covered by the Privacy Notice Concerning Financial Information section.

CarePlus
HEALTH PLANS

Discrimination is Against the Law

CarePlus Health Plans, Inc. ("CarePlus") complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. CarePlus does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

CarePlus provides:

- Free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Video remote interpretation
  - Written information in other formats
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with:

CarePlus Health Plans, Inc.
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172

Telephone: 1-800-794-5907 (TTY users should call 711)
From October 1 - March 31st, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30th, we are open Monday-Friday from 8 a.m. to 8 p.m. You may always leave a voice mail message after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

Fax: 1-800-956-4288

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

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, D.C. 20201
1-800-368-1019; 800-537-7697 (TDD)

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

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-794-5907 (TTY: 711) 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-794-5907 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-800-794-5907 (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-794-5907 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).

CarePlus Health Plans, Inc.
P.O. Box 14098
Lexington, KY 40512-4098

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Important information about changes to your Medicare drug and health plan



Look inside

Here's a summary of what's changed about your **CarePlus plan** starting on Jan. 1, 2019.

CarePlus HEALTH PLANS

CarePlusHealthPlans.com
1-800-794-5907 (TTY: 711)