



Health Plans

# Annual Notice of Changes for 2021

## Classic Plan (HMO-POS) offered by Health First Health Plans

### Annual Notice of Changes for 2021

You are currently enrolled as a member of the *Classic Plan (HMO-POS)*. 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 2.1 and 2.5 for information about benefit and cost changes for our plan.
- Check the changes in the booklet to our prescription drug coverage to see if they affect you.
  - Will your drugs be covered?
  - Are your drugs in a different tier, with different cost sharing?
  - 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 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
  - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit

[go.medicare.gov/drugprices](https://www.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, including specialists you see regularly, in our network?
  - What about the hospitals or other providers you use?
  - Look in Section 2.3 for information about our Provider Directory.
- Think about your overall health care costs.
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How much will you spend on your premium and deductibles?
  - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

## 2. **COMPARE:** Learn about other plan choices

- Check coverage and costs of plans in your area.
  - Use the personalized search feature on the Medicare Plan Finder at [www.medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) website.
  - 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 don't join another plan by December 7, 2020, you will be enrolled in the Classic Plan (HMO-POS).
- 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, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in the Classic Plan (HMO-POS).

- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

### **Additional Resources**

- Please contact our Customer Service number at 1-800-716-7737 for additional information. (TTY users should call 1-800-955-8771.) Hours are weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 a.m. to 8 p.m.
- This information is also available at no cost in other formats. You may request your materials be read aloud, e-mailed, or mailed in large print by contacting Customer Service.
- **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 [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

### **About the Classic Plan (HMO-POS)**

- Health First Health Plans is an HMO Plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal
- When this booklet says “we,” “us,” or “our,” it means Health First Health Plans. When it says “plan” or “our plan,” it means the Classic Plan (HMO-POS).

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## Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for the Classic Plan (HMO-POS) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at myHFHP.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

| Cost   | 2020 (this year)   | 2021 (next year)   |
|--|--|--|
| <p><b>Monthly plan premium*</b></p> <p>* Your premium may be higher or lower than this amount. See Section 2.1 for details.</p>  | \$97   | \$97   |
| <p><b>Maximum out-of-pocket amount</b></p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</p>   | <p>\$3,750 (In-Network)</p> <p>\$10,000 (Point of Service)</p>   | <p>\$3,750 (In-Network)</p> <p>\$10,000 (Point of Service)</p>   |
| <p><b>Doctor office visits</b></p>   | <p>Primary care visits: \$0 per visit</p> <p>Specialist visits: \$30 per visit</p>   | <p>Primary care visits: \$0 per visit</p> <p>Specialist visits: \$30 per visit</p>   |
| <p><b>Inpatient hospital stays</b></p> <p>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.</p> | <p>You pay \$180 for each day for days 1-7 of a covered inpatient stay during a benefit period.</p> <p>You pay \$0 for each day for days 8-90 of a covered inpatient stay during a benefit period.</p> | <p>You pay \$180 for each day for days 1-7 of a covered inpatient stay during a benefit period.</p> <p>You pay \$0 for each day for days 8-90 of a covered inpatient stay during a benefit period.</p> |

| Cost   | 2020 (this year)   | 2021 (next year)   |
|--|--|--|
| <p><b>Part D prescription drug coverage</b><br/>(See Section 2.6 for details.)</p> | <p>Deductible: N/A</p> <p>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$5</li> <li>• Drug Tier 2: \$15</li> <li>• Drug Tier 3: \$45</li> <li>• Drug Tier 4: \$90</li> <li>• Drug Tier 5: 33%</li> <li>• Drug Tier 6: \$0</li> </ul> | <p>Deductible: N/A</p> <p>Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1:<br/>Standard cost-sharing: You pay \$5 per prescription<br/>Preferred cost-sharing: You pay \$3 per prescription</li> <li>• Drug Tier 2:<br/>Standard cost-sharing: You pay \$15 per prescription<br/>Preferred cost-sharing: You pay \$10 per prescription</li> <li>• Drug Tier 3:<br/>Standard cost-sharing: You pay \$45 per prescription<br/>Preferred cost-sharing: You pay \$40 per prescription</li> <li>• Drug Tier 4:<br/>Standard cost-sharing: You pay \$90 per prescription<br/>Preferred cost-sharing: You pay \$80 per prescription</li> <li>• Drug Tier 5:<br/>You pay 33% of the total cost<br/>Preferred cost-sharing: You pay 33% of the total cost</li> <li>• Drug Tier 6:<br/>Standard cost-sharing: You pay \$0 per prescription<br/>Preferred cost-sharing: You pay \$0 per prescription</li> </ul> |

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## SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in the Classic Plan (HMO-POS) in 2021

If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our Classic Plan (HMO-POS). This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through the Classic Plan (HMO-POS). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in the Classic Plan (HMO-POS) and the benefits you will have on January 1, 2021 as a member of the Classic Plan (HMO-POS).

## SECTION 2 Changes to Benefits and Costs for Next Year

### Section 2.1 – Changes to the Monthly Premium

| Cost  | 2020 (this year) | 2021 (next year) |
|---|------------------|------------------|
| <b>Monthly premium</b><br>(You must also continue to pay your Medicare Part B premium.) | \$97             | \$97             |

- 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. Please see Section 7 regarding “Extra Help” from Medicare.

**Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount**

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

| Cost  | 2020 (this year)  | 2021 (next year)  |
|---|---|---|
| <p><b>Maximum out-of-pocket amount</b></p> <p>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.</p> | <p>\$3,750 (In Network)</p> <p>Once you have paid \$3,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services in network for the rest of the calendar year.</p> <p>\$10,000 (Point of Service)</p> <p>Once you have paid \$10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services out of network for the rest of the calendar year.</p> | <p>\$3,750 (In Network)</p> <p>Once you have paid \$3,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services in network for the rest of the calendar year.</p> <p>\$10,000 (Point of Service)</p> <p>Once you have paid \$10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services out of network for the rest of the calendar year.</p> |

**Section 2.3 – Changes to the Provider Network**

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at myHFHP.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

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## Section 2.4 – Changes to the Pharmacy Network

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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 Pharmacy Directory is located on our website at [myHFHP.org](http://myHFHP.org). You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

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## Section 2.5 – Changes to Benefits and Costs for Medical Services

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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 *2021 Evidence of Coverage*.

| Cost   | 2020 (this year)   | 2021 (next year)                                   |
|--|--|--|
| <b>Acupuncture for chronic low back pain</b> | Acupuncture for chronic low back pain is <u>not</u> covered. | You pay \$20 for each Medicare-covered visit.      |
| <b>Ambulance services (PA)</b>               | You pay \$185 for a Medicare-covered one way trip.           | You pay \$230 for a Medicare-covered one way trip. |

| Cost  | 2020 (this year)  | 2021 (next year)  |
|---|---|---|
| <b>Cardiac rehabilitation services (PA)</b>                                   | You pay \$20 for each Medicare-covered therapy visit.   | You pay \$15 for each Medicare-covered therapy visit.   |
| <b>Dental services</b>  | You will be reimbursed up to \$200 for the purchase of supplemental preventive dental and other routine dental services each calendar year.             | You will be reimbursed up to \$225 for the purchase of supplemental preventive dental and other routine dental services each calendar year.             |
| <b>Emergency care</b>   | You pay \$80 for each Medicare-covered visit.   | You pay \$90 for each Medicare-covered visit.   |
| <b>Hearing services</b>   | You will be reimbursed up to \$250 for the purchase of hearing aid devices (all types) per calendar year.   | You will be reimbursed up to \$350 for the purchase of one hearing aid device (all types) per calendar year.  |
| <b>Outpatient diagnostic tests and therapeutic services and supplies (PA)</b> | You pay \$115 for each type of Medicare-covered diagnostic radiology service including MRI, CT Scans, Nuclear Scans and PET scans, per date of service. | You pay \$165 for each type of Medicare-covered diagnostic radiology service including MRI, CT Scans, Nuclear Scans and PET scans, per date of service. |
| <b>Outpatient rehabilitation services (PA)</b>                                | You pay \$20 for each Medicare-covered therapy visit.   | You pay \$15 for each Medicare-covered therapy visit.   |
| <b>Over-the-Counter (OTC) Items</b>   | Over-the-Counter Items are <u>not</u> covered.  | You will receive \$15 every three (3) months to be used for covered OTC non-prescription drugs.   |

| Cost  | 2020 (this year)  | 2021 (next year)  |
|---|---|---|
| <b>Pulmonary rehabilitation services (PA)</b>   | You pay \$20 for each Medicare-covered therapy visit.   | You pay \$15 for each Medicare-covered therapy visit.   |
| <b>Skilled nursing facility (SNF) care (PA)</b> | You pay \$40 each day for days 21-100 of a covered stay during a benefit period.  | You pay \$100 each day for days 21-100 of a covered stay during a benefit period.   |
| <b>Urgently needed services</b>                 | You pay \$0 for each Medicare-covered Telehealth Urgent Care visit.   | You pay \$25 for each Medicare-covered Telehealth Urgent Care visit.  |
| <b>Vision care</b>                              | You will be reimbursed up to \$125 for the purchase of contact lenses, frames and prescription lenses per calendar year from any licensed provider, even if they are not in the Health First network. | You will be reimbursed up to \$150 for the purchase of contact lenses, frames and prescription lenses per calendar year from any licensed provider, even if they are not in the Health First network. |

## Section 2.6 – Changes to Part D Prescription Drug Coverage

### Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

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 Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service 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. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you have a current formulary exception, we may extend this to the following year. If it is extended, you will receive a letter in December notifying you that your authorization has been extended into the new year. If you do not receive this letter, or if you are not sure when your authorization expires, please contact Customer Service.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

## Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by September 30, 2020, please call Customer Service and ask for the “LIS Rider.”

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 *Evidence of Coverage*,

which is located on our website at myHFHP.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

### Changes to the Deductible Stage

| Stage                                   | 2020 (this year)   | 2021 (next year)   |
|---|--|--|
| <b>Stage 1: Yearly Deductible Stage</b> | 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

Please see the following chart for the changes from 2020 to 2021.

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   | 2020 (this year)   | 2021 (next year)   |
|---|--|--|
| <b>Stage 2: Initial Coverage Stage</b><br><b>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</b> | <p>Your cost for a one-month supply filled at a network pharmacy:</p> <p><b>Tier 1 Preferred Generic Drugs:</b><br/>Standard cost sharing:<br/>You pay \$5 per prescription<br/>Preferred cost sharing:<br/>N/A</p> <p><b>Tier 2 Generic Drugs:</b><br/>Standard cost sharing:<br/>You pay \$15 per prescription<br/>Preferred cost sharing:<br/>N/A</p> <p><b>Tier 3 Preferred Brand Drugs</b><br/>Standard cost sharing:<br/>You pay \$45 per prescription</p> | <p>Your cost for a one-month supply filled at a network pharmacy:</p> <p><b>Tier 1 Preferred Generic Drugs:</b><br/>Standard cost sharing:<br/>You pay \$5 per prescription<br/>Preferred cost sharing:<br/>You pay \$3 per prescription</p> <p><b>Tier 2 Generic Drugs:</b><br/>Standard cost sharing:<br/>You pay \$15 per prescription<br/>Preferred cost sharing:<br/>You pay \$10 per prescription</p> <p><b>Tier 3 Preferred Brand Drugs</b></p> |

| Stage  | 2020 (this year)  | 2021 (next year)  |
|--|---|---|
| <p><b>Stage 2: Initial Coverage Stage (continued)</b></p> <p>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.</p> <p>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.</p> | <p>Preferred cost sharing: N/A</p> <p><b>Tier 4 Non-Preferred Drugs</b><br/>Standard cost sharing: You pay \$90 per prescription<br/>Preferred cost sharing: N/A</p> <p><b>Tier 5 Specialty Drugs</b><br/>Standard cost sharing: You pay 33% of the total cost.<br/>Preferred cost sharing: N/A</p> <p><b>Tier 6 Select Care Drugs:</b> Standard cost sharing: You pay \$0 per prescription<br/>Preferred cost sharing: N/A</p> <hr/> <p>Once your total drug costs have reached \$4,020, you will move to the next stage (the Coverage Gap Stage).</p> | <p>Standard cost sharing: You pay \$45 per prescription<br/>Preferred cost sharing: You pay \$40 per prescription</p> <p><b>Tier 4 Non-Preferred Drugs</b><br/>Standard cost sharing: You pay \$90 per prescription<br/>Preferred cost sharing: You pay \$80 per prescription</p> <p><b>Tier 5 Specialty Drugs</b><br/>Standard cost sharing: You pay 33% of the total cost.<br/>Preferred cost sharing: You pay 33% of the total cost</p> <p><b>Tier 6 Select Care Drugs:</b> Standard cost sharing: You pay \$0 per prescription<br/>Preferred cost sharing: You pay \$0 per prescription</p> <hr/> <p>Once your total drug costs have reached \$4,130, you will move to the next stage (the Coverage Gap Stage).</p> |

**Changes to the Coverage Gap and Catastrophic Coverage Stages**

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

**Stage or the Catastrophic Coverage Stage.** For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

### SECTION 3 Administrative Changes

| Description  | 2020 (this year)   | 2021 (next year)  |
|--|--|---|
| Preferred Cost Sharing Network Pharmacy  | Health First has a standard retail pharmacy network.   | Health First has a standard and a preferred cost sharing retail pharmacy network  |
| Covering a Part D drug for you that is not on our List of Covered Drugs (Tiering exceptions) | If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 | If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for generic drugs and Tier 5 for brand name drugs. |

### SECTION 4 Deciding Which Plan to Choose

#### Section 4.1 – If you want to stay in the Classic Plan (HMO-POS)

**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 be enrolled in our Classic Plan (HMO-POS).

#### Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR--* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to [www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare). **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Health First Health Plans 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 the Classic Plan (HMO-POS).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from the Classic Plan (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

## SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2021.

### 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. 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, 2021, 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, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 6 Programs That Offer Free Counseling about Medicare

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

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHINE at 1-800-963-5337. You can learn more about SHINE by visiting their website ([www.floridashine.org](http://www.floridashine.org)).

## SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida ADAP Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-352-2437.

## SECTION 8 Questions?

### Section 8.1 – Getting Help from the Classic Plan (HMO-POS)

Questions? We're here to help. Please call Customer Service at 1-800-716-7737. (TTY only, call 1-800-955-8771). We are available for phone calls weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 a.m. to 8 p.m. Calls to these numbers are free.

#### **Read your 2021 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 2021. For details, look in the 2021 Evidence of Coverage for the Classic Plan (HMO-POS). The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is located on our website at [myHFHP.org](http://myHFHP.org). You may also call Customer Service to ask us to mail you an Evidence of Coverage.

#### **Visit our Website**

You can also visit our website at [myHFHP.org](http://myHFHP.org). As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

### Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

#### **Visit the Medicare Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to [www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare)).

**Read *Medicare & You 2021***

You can read the *Medicare & You 2021* 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 ([www.medicare.gov](http://www.medicare.gov)) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.