Health First Health Plans

Annual Notice of Changes for 2022

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

Annual Notice of Changes for 2022

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.**

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 2022 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second

Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including 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 website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in 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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in the Classic Plan (HMO-POS).
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022.** You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our 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, mailed in large print or in Braille or in audio tape 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 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 2022

The table below compares the 2021 costs and 2022 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	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$97	$97
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.)	$3,750 (In-Network) $10,000 (Point of Service)	$3,750 (In-Network) $10,000 (Point of Service)
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $30 per visit	Primary care visits: $0 per visit Specialist visits: $30 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.	You pay $180 for each day for days 1-7 of a covered inpatient stay during a benefit period. You pay $0 for each day for days 8-90 of a covered inpatient stay during a benefit period.	You pay $180 for each day for days 1-7 of a covered inpatient stay during a benefit period. You pay $0 for each day for days 8-90 of a covered inpatient stay during a benefit period.

Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: N/A Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Standard cost-sharing: You pay $5 per prescription Preferred cost-sharing: You pay $3 per prescription • Drug Tier 2: Standard cost-sharing: You pay $15 per prescription Preferred cost-sharing: You pay $10 per prescription • Drug Tier 3: Standard cost-sharing: You pay $45 per prescription Preferred cost-sharing: You pay $40 per prescription • Drug Tier 4: Standard cost-sharing: You pay $90 per prescription Preferred cost-sharing: You pay $80 per prescription • Drug Tier 5: You pay 33% of the total cost Preferred cost-sharing: You pay 33% of the total cost • Drug Tier 6: Standard cost-sharing: You pay $0 per prescription Preferred cost-sharing: You pay $0 per prescription	Deductible: N/A Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: Standard cost-sharing: You pay $0 per prescription Preferred cost-sharing: You pay $0 per prescription You pay $0 for Formulary insulins in Tier 1 •Drug Tier 2: Standard cost-sharing: You pay $15 per prescription Preferred cost-sharing: You pay $10 per prescription • Drug Tier 3: Standard cost-sharing: You pay $45 per prescription Preferred cost-sharing: You pay $40 per prescription You pay no more than $35 for Formulary insulins in Tier 3. • Drug Tier 4: Standard cost-sharing: You pay $90 per prescription Preferred cost-sharing: You pay $80 per prescription • Drug Tier 5: You pay 33% of the total cost Preferred cost-sharing: You pay 33% of the total cost

Cost	2021 (this year)	2022 (next year)
		To find out which drugs are Formulary insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed on the back cover of this booklet).

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in the Classic Plan (HMO-POS) in 2022

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our the Classic Plan (HMO-POS). This means starting January 1, 2022, 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, 2022 as a member of the Classic Plan (HMO-POS).

SECTION 2 Changes to Benefit and Cost for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$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	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount 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.	*$3,750 (In Network)* 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. $10,000 (Point of Service) 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.	*$3,750 (In Network)* 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 for the rest of the calendar year. $10,000 (Point of Service) 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.

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 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider 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. 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. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

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

Opioid treatment program services

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

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

Cost	2021 (this year)	2022 (next year)
Cardiac rehabilitation services	Cardiac rehabilitation services require prior authorization.	Cardiac rehabilitation services do not require prior authorization.
Dental services (PA)	You will be reimbursed up to $225 for the purchase of supplemental preventive dental and other routine dental services each calendar year. You may choose to see any provider licensed to perform these services even if they are not in the Health First Network. There is a plan coverage limit for supplemental preventive dental benefits and other routine dental services every year, including, but not limited to, dentures, extractions, crowns, etc. You may choose to see any provider licensed to perform these services even if they are not in the Health First Network. • Oral exam* • Cleanings* • Dental x-rays* • Fluoride Treatments*	The maximum plan allowance for supplemental preventive dental benefits and other routine dental services is $1,000 every calendar year. Dental services must be provided by a contracted provider. There is a plan allowance for supplemental preventive dental benefits and other routine dental services every calendar year, including: • One (1) oral exam every six months* • One (1) prophylaxis (cleaning) every six months* • One (1) fluoride treatment every calendar year* • Dental X-rays (X-ray periodicities can vary every 12 to 36 months, depending on the procedure as different types of X-rays are covered at different periodicities. For dental X-rays, the dental codes range in periodicity depending upon what is deemed

Cost	2021 (this year)	2022 (next year)
Dental services (PA) cont.	*Amounts you pay for services/items do not count toward your maximum out-of-pocket	medically appropriate per ADA guidelines.)* • Restorative services every three (3) years* • Periodontics every 6 to 36 months (The periodontics ranges relate to the frequency of the procedures performed.)* • Extractions once per tooth* • Other Oral/Maxillofacial Surgery every 60 months or per lifetime, depending on the procedure* • Other Services are covered every 6 to 24 months, depending on the procedure* *Amounts you pay for services/items do not count toward your maximum out-of-pocket
Diabetes self-management training, diabetic services and supplies	Diabetes self-management training requires prior authorization.	Diabetes self-management training does <u>not</u> require prior authorization.

Cost	2021 (this year)	2022 (next year)
Hearing services	You pay $15 for one routine hearing test every calendar year. You will be reimbursed up to $350 for the purchase of one hearing aid device (all types) per calendar year. Fitting/evaluation for hearing aids is not covered. There is a plan coverage limit for the purchase of hearing aids from any licensed provider, even if they are not in the Health First network	You pay $0 for one (1) routine hearing exam every calendar year. The maximum plan allowance for one (1) pair of hearing aids (all types) is $350 every calendar year. You pay $0 for one (1) fitting/evaluation for hearing aids every calendar year. Hearing services must be provided by a contracted provider.
Home health agency care (PA)	After 35 hours, home health agency care requires prior authorization (approval in advance) to be covered. Your PCP will coordinate this.	Home health agency care requires prior authorization (approval in advance) to be covered. Your PCP will coordinate this.
Medicare Part B prescription drugs (PA)	Part B step therapy is not covered.	Some drugs such as certain infusions for the treatment of cancer, blood disorders, autoimmune disorders, eye problems, Multiple Sclerosis, and Asthma may be subject to Part B step therapy.

Cost	2021 (this year)	2022 (next year)
Opioid treatment program services	Opioid treatment program services require prior authorization. Covered services do not include intake activities and periodic assessments.	Opioid treatment program services do not require prior authorization. Covered services include intake activities and periodic assessments.
Outpatient hospital observation	If you require specialty imaging services, separate cost sharing may apply.	Specialty imaging services will not apply separate cost-sharing.
Outpatient hospital services (PA)	If you require specialty imaging services, separate cost sharing may apply.	Specialty imaging services will not apply separate cost-sharing.
Outpatient mental health care (PA)	Outpatient mental health care services do not require prior authorization.	Outpatient mental health care services require prior authorization.
Outpatient rehabilitation services (PA)	You pay $15 for each Medicare-covered therapy visit. Outpatient rehabilitation services require prior authorization (approval in advance) for more than twenty (20) visits. Your PCP will coordinate this.	You pay $20 for each Medicare-covered therapy visit. All outpatient rehabilitation services except speech-language pathology services require prior authorization (approval in advance) for more than twenty (20) visits. Your PCP will coordinate this.

Cost	2021 (this year)	2022 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (PA)	You pay $150 for each Medicare-covered outpatient admission to an ambulatory surgical center. You pay $150 for each Medicare-covered outpatient admission to an outpatient hospital facility.	You pay $165 for each Medicare-covered outpatient admission to an ambulatory surgical center. You pay $165 for each Medicare-covered outpatient admission to an outpatient hospital facility.
Over-the-Counter (OTC) Items	Coverage does not include nicotine replacement therapy (NRT) that does not duplicate any Part D OTC or formulary drugs.	Coverage includes nicotine replacement therapy (NRT) that does not duplicate any Part D OTC or formulary drugs.
Point-of-Service - Ambulance Ground/Air	You pay $230 for Out-of-Network Ground/Air Ambulance Services	You pay 20% for Out-of-Network Ground/Air Ambulance Services
Pulmonary rehabilitation services	Pulmonary rehabilitation services require prior authorization.	Pulmonary rehabilitation services do not require prior authorization.
Skilled nursing facility (SNF) care (PA)	One (1) day prior inpatient hospital stay is required.	Zero (0) day prior inpatient hospital stay is required.
Supervised Exercise Therapy (SET)	Supervised exercise therapy requires prior authorization.	Supervised exercise therapy does not require prior authorization.
Urgently needed services	You pay $25 for each Medicare-covered Telehealth Urgent Care visit. You pay $25 for each worldwide urgent care coverage visit.	You pay $0 for each Medicare-covered Telehealth Urgent Care visit. You pay $90 for each worldwide urgent care coverage visit.

Cost	2021 (this year)	2022 (next year)
Vision care	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.	The maximum plan allowance for supplemental eye wear is $300 every calendar year. Vision services must be provided by a contracted provider.

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 you haven't received this insert by September 30, 2021, 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	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; 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 Preferred Generic Drugs:** Standard cost sharing: You pay $5 per prescription Preferred cost sharing: You pay $3 per prescription **Tier 2 Generic Drugs**: Standard cost sharing: You pay $15 per prescription Preferred cost sharing: You pay $10 per prescription **Tier 3 Preferred Brand Drugs:** Standard cost sharing: You pay $45 per prescription Preferred cost sharing: You pay $40 per prescription **Tier 4 Non-Preferred Drugs** Standard cost sharing: You pay $90 per prescription Preferred cost sharing: You pay $80 per prescription **Tier 5 Specialty Drugs** Standard cost sharing: You pay 33% of the total cost. Preferred cost sharing: You pay 33% of the total cost **Tier 6 Select Care Drugs:** Standard cost sharing: You pay $0 per prescription Preferred cost sharing: You pay $0 per prescription. Part D Senior Savings Model (select insulins for members without low income subsidy): Not Covered.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic** Standard cost sharing: You pay $0 per prescription Preferred cost sharing: You pay $0 per prescription You pay $0 for Formulary insulins in Tier 1 **Tier 2 Generic**: Standard cost sharing: You pay $15 per prescription Preferred cost sharing: You pay $10 per prescription **Tier 3 Preferred Brand:** Standard cost sharing: You pay $45 per prescription Preferred cost sharing: You pay $40 per prescription You pay no more than $35 for Formulary insulins in Tier 3 **Tier 4 Non-Preferred Drug:** Standard cost sharing: You pay $90 per prescription Preferred cost sharing: You pay $80 per prescription **Tier 5 Specialty Tier:** Standard cost sharing: You pay 33% of the total cost. Preferred cost sharing: You pay 33% of the total cost Part D Senior Savings Model Program (select insulins for members without low income subsidy): You pay no more than $35 per thirty (30) day supply for Formulary insulins.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued) 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.	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage. The Classic Plan (HMO-POS) offers additional gap coverage for Formulary insulins. During the Coverage Gap stage, your out-of-pocket costs for Formulary insulins will be no more than $35 per thirty (30) day supply.

SECTION 3 Administrative Changes

Description	2021 (this year)	2022 (next year)
Part D Senior Savings Model Program: This program provides improved access to and affordability of select insulin drugs to members without Low Income Subsidy.	Part D Senior Savings Model Program (select insulins for members without low income subsidy): Not Covered.	Maximum $35 copay for 30-day supply or a $105 copay for 90-day supply for Formulary insulin drugs for members without Low Income Subsidy. To find out which drugs are Formulary insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Services are printed on the back cover of this booklet)
Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary 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 for generic drugs and Tier 5 for brand name drugs.	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.
Ways to pay your Plan Premium	You can pay your plan premium with a credit or debit card by phone.	Credit and debit cards are not accepted for over the phone premium payments at this time.
Ways to pay your Plan Premium	You can pay your premium, in person, by stopping by our office.	In person premium payments will not be accepted.

Description	2021 (this year)	2022 (next year)
Preferred Pharmacies	Walgreens is a preferred Pharmacy CVS is NOT a preferred pharmacy Publix is NOT a preferred pharmacy	Walgreens is NOT a preferred Pharmacy CVS is a preferred pharmacy Publix is a preferred pharmacy
Where to mail your Premium	Please mail your check, along with the appropriate invoice to: Health First Health Plans P.O. Box 628262 Orlando, FL 32862-8262	Please mail your check, along with the appropriate invoice to: Health First Health Plans c/o OSCAR P.O. Box 628752 Orlando, FL 32862-8752
Changes to the Pharmacy Benefit Manager (PBM) vendor	Express Scripts is the PBM vendor	CVS is the PBM vendor There is no change for you in the process at the pharmacy. Please provide your new ID card at the Pharmacy for prescriptions filled on or after January 1, 2022, and they will bill your claims to the appropriate PBM
Behavioral and Mental Health Services	Behavioral and mental health services are managed by Magellan	Behavioral and mental health services are managed by Optum Health.
Hearing Benefit Vendor	You may choose to see any provider licensed to perform these services even if they are not in the Health First Network.	TruHearing will become the hearing benefits administrator for your Medicare Advantage Plan. Beginning January 1, 2022, you must visit providers participating with TruHearing in order for your services to be covered in-network.

Description	2021 (this year)	2022 (next year)
Vision Benefit Vendor	You may choose to see any provider licensed to perform these services even if they are not in the Health First Network.	Davis Vision will become the vision benefits administrator for your Medicare Advantage plan. Beginning January 1, 2022, you must visit providers participating with Davis Vision in order for your services to be covered in-network.
Dental Benefit Vendor	You may choose to see any provider licensed to perform these services even if they are not in the Health First Network.	Liberty Dental will become the dental benefits administrator for your Medicare Advantage plan. Beginning January 1, 2022, you must visit providers participating with Liberty Dental in order for your services to be covered in-network.
What to do if you are having trouble paying your Premium	If we have not received your premium payment by the first day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within 90 days.	If we have not received your premium payment by the first day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your full premium payment within 6 months.
Availability of Materials in Alternate Formats	You may request your materials be read aloud, e-mailed, or mailed in large print by contacting Customer Service.	You may request your materials be read aloud, mailed in large print or in Braille or in audio tape by contacting Customer Service

Description	2021 (this year)	2022 (next year)
Transportation	Transportation Services are managed by Lyft	Transportation Services are managed by Circulation
Over-the-Counter (OTC) Medication vendor	WEX is the OTC medication payment solution vendor	InComm.is the OTC medication payment solution vendor
Coverage Gap Stage	For Generic drugs in Tier 1 from a Standard Retail Pharmacy, you pay $5 copay. For Generic drugs in Tier 1 from a Preferred Retail Pharmacy, you pay $3 copay. For Generic drugs from a Standard Retail Pharmacy in Tier 2, you pay $15 copay. For Generic drugs in Tier 2 from a Preferred Retail Pharmacy, you pay $10. For Select Care drugs in Tier 6, you pay $0. For brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee).	For Preferred Generic drugs in Tier 1 from a Standard Retail Pharmacy, you pay $0 copay. For Preferred Generic drugs in Tier 1 from a Preferred Retail Pharmacy, you pay $0 copay. For Generic drugs from a Standard Retail Pharmacy in Tier 2, you pay $15 copay. For Generic drugs from a Preferred Retail Pharmacy in Tier 2, you pay $10 copay. For all other drugs during this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic
Reimbursements for Supplemental Benefits (Dental, Hearing, and Vision)	Allowances for Dental, Hearing, and Vision Supplemental benefits are provided on a preloaded debit card.	Dental, Hearing, and Vision Supplemental benefits are processed as claims when using your in-network providers

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 the 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 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, 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 the *Medicare & You 2022* handbook, 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. **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, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area 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, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

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

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

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. **"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 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. Calls to this numbers are free.

Read your 2022 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 Evidence of Coverage for 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. 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. 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). 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 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (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.