

Health Pointe Direct Complete Plan (HMO I-SNP) offered by Health Pointe of New York, LLC

Annual Notice of Changes for 2020

You are currently enrolled as a member of Health Pointe Direct Complete Plan (HMO I-SNP). 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, 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 2020 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 <https://go.medicare.gov/drugprices>. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors, 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 <https://www.medicare.gov> website. Click “Find health & drug plans.”
 - Review the list in the back of your Medicare & You handbook.
 - Look in Section 4.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

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

- If you want to **keep** Health Pointe Direct Complete Plan, you don’t need to do anything. You will stay in Health Pointe Direct Complete Plan.
- To change to a **different plan** that may better meet your needs, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-844-269-3442 for additional information. (TTY users should call 711.) From October 1 to March 31, we are open 7 days a week, from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, from 8 a.m. to 8 p.m. EST.
- This document is available to order in Braille, large print and audio tape. To request this document in an alternate format, please call Member Services at the phone number printed on the back of this booklet.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About Health Pointe Direct Complete Plan

- When this booklet says “we,” “us,” or “our,” it means Health Pointe of New York, LLC. When it says “plan” or “our plan,” it means Health Pointe Direct Complete Plan.

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Health Pointe Direct Complete Plan 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.healthpointeny.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

These are 2019 cost-sharing amounts and may change for 2020. Health Pointe Direct Complete Plan will provide updated rates as soon as they are released

Cost	2019 (this year)	2020 (next year)
Monthly plan premium*	\$0	\$0
Drug plan premium	\$39.30	\$36.60
* Your premium may be higher or lower than this amount. See Section 2.1 for details.		
Maximum out-of-pocket amount	\$6,700	\$6,700
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.)		
Doctor office visits	Primary care visits: 20% of the cost per visit	Primary care visits: 0% coinsurance for primary care services provided at the Nursing Home, 20% coinsurance for primary care services provided outside the Nursing Home per visit
	Specialist visits: 20% of the cost per visit	Specialist visits: 5-20% per visit

Cost	2019 (this year)	2020 (next year)
<p>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.</p>	<p>For each Medicare covered hospital stay: \$1364 deductible each benefit period.</p> <p>Days 1–60: \$0 coinsurance for each benefit period.</p> <p>Days 61–90: \$341 coinsurance per day of each benefit period.</p> <p>Days 91 and beyond: \$682 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</p>	<p>For each Medicare covered hospital stay: \$1408 deductible each benefit period.</p> <p>Days 1–60: \$0 coinsurance for each benefit period.</p> <p>Days 61–90: \$352 copay per day of each benefit period.</p> <p>Days 91 and beyond: \$704 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</p>
<p>Part D prescription drug coverage (See Section 2.6 for details.)</p>	<p>Deductible: \$415</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$5.75 • Drug Tier 2: 25% 	<p>Deductible: \$435</p> <p>Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: 25%

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Health Pointe Direct Complete in 2020

If you do nothing to change your Medicare coverage by December 7, 2019, we will automatically enroll you in our Health Pointe Direct Complete. This means starting January 1, 2020, you will be getting your medical and prescription drug coverage through Health Pointe Direct Complete. 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, you can do so between January 1 and March 31. You can also change plans 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 Health Pointe Direct Complete and the benefits you will have on January 1, 2020 as a member of Health Pointe Direct Complete.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$39.30	\$36.60

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

Section 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	2019 (this year)	2020 (next year)
<p>Maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and deductibles) 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>\$6,700</p> <p>Once you have paid \$6700 out-of-pocket for Part A and Part B services</p> <p>Once you have paid \$6700 for Part A and Part B services you receive from in-network providers, the plan will cover your services you receive from in-network providers at no cost to you for the rest of the year.</p>	<p>\$6,700</p> <p>Once you have paid \$6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your Part A and Part B services 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 www.healthponteny.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2020 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 and managing 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. An updated Pharmacy Directory is located on our website at www.healthpointeny.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 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 *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Health and wellness education programs Music therapy is intended to help members with stress relief and pain management, while also improving mental and emotional health. Offered once per quarter.		You pay a \$0 copay

Cost	2019 (this year)	2020 (next year)
<p>Hearing services Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>20% of the cost for Medicare-covered diagnostic hearing exams.</p>	<p>20% of the cost for Medicare-covered diagnostic hearing exams. Hearing aids are provided every two years.</p>
<p>Physician/Practitioner services, including doctor’s office visits</p>	<p>You pay 20% of the cost for each Primary Care Physician visit for Medicare covered benefits.</p> <p>When you get Medicare Part B, you can get a one-time physical within the first the first 6 months of your new Part B coverage. The coverage does not include lab tests. \$0 copay for routine exams. Limited to 1 each year.</p>	<p>You pay 0% coinsurance for primary care services provided at the Nursing Home, 20% coinsurance for primary care services provided outside the Nursing Home.</p> <p>You pay 5-20% for Specialty Services.</p> <p>When you get Medicare Part B, you can get a one-time physical within the first the first 6 months of your new Part B coverage. The coverage does not include lab tests. \$0 copay for routine exams. Limited to 1 each year.</p>

Cost	2019 (this year)	2020 (next year)
<p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>You pay 20% of the cost for each Medicare-covered medically necessary foot care visit.</p>	<p>You pay 5% coinsurance for Medicare-covered podiatry services provided in the Nursing Home, 20% coinsurance for Medicare-covered podiatry services provided outside the Nursing Home.</p>
<p>Dental Services</p>	<p>You pay 20% of the Medicare-covered dental services.</p>	<p>Dental services approved by Medicare during the contract year will be covered.</p> <p>Upper/Lower denture replacement every 4 years.</p>

Cost	2019 (this year)	2020 (next year)
Opioid Treatment Program Services	NA	<p>Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:</p> <ul style="list-style-type: none"> • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing <p>You pay 20% of the cost for Opioid Treatment Services.</p> <p><i>Authorization and referral are required.</i></p>

Cost	2019 (this year)	2020 (next year)
<p>Vision care Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) 	<p>You pay \$0 copay for diagnosis and treatment for diseases and conditions of the eye. Up to 1 routine exam per year.</p> <p>You pay \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>You pay \$0 copay for up to one pair of eyeglasses every two years.</p> <p>You pay \$0 copay for up to one pair of contacts every two years</p> <p>You pay \$0 copay for one pair of lenses every two years.</p> <p>You pay \$0 copay for up to one frame every two years.</p> <p>You receive \$350 every two years towards the purchase of eyewear</p>	<p>You pay \$0 copay for diagnosis and treatment for diseases and conditions of the eye. Up to 1 routine exam per year.</p> <p>You pay \$0 copay for up to one pair of eyeglasses every two years.</p> <p>You pay \$0 copay for up to one pair of contacts every two years</p> <p>You pay \$0 copay for up to one frame every two years.</p> <p>You receive \$100 every two years towards the purchase of eyewear</p>

Cost	2019 (this year)	2020 (next year)
<p>Inpatient hospital care 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>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy 	<p>For each Medicare covered hospital stay: \$1,364 deductible each benefit period.</p> <p>Days 1–60: \$0 coinsurance for each benefit period.</p> <p>Days 61–90: \$341 coinsurance per day of each benefit period.</p> <p>Days 91 and beyond: \$682 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</p> <p>Beyond lifetime reserve days: all costs.</p> <p>A benefit period begins with a hospitalization and ends when you have not received hospital or skilled care for 60 days. If you go to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>For each Medicare covered hospital stay: \$1408 deductible each benefit period.</p> <p>Days 1–60: \$0 coinsurance for each benefit period.</p> <p>Days 61–90: \$352 coinsurance per day of each benefit period.</p> <p>Days 91 and beyond: \$704 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</p> <p>Beyond lifetime reserve days: all costs.</p> <p>A benefit period begins with a hospitalization and ends when you have not received hospital or skilled care for 60 days. If you go to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>

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. If you don’t see your drug on this list, it might still be covered. **You can get the complete Drug List** by calling Member Services (see the back cover) or visiting our website (www.healthpointeny.com).

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
 - 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 other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (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.

Current formulary exceptions may expire within the next year and new prior authorization requests may need to be submitted as needed.

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 didn’t receive this insert with this packet please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 8.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.healthpointeny.com. You can also review the attached *Evidence of Coverage* 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*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (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 \$415. During this stage, you pay \$5.75 cost-sharing for drugs on Tier 1 and the full cost of drugs on Tier 2 until you have reached the yearly deductible.	The deductible is \$435. During this stage, you pay the full cost of drugs on tier 1 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

For drugs on Tier 1, your cost-sharing in the initial coverage stage is changing from copayment to coinsurance. Please see the following chart for the changes from 2019 to 2020.

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	2019 (this year)	2020 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Tier 1: You pay \$5.75 per prescription.</p> <p>For 2019 you paid a \$5.75 copayment for drugs on Tier 1. For 2020 you will pay a 25% coinsurance for drugs on this tier.</p> <p>Tier 2: You pay 25% of the total cost.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p>Tier 1: You pay 25% of the total cost.</p>
<p>Stage 2: Initial Coverage Stage (continued)</p> <p>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 <i>Evidence of Coverage</i>.</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>Once your total drug costs have reached \$3,820, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$4,020, 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 the Initial Coverage Stage, for drugs on Tier 1, your cost-sharing is changing from a copayment to coinsurance. For information about your costs in these stages, look 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 Health Pointe Direct Complete

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

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 2020 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 2020*, 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 <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from Health Pointe Direct Complete.
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from Health Pointe Direct Complete.
- 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 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 4 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, 2020.

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*.

You can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 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 New York, the SHIP is called New York State Health Insurance Information, Counseling and Assistance Program (HIICAP).

New York State Health Insurance Information, Counseling and Assistance Program (HIICAP) 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. New York State Health Insurance Information, Counseling and Assistance Program (HIICAP) 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 HIICAP at 1-800-701-0501. You can learn more about HIICAP by visiting their website (www.aging.ny.gov/HealthBenefits/HIICAPIndex.cfm).

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.** 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).
- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmaceutical Insurance Program (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 Section 6 of this booklet).

SECTION 7 Questions?

Section 7.1 – Getting Help from Health Pointe Direct Complete

Questions? We're here to help. Please call Member Services at 1-844-269-3442. (TTY only, call 711). Calls to these numbers are free.

Read your 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Health Pointe Direct Complete. 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.healthpointeny.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.healthpointeny.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 (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on “Find health & drug plans”).

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<https://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.