HAP Senior Plus Option 3 (PPO) offered by Alliance Health and Life Insurance Company

Annual Notice of Changes for 2021

You are currently enrolled as a member of *HAP Senior Plus Option 3.* 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, 2.2 and 2.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit

go.medicare.gov/drugprices. 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 handbook.
- Look in Section 4.2 to learn more about your choices.

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

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

- If you don't join another plan by December 7, 2020, you will be enrolled in *HAP Senior Plus Option 3.*
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15 and December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in *HAP Senior Plus Option 3*.
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at (888) 658-2536 for additional information. (TTY users should call 711). Hours are April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- This booklet is available in alternate formats such as large print or audio tapes.
- **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 *HAP Senior Plus Option 3*

- *Health Alliance Plan (HAP)* has HMO, HMO-POS, PPO plans with Medicare contracts. Enrollment depends on contract renewal.
- When this booklet says "we," "us," or "our," it means *Health Alliance Plan (HAP).* When it says "plan" or "our plan," it means *HAP Senior Plus Option 3*.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for *HAP Senior Plus Option 3 (PPO)* 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.hap.org/medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$149	$160
Deductible	**Out-of-network only** $100	**Out-of-network only** $100
Maximum out-of-pocket amounts 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.)	From network providers: $4,500 From network and out-of-network providers combined: $6,500	From network providers: $4,500 From network and out-of-network providers combined: $6,500
Doctor office visits	**In-network** Primary care visits: $15 Copay per visit Specialist visits: $35 Copay per visit **Out-of-network** Primary care visits: 25% Coinsurance per visit Specialist visits: 25% Coinsurance per visit	**In-network** Primary care visits: $15 Copay per visit Specialist visits: $35 Copay per visit **Out-of-network** Primary care visits: 25% Coinsurance per visit Specialist visits: 25% Coinsurance per visit

Cost	2020 (this year)	2021 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network** $200 Copay per day for days 1- 6 $0 Copay per day for days 7- 90 **Out-of-network** 25% Coinsurance per admission	**In-network** $215 Copay per day for days 1 - 7 $0 Copay per day for days 8 - 90 **Out-of-network** 25% Coinsurance per admission
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copays/coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard:* $7 *Preferred:* $0 • Drug Tier 2: *Standard:* $15 *Preferred:* $10 • Drug Tier 3: *Standard:* $47 *Preferred:* $42 • Drug Tier 4: *Standard:* 42% *Preferred:* 40% • Drug Tier 5: *Standard:* 33% *Preferred:* 33% • Drug Tier 6: *Did not exist in 2020*	Deductible: $0 Copays/coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard:* $7 *Preferred:* $0 • Drug Tier 2: *Standard:* $15 *Preferred:* $10 • Drug Tier 3: *Standard:* $47 *Preferred:* $42 • Drug Tier 4: *Standard:* 50% *Preferred:* 48% • Drug Tier 5: *Standard:* 33% *Preferred:* 33% • Drug Tier 6: *Standard:* $0 *Preferred:* $0

Cost	2020 (this year)	2021 (next year)
Senior Savings Model Insulins To find out which drugs are select 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).	Senior Savings Model did not exist in 2020.	Maximum copays for Senior Savings Model insulins are $35 for a 30-day supply.

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in *HAP Senior Plus Option 3* in 2021

If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our *HAP Senior Plus Option 3*. This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through *HAP Senior Plus Option 3*. 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 *HAP Senior Plus Option 3* and the benefits you will have on January 1, 2021, as a member of *HAP Senior Plus Option 3.*

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$149	$160
Optional dental plan monthly premium	Delta Dental Plan 1 Member Pays $21.40 per month Delta Dental Plan 2 Member Pays $41.30 per month	Delta Dental 25 Member Pays $19.00 per month Delta Dental 50 Member Pays $21.00 per month Delta Dental 70 Member Pays $40.80 per month

- 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 Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. If you choose an optional supplemental dental plan, your plan premium and your costs for services also do not count toward your maximum out-of-pocket amount.	$4,500	$4,500 Once you have paid $4,500 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$6,500	$6,500 Once you have paid $6,500 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Cost	2020 (this year)	2021 (next year)
Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. If you choose an optional supplemental dental plan, your plan premium and your costs for services also do not count toward your maximum out-of-pocket amount.		

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.hap.org/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

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

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

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 www.hap.org/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

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 *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture	**In-Network:** Not Covered	**In-Network:** You pay a $15 copay for acupuncture services for chronic low back pain from a primary care provider per visit. You pay a $35 copay for acupuncture services for chronic low back pain from a specialist provider per visit. Limited to 20 visits per year for chronic low back pain.
	Out-of-Network: Not Covered	**Out-of-Network:** You pay 25% coinsurance for acupuncture services for chronic low back pain per

Cost	2020 (this year)	2021 (next year)
		visit. Limited to 20 visits per year for chronic low back pain.
Ambulatory Surgical Center (ASC) Services	**In-Network:** You pay a $75 copay for ASC services. **Out-of-Network:** You pay 25% coinsurance for ASC services.	**In-Network:** You pay a $100 copay for ASC services. **Out-of-Network:** You pay 25% coinsurance for ASC services.
Diabetic Supplies	**In-Network:** You pay nothing for all diabetic supplies. **Out-of-Network:** You pay 25% coinsurance for all diabetic supplies.	**In-Network:** You pay nothing for continuous glucose monitors when obtained from a pharmacy. You pay a 20% coinsurance for continuous glucose monitors when obtained from a durable medical equipment provider. You pay nothing for all other diabetic supplies. **Out-of-Network:** You pay 25% coinsurance for all diabetic supplies.
Eyewear	You get a $100 allowance for eyewear per year. Must be obtained from a HAP provider.	You get a $125 allowance for eyewear per year. Must be obtained from an EyeMed provider. In-network retailers include Henry Ford OptimEyes, LensCrafters, Target Optical, Pearle Vision, and America's

Cost	2020 (this year)	2021 (next year)
		Best. This year you'll be able to order eyewear online or in-person through our new routine vision provider, EyeMed.
Health and Wellness Education Programs	Silver&Fit® Exercise and Healthy Aging Program You pay nothing for this benefit. This program is offered to eligible Medicare Advantage beneficiaries. Members have the following choices available: 1. A fitness center membership: You can go to a Silver&Fit® fitness club, YMCA or exercise center near you that takes part in the program, or 2. A home fitness program: You can choose from a variety of home fitness kits if you can't get to a fitness center or want to work out at home. You can get up to 2 kits each benefit year. Silver&Fit® members can also access low-impact Silver&Fit® classes (where available) focusing on improving and increasing muscular strength and endurance, mobility, flexibility, range of motion,	Peerfit Move® Fitness program You pay nothing for this benefit. Peerfit Move® is a flexible fitness benefit with monthly credits to use on a variety of larger gyms or local fitness studios. Members will have 32 credits each month to utilize on their choice of fitness experiences. Credits can be used for a monthly gym membership with unlimited visits, access to amenities and classes, fitness studio classes and/or Fit Kits which include at-home fitness boxes. Members also have access to unlimited fitness videos at $0 copay which utilize zero credits. Any unused credits from the monthly allotment do not carry over to the next month but will be refreshed on the first of each month. Members will have the option of purchasing additional credits. For more information regarding the

Cost	2020 (this year)	2021 (next year)
	balance, agility and coordination; Healthy Aging classes (online or DVD); a quarterly newsletter; and web tools. To learn more about the Silver&Fit® Program, visit www.hap.org/medicare. If you have questions, call Silver&Fit® toll-free at 1-877-427-4788 (TTY/TDD: 711), Monday through Friday, 8 a.m. to 9 p.m. Eastern Time. Non-standard services that call for an added fee are not part of the Silver&Fit® program and will not be reimbursed. The Silver&Fit® program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit® is a federally registered trademark of ASH.	fitness membership, please visit www.PeerfitMove.com, email move@peerfit.com or call the Customer Service department at 1-855-378-6683. Customer Service hours of operation are: October 1 – March 31: Live Customer Service Representatives (CSRs) available seven days a week, from 8:00 a.m. EST to 11:00 p.m. EST. Interactive voice response system is available after hours and on Thanksgiving and Christmas Day; April 1 – September 30: Live CSRs available Monday through Friday, from 8:00 a.m. EST to 11:00 p.m. EST. Interactive voice response system is available after hours and on Saturdays, Sundays and Federal Holidays.
Inpatient Hospital and Psychiatric Hospital Stays	**In-Network:** You pay a $210 copay for days 1 - 6 for inpatient hospital stays. You pay nothing for days 7 - 90 for inpatient hospital stays. **Out-of-Network:** You pay 25% coinsurance for inpatient hospital stays.	**In-Network:** You pay a $215 copay for days 1 - 7 for inpatient hospital stays. You pay nothing for days 8 - 90 for inpatient hospital stays. **Out-of-Network:** You pay 25% coinsurance for inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
Opioid Treatment Services Includes telehealth visits	**In-Network:** You pay a $15 copay for opioid treatment services per visit. **Out-of-Network:** You pay 25% coinsurance for opioid treatment services per visit.	**In-Network:** You pay nothing for opioid treatment services per visit. **Out-of-Network:** You pay 25% coinsurance for opioid treatment services per visit.
Outpatient Hospital Services	**In-Network:** You pay a $150 copay for outpatient hospital services. **Out-of-Network:** You pay 25% coinsurance for outpatient hospital services.	**In-Network:** You pay a $210 copay for outpatient hospital services. **Out-of-Network:** You pay 25% coinsurance for outpatient hospital services.
Outpatient Observation Services	**In-Network:** You pay a $150 copay for outpatient observation services. **Out-of-Network:** You pay 25% coinsurance for outpatient observation services.	**In-Network:** You pay a $210 copay for outpatient observation services. **Out-of-Network:** You pay 25% coinsurance for outpatient observation services.
Podiatry Services Includes telehealth visits	**In-Network:** You pay a $35 copay for all podiatry services per visit.	**In-Network:** You pay nothing for podiatry services condition specific for diabetes. You pay a $35 copay for all other podiatry services per visit.

Cost	2020 (this year)	2021 (next year)
	Out-of-Network: You pay 25% coinsurance for all podiatry services per visit.	**Out-of-Network:** You pay 25% coinsurance for all podiatry services per visit.
Preventive Dental Services Must be obtained from a Delta Dental provider.	You get 1 oral exam and 1 prophylaxis (cleaning) per year.	You get 2 oral exams and 2 prophylaxis (cleanings) per year.
Skilled Nursing Facility (SNF)	**In-Network:** You pay a $178 copay for days 21 - 100 for SNF care. **Out-of-Network:** You pay 25% coinsurance for days 21 - 100 for SNF care.	**In-Network:** You pay a $184 copay for days 21 - 100 for SNF care. **Out-of-Network:** You pay 25% coinsurance for days 21 - 100 for SNF care.
Visitor/Traveler Benefit	Not Covered.	In-network cost share applies for all plan covered services up to 6 months while visiting the continental United States (excludes out of the service area in Michigan).
Worldwide Ambulance Services	**In-Network:** You pay a $150 copay for ambulance services for each one-way trip. **Out-of-Network:** You pay 25% coinsurance for ambulance services for each one-way trip.	**In-Network:** You pay a $200 copay for ambulance services for each one-way trip. **Out-of-Network:** You pay 25% coinsurance for ambulance services for each one-way trip.
Worldwide Urgently Needed Services	**In-Network:** You pay a $40 copay for urgently needed services per visit.	**In-Network:** You pay a $65 copay for urgently needed services per visit.

Cost	2020 (this year)	2021 (next year)
Includes telehealth visits	**Out-of-Network:** You pay a $40 copay for urgently needed services per visit.	**Out-of-Network:** You pay a $65 copay for urgently needed services per visit.

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 already been approved to receive a medication, your approval is valid through the date listed on your approval letter. Most exceptions are approved for 1 year, although some are only approved through the end of the calendar year.

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 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 www.hap.org/medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
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. There is no deductible for *HAP Senior Plus Option 3* for select insulins. You pay a monthly copay of $10 to $35 for select insulins.

Changes to Your Cost Sharing in the Initial Coverage Stage

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

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage 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. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage.* 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. You pay $10 to $35 for select insulins.	Your cost for a one-month supply at a network pharmacy: **Preferred Generics:** *Standard cost sharing:* You pay $7 per prescription. *Preferred cost sharing* You pay $0 per prescription **Generics:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing* You pay $10 per prescription **Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing* You pay $42 per prescription **Non-Preferred Drug:** *Standard cost sharing:* You pay 42% of the total cost. *Preferred cost sharing* You pay 40% of the total cost **Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Preferred Generics:** *Standard cost sharing:* You pay $7 per prescription. *Preferred cost sharing* You pay $0 per prescription **Generics:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing* You pay $10 per prescription **Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing* You pay $42 per prescription **Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost. *Preferred cost sharing* You pay 48% of the total cost **Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued)	*Preferred cost sharing* You pay 33% of the total cost **Select Care Drugs:** *Did not exist in 2020.* Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	*Preferred cost sharing* You pay 33% of the total cost **Select Care Drugs:** *Standard cost sharing:* You pay $0 per prescription *Preferred cost sharing* You pay $0 per prescription Once your total drug costs have reached $4,130, 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*.

HAP Senior Plus Option 3 offers additional coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $10 to $35.

SECTION 3 Administrative Changes

Description	2020 (this year)	2021 (next year)
Change in option for paying the monthly premium	Cash payments are accepted in person for the monthly premium.	Cash payments will no longer be accepted for the monthly premium.
Days supply for opioid medications	Each new fill or refill for prescriptions for opioid medications are limited to a 90-day supply dispensed for members who received authorization for greater than a 7-day supply.	Each new fill or refill for prescriptions for opioid medications are limited to a 30-day supply dispensed for members who received authorization for greater than a 7-day supply.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in *HAP Senior Plus Option 3*

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 *HAP Senior Plus Option 3*.

Section 4.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

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

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

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

As a reminder, *Alliance Health and Life Insurance Company* offers other Medicare health plans and Medicare prescription drug 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 *HAP Senior Plus Option 3.*
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *HAP Senior Plus Option 3.*
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).

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

SECTION 5 Deadline for Changing Plans

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

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

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

Michigan Medicare/Medicaid Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Michigan Medicare/Medicaid Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Michigan Medicare/Medicaid Assistance Program at (800) 803-7174. You can learn more about Michigan Medicare/Medicaid Assistance Program by visiting their website (www.mmapinc.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 Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Michigan Drug Assistance Program, HIV Care Section, 888-826-6565 (toll-free).

SECTION 8 Questions?

Section 8.1 – Getting Help from *HAP Senior Plus Option 3*

Questions? We're here to help. Please call Customer Service at (888) 658-2536. (TTY only, call 711.) We are available for phone calls April 1st through September 30th Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for *HAP Senior Plus Option 3.* 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.hap.org/medicare. 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 www.hap.org/medicare. 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 2021*

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

HAP Senior Plus Option 3 Customer Service

Method	Customer Service – Contact Information
CALL	(888) 658-2536. Calls to this number are free. Our normal business hours are: April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
TTY	711. Calls to this number are free. Our normal business hours are: April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
WRITE	HAP Medicare Solutions, ATTN: Customer Service, 2850 West Grand Blvd, Detroit, MI 48202
WEBSITE	www.hap.org/medicare

Michigan Medicare/Medicaid Assistance Program

Michigan Medicare/Medicaid Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	(800) 803-7174
TTY	711. Calls to this number are free. Our normal business hours are: April 1st through September 30th: Monday through Friday, 8 a.m. to 8 p.m.; October 1st through March 31st: Seven days a week, 8 a.m. to 8 p.m. Prescription drug benefit related calls: Available 24 hours a day, seven days a week.
WRITE	6105 West St. Joseph, Suite 204, Lansing, MI 48917-4850
WEBSITE	www.mmapinc.org

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