Hamaspik Medicare Select (HMO DSNP)

offered by Hamaspik, Inc.

Annual Notice of Changes for 2021

You are currently enrolled as a member of Hamaspik Medicare Select (HMO DSNP). Next year, there will be some changes to the plan's costs and benefits. This booklet tells you about the changes.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 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 of this Annual Notice of Changes 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. 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 & Pharmacy 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 website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3 of this Annual Notice of Changes 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 Hamaspik Medicare Select.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 4 of this Annual Notice of Changes, or Section 10 of your Evidence of Coverage ("How to End Your Membership in the Plan"), to learn more about your choices.

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 Hamaspik Medicare Select.
- If you join another plan between **October 15** and **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 Member Services number at 1-833-426-2774 for additional information. (TTY users should call 711.) Hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2020 thru March 31, 2021. From April 2021 thru September 2021, our Member Service Department will be available Monday thru Friday, 8:00 am to 8:00 pm.

- This document is available for free in Spanish.
- This information is also available in alternate formats such as large print and braille. Please call Member Service at the above numbers for more information.
- **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 for more information.

About Hamaspik Medicare Select

- Hamaspik Medicare Select is a HMO plan with a Medicare contract. The plan also has a written agreement with the New York State New York State Medicaid program to coordinate your New York State Medicaid benefits. Enrollment in Hamaspik Medicare Select depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Hamaspik Medicare Select. When it says "plan" or "our plan," it means Hamaspik Medicare Select.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Hamaspik Medicare Select in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.hamaspik.com. You may also request a copy of the 2021 *Evidence of Coverage* from member services. This document provides complete information about any benefit or cost changes affect you.

If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium	$0 premium	$0 premium
Deductible	If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.	If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.

Cost	2020 (this year)	2021 (next year)
Doctor office visits	**Primary care visits:** Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits. **Specialist visits:** Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each specialist doctor visit for Medicare-covered benefits. You do not need a referral or an authorization for visits to a PCP or specialist.	**Primary care visits:** Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits. **Specialist visits:** Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each specialist visit for Medicare-covered benefits. Additional telehealth services are covered in 2021 for primary care physician and specialist services. You do not need a referral or an authorization for visits to a PCP or specialist.

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**.**	Depending on your level of income and New York State Medicaid eligibility, in 2020 you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period, • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. Authorization is required, except when the admission is the result of an emergency or urgently needed services If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.	Depending on your level of income and New York State Medicaid eligibility, in 2020, you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period, • Days 1-60: $0 coinsurance for each benefit period. • Days 61-90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. These amounts may change in 2021. We will update this information when it becomes available. Authorization is required, except when the admission is the result of an emergency or urgently needed services. If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 or $435 of Tier 1 drugs Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: For generic drugs (including brand name drugs treated as generic), you pay either a $0 copay, or a $1.30 copay, or a $3.60 copay or 25% coinsurance. • For all other drugs: you will pay a $0 copay, or a $3.90 copay, or a $8.95 copay, or 25% coinsurance.	Deductible: $0 or $445 of Tier 1 drugs Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: For generic drugs (including brand name drugs treated as generic), you will pay either a $0 copay, or a $1.30 copay, or a $3.70 copay, or 25% coinsurance • For all other drugs: you will pay a $0 copay, or a $4.00 copay or a $9.20 copay, or 25% coinsurance.
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 2.2 for details.)	Your maximum out-of-pocket amount is $6,700. If you are eligible for Medicare cost-sharing assistance under New York State 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.	Your maximum out-of-pocket amount is $7,550. If you are eligible for Medicare cost-sharing assistance under New York State 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.

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Hamaspik Medicare Select in 2021.

If you do nothing to change your Medicare coverage in 2020, we will automatically enroll you in our Hamaspik Medicare Select. This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through Hamaspik Medicare Select. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan. If you want to change plans, you can do so between October 15 and December 7. The change will take effect on January 1, 2021.

The information in this document tells you about the differences between your current benefits in Hamaspik Medicare Select and the benefits you will have on January 1, 2021, as a member of Hamaspik Medicare Select.

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)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by New York State Medicaid.)	$0 premium	$0 premium

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," and in 2021, the amount established by Medicare is $7,550. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from New York State Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for New York State 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.	As a member of Hamaspik Medicare Select, the most you will have to pay out-of-pocket for Part A and Part B services in 2020 is $6,700.	As a member of Hamaspik Medicare Select, the most you will have to pay out-of-pocket for Part A and Part B services in 2021 is $7,550. Once you have paid $7,550 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 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. We included a copy of our Provider & Pharmacy Directory in the envelope with this booklet. An updated Provider & Pharmacy Directory is located on our website at *www.hamaspik.com*. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **Please review the 2021 Provider & Pharmacy 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.

Section 2.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. We included a copy of our Provider & Pharmacy Directory in the envelope with this booklet. An updated Provider & Pharmacy Directory is located on our website at www.hamaspik.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **Please review the 2021 Provider & Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* 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 *2021 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at www.hamaspik.com. You can also review the enclosed *Summary of Benefits* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Inpatient hospital stays **Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.**	Depending on your level of income and New York State Medicaid eligibility, in 2020 you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period, • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. Authorization is required except when the admission is the result of an emergency or urgently needed services If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.	Depending on your level of income and New York State Medicaid eligibility, in 2020, you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period, • Days 1-60: $0 coinsurance for each benefit period. • Days 61-90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. These amounts may change in 2021. We will update this information when it becomes available. Authorization is required except when the admission is the result of an emergency or urgently needed services. If you are eligible for Medicare cost-sharing assistance under New York State Medicaid, you pay $0.

Cost	2020 (this year)	2021 (next year)
Physician/Practitioner services, including doctor's office visits	Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each primary care or specialist doctor visit. You do not need a referral or an authorization for visits to a PCP or specialist.	Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each primary care or specialist doctor visit. Additional telehealth services are covered for primary care physician and physician specialist services. Telehealth services allow members to access health care services remotely while your provider manages your care. You do not need a referral or an authorization for visits or telehealth services provided by a PCP or specialist.
Outpatient Substance Abuse Services	Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each Medicare-covered individual and group substance abuse outpatient treatment visit. Authorization is not required.	Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% of the cost for each Medicare-covered individual and group substance abuse outpatient treatment visits. Additional telehealth services are covered for outpatient individual and group sessions for substance abuse. Telehealth services allow members to access health care services remotely while your provider manages your care. Authorization is not required for outpatient substance abuse services.

Cost	2020 (this year)	2021 (next year)
Acupuncture	Acupuncture is not covered.	Medicare covers up to 12 visits in 90 days for the treatment of chronic low back pain. For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • Not associated with surgery; and • Not associated with pregnancy. An additional eight visits will be covered for those patients demonstrating improvement. Depending on your level of income and Medicaid eligibility, you pay 0% or 20% of the cost for each Medicare-covered acupuncture visit. In addition, you are covered for 12 acupuncture treatments each year for other health issues. Prior authorization is not required.

Cost	2020 (this year)	2021 (next year)
Hearing Services	Diagnostic hearing and balance evaluations are covered when performed by your provider to determine if you need medical treatment and if you are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Depending on your income and level of New York State Medicaid eligibility, you pay 0% or 20% coinsurance for Medicare covered services. You are also covered for: • 1 routine hearing exam every 2 years • Evaluation and fitting for hearing aids every 2 years • 2 hearing aids every two years • $1,000 in coverage every two years applicable to both ears combined There is no copayment for these services. Authorization is not required.	Diagnostic hearing and balance evaluations are covered when performed by your provider to determine if you need medical treatment and if you are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Depending on your level of income and New York State Medicaid eligibility, you pay 0% or 20% coinsurance for Medicare covered services. Authorization is not required. You may be eligible for additional hearing exams and hearing aids by using your Medicaid benefits.

Inpatient Mental Health	Depending on your level of income and New York State Medicaid eligibility in 2020, you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period. • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. Medicare beneficiaries are covered for up to 190 days of inpatient psychiatric hospital services during your lifetime. The 190 limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital, You may be covered for inpatient psychiatric days from New York State Medicaid. Except in an emergency, authorization rules apply.	Depending on your level of income and New York State Medicaid eligibility, in 2020, you pay the following amounts for each benefit period: • $0 or $1,408 deductible for each benefit period, • Days 1–60: $0 coinsurance for each benefit period. • Days 61–90: $0 or $352 coinsurance per day of each benefit period. • Days 91 and beyond: $0 or $704 coinsurance forr each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: $0 or all costs. These amounts may change in 2021. We will update this information when it becomes available. Medicare beneficiaries are covered for up to 190 days of inpatient psychiatric hospital services during your lifetime. The 190 limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital, You may be covered for inpatient psychiatric days from New York State Medicaid. Except in an emergency, authorization rules apply.

Cost	2020 (this year)	2021 (next year)
Outpatient Mental Health Services	Outpatient Mental Health Services include services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional. You pay 0% or 20% of the cost for Medicare-covered individual or group therapy visits. Authorizations are not required.	Outpatient Mental Health Services include services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional. Additional telehealth services are covered for individual and group sessions for mental health specialty services. Telehealth services allow members to access health care services remotely while your mental health provider manages your care. You pay 0% or 20% of the cost for Medicare-covered individual or group therapy visits and telehealth services. Authorizations are not required.

Cost	2020 (this year)	2021 (next year)
Skilled Nursing Facility	Depending on your level of income and New York State Medicaid eligibility, you pay the following per benefit period. In 2020, the amounts were: You pay: • Days 1–20: $0 • Days 21–100: $0 or $176 co-insurance • Days 101 and beyond: all costs. New York State Medicaid may cover additional days of SNF care. Authorization is required.	Depending on your level of income and New York State Medicaid eligibility, you pay the following per benefit period. In 2020, the amounts were: You pay: • Days 1–20: $0 • Days 21–100: $0 or $176 co-insurance • Days 101 and beyond: all costs. These amounts may change in 2021. We will update this information when it becomes available. New York State Medicaid may cover additional days of SNF care. Authorization is required.

Cost	2020 (this year)	2021 (next year)
Wellness Programs	You are covered for: • Health education materials, which will focus on a variety of health conditions. • Nurse Hotline, which is available on weekends and holidays when the care management offices are closed. There is no cost to you for these wellness services. Authorization is not required.	You are covered for: • Health education materials, which will focus on a variety of health conditions. • Nurse Hotline, which is available on weekends and holidays when the care management offices are closed. • Physical Fitness Benefit. The fitness benefit is delivered through contracted gyms and fitness centers. There is no cost to you for these wellness services. Authorization is not required.
Over-the Counter Health Items	We cover a maximum of $32.50 per month for covered over-the-counter (OTC) products. Products are available for members to order and will be delivered to your home. There is no cost for shipping and delivery.	We cover a maximum of $105.00 per month for covered over-the-counter (OTC) products. Products are available for members to order and will be delivered to your home. There is no cost for shipping and delivery.

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 in this envelope and provided electronically. The Drug List included in this envelope includes the drugs

that we will cover next year. **You can also get the Drug List** by calling Member Services (see the back cover) or visiting our website (www.hamaspik.org.)

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or 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.

At the beginning of 2021, 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 were approved in 2020 for a formulary exception or prior authorization for a medication that you take, the approval may carry over into next year. The approval lasts for 12 months from the date that you received it.

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.

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 will include a separate insert with your Evidence of Coverage, 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.

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	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	The deductible is $435. Because we have no deductible, this payment stage does not apply to you. Your deductible amount is either $0 or $435 in *2020*, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $445. Because we have no deductible, this payment stage does not apply to you. Your deductible amount is either $0 or $445, 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	2020 (this year)	2021 (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 that provides standard cost sharing. For **information about the costs for a long-term supply or for mail-order prescriptions look in Chapter 6, Section 5 of your *Evidence of Coverage***.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Generic Drugs:** You pay*:* $0, $1.30, $3.60, or a 25% coinsurance per prescription **Tier 1 – All Other Drugs:** You pay: $0, $3.90, $8.95, or a 25% coinsurance per prescription Once you have paid $6,350 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Generic Drugs:** You pay*:* $0, $1.30, $3.70, or a 25% coinsurance per prescription **Tier 1 – All Other Drugs:** You pay: $0, $4.00, $9.20, or a 25% coinsurance per prescription Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage 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 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Hamaspik Medicare Select*

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 Hamaspik Medicare Select plan.

Section 3.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,

-- *OR*—

- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **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 Hamaspik Medicare Select.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Hamaspik Medicare Select.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).

    – or –

    - Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

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 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to 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 New York State 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.

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 Section 4 of this Annual Notice of Changes, and Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and New York State Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York State, the SHIP is called the New York State Health Insurance Assistance Program.

The New York State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The New York State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call the New York State Health Insurance Assistance Program at 1-800-701-0501. You can learn more about the New York State Health Insurance Assistance Program by visiting their website:
https://www.shiptacenter.org/about-medicare/regional-ship-location/new-york

For questions about your New York State Medicaid benefits, contact the New York State Department of Health at 1-800-541-2831. Their hours are 8:30 a.m. to 4:45 p.m., Monday through Friday. The TTY number is 711.

Ask how joining another plan or returning to Original Medicare affects how you get your New York State New York State Medicaid coverage.

SECTION 6 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 New York State 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 New York State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmacy Insurance Coverage (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 7 of your Evidence of Coverage, or Section 5 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/ under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York State AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the New York State AIDS Drug Assistance Program, at 1-800-542-2437.

SECTION 7 Questions?

Section 7.1 – Getting Help from Hamaspik Medicare Select

Questions? We're here to help. Please call Member Services at 1-833-426-2774. (TTY only, call 711.) Member Services is available 7 days a week, from 8:00 am to 8:00 pm, October 1, 2020 thru March 31, 2021.

From April 1, 2021 thru September 30, 2021, our Member Service Department will be available Monday thru Friday, 8:00 am to 8:00 pm. 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 Hamaspik Medicare Select. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.hamaspik.org. You can also request a copy of the 2021 Evidence of Coverage, in order to see if other benefit or cost changes affect you.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (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).

Read *Medicare & You 2021*

You can read *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) 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 7.3 – Getting Help from New York State Medicaid

To get information from New York State Medicaid you can call the New York State Department of Health at 1-800-541-2831.

The TTY number is 711. Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.