The Secure Plan (HMO) offered by Health First Health Plans

Annual Notice of Changes for 2022

You are currently enrolled as a member of the Secure Plan (HMO). 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 2.4 for information about benefit and cost changes for our plan.

☐ 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

OMB Approval 0938-1051 (Expires: February 29, 2024)

☐ 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 Secure Plan (HMO).
- 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 Secure Plan (HMO).
- 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 Secure Plan (HMO)

- 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 Secure Plan (HMO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for the Secure Plan (HMO) 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	$0	$0
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.)	$3,000	$3,000
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $20 per visit	Primary care visits: $0 per visit Specialist visits: $20 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 $200 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 $200 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.

Annual Notice of Changes for 2022
Table of Contents

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

If you do nothing to change your Medicare coverage by December 7, 2021, we will automatically enroll you in our Secure Plan (HMO). This means starting January 1, 2022, you will be getting your medical coverage through the Secure Plan (HMO). 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 Secure Plan (HMO) and the benefits you will have on January 1, 2022 as a member of the Secure Plan (HMO).

SECTION 2 Changes to Benefits and Costs 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.)	$0	$0

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.	$3,000 Once you have paid $3,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	$3,000 Once you have paid $3,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services 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 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.

Cost	2021 (this year)	2022 (next year)
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* *Amounts you pay for services/items do not count toward your maximum out-of-pocket	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 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

Cost	2021 (this year)	2022 (next year)
Diabetes self-management training, diabetic services and supplies	Diabetes self-management training requires prior authorization.	Diabetes self-management training does not require prior authorization.
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)	Outpatient rehabilitation services require prior authorization (approval in advance) for more than twenty (20) visits. Your PCP will coordinate this.	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.
Pulmonary rehabilitation services	Pulmonary rehabilitation services require prior authorization.	Pulmonary rehabilitation services do not require prior authorization.
Skilled nursing facility 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.

Cost	2021 (this year)	2022 (next year)
Urgently needed services	You pay $30 for each Medicare-covered Telehealth Urgent Care visit. You pay $30 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.
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 3 Administrative Changes

Description	2021 (this year)	2022 (next year)
Behavioral and Mental Health Services	Behavioral and mental health services are managed by Magellan	Behavioral and mental health services are managed by Optum Health.
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.

Description	2021 (this year)	2022 (next year)
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
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 for your services to be covered in-network.
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
Transportation	Transportation Services are managed by Lyft	Transportation Services are managed by Circulation
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

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in the Secure Plan (HMO)

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 Secure Plan (HMO).

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, there may be 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 (SHIP) (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 Secure Plan (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from the Secure Plan (HMO).
- 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 8, 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 8, 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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida ADAP Program. Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Contact the Florida ADAP Program at 1-800-352-2437. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Florida ADAP Program at 1-800-352-2437.

SECTION 8 Questions?

Section 8.1 – Getting Help from the Secure Plan (HMO)

Questions? We're here to help. Please call Customer Service at 1.800.716.7737. (TTY only, call (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 these 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 Secure Plan (HMO). 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*).

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.