HealthPartners UnityPoint Health Align (PPO) offered by HealthPartners UnityPoint Health, Inc.

Annual Notice of Changes for 2021

You are currently enrolled as a member of HealthPartners UnityPoint Health Align. 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 1.1 and 1.5 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 1.6 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 1.3 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 2.2 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 HealthPartners UnityPoint Health Align.
- 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 HealthPartners UnityPoint Health Align.
- 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 Member Services number at 888-360-0544 for additional information. (TTY users should call 711). Hours are:

  From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

  From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

- This information is available in a different format, including large print. Please call Member Services if you need plan information in another format (phone numbers are in Section 6.1 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HealthPartners UnityPoint Health Align

- HealthPartners UnityPoint Health is a PPO plan with a Medicare contract. Enrollment in HealthPartners UnityPoint Health depends on contract renewal.

- When this booklet says "we," "us," or "our," it means HealthPartners UnityPoint Health. When it says "plan" or "our plan," it means HealthPartners UnityPoint Health Align.

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Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for HealthPartners UnityPoint Health Align 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 **healthpartnersunitypointhealth.com**. You may also call Member Services 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 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $3,700 From network and out-of-network providers combined: $10,000	From network providers: $3,900 From network and out-of-network providers combined: $6,500
Doctor office visits	Primary care visits: In-Network: $0 copay per visit Out-of-Network: 40% of the total cost Specialist visits: In-Network: $35 copay per visit Out-of-Network: 40% of the total cost	Primary care visits: In-Network: $0 copay per visit Out-of-Network: $60 copay per visit Specialist visits: In-Network: $35 copay per visit Out-of-Network: $60 copay 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: $325 copay per day for days 1-5; nothing for additional days per stay Out-of-Network: 40% of the total cost	In-Network: $345 copay per day for days 1-5; nothing for additional days per stay Out-of-Network: $525 copay per day for days 1-5; nothing for additional days per stay
Part D prescription drug coverage (See Section 1.6 for details.) 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 Member Services (phone numbers for Member Services are in Section 6.1 of this booklet).	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 per prescription • Drug Tier 2: $9 per prescription • Drug Tier 3: $47 per prescription • Drug Tier 4: $100 per prescription • Drug Tier 5: 31% of the total cost	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 per prescription • Drug Tier 2: $9 per prescription • Drug Tier 3: $47 per prescription $35 for select insulins • Drug Tier 4: $100 per prescription • Drug Tier 5: 33% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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.)	$0	$0

- 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 5 regarding "Extra Help" from Medicare.

Section 1.2 – 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) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,700	$3,900 Once you have paid $3,900 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2020 (this year)	2021 (next 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 maximum out-of-pocket amount.	$10,000	$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.

Section 1.3 – 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 **healthpartnersunitypointhealth.com**. You may also call Member Services 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 1.4 – 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 **healthpartnersunitypointhealth.com**. You may also call Member Services 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 1.5 – 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 (Out-of-Network)	You pay 40% of the total cost for Medicare-covered acupuncture services.	You pay a $60 copay per visit for Medicare-covered acupuncture services.
Cardiac rehabilitation services (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Chiropractic services (Out-of-Network)	You pay 40% of the total cost.	You pay a $60 copay per visit.

Cost	2020 (this year)	2021 (next year)
Dental Services (In and Out-of-Network)		
• Preventive and Comprehensive Dental Services		
o Oral surgery (other than non-surgical extractions), and surgical periodontics	Oral surgery (other than non-surgical extractions) and surgical periodontics are not covered.	You pay a $0 copay up to the calendar year maximum benefit of $1,000, after which you pay all charges.
o Special restorative care	Special restorative care is not covered.	You pay 50% of the total cost up to the calendar year maximum benefit of $1,000, after which you pay all charges.
o Prosthetic dental services	Prosthetic dental services are not covered.	You pay 50% of the total cost up to the calendar year maximum benefit of $1,000, after which you pay all charges. The $1,000 maximum benefit per calendar year is combined In-Network and Out-of-Network.
Diabetes self-management training, diabetic services and supplies (Out-of-Network)		
• Supplies to monitor your blood glucose and therapeutic custom-molded shoes and inserts	You pay 40% of the total cost.	You pay 20% of the total cost.

Cost	2020 (this year)	2021 (next year)
Durable medical equipment (DME) and related supplies (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Hearing services (In and Out-of-Network)		
• Diagnostic hearing exams	You pay 40% of the total cost for services received from Out-of-Network providers.	You pay 20% of the total cost for services received from Out-of-Network providers.
• Routine hearing exams	You pay 40% of the total cost for services received from Out-of-Network providers.	You pay 20% of the total cost for services received from Out-of-Network providers.
• TruHearing Hearing Aids	A rechargeable battery option is available on some Premium hearing aids for an additional $75 per aid.	A rechargeable battery option is available on some Premium hearing aids for an additional $50 per aid.
Home health agency care (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Home infusion therapy (In and Out-of-Network) • Professional services, including nursing services • Patient training and education not otherwise covered under the DME benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	Professional services, patient training/education, and remote monitoring and monitoring services are not covered.	You pay 20% of the total cost for services received from In-Network providers. You pay 20% of the total cost for services received from Out-of-Network providers.

Cost	2020 (this year)	2021 (next year)
Hospice care (Out-of-Network) • Hospice consultation services	You pay 40% of the total cost.	You pay a $60 copay per visit.
Inpatient hospital care (In and Out-of-Network)	You pay a $325 copay per day for days 1-5; nothing for additional days per stay for services received from In-Network providers. You pay 40% of the total cost for services received from Out-of-Network providers.	You pay a $345 copay per day for days 1-5; nothing for additional days per stay for services received from In-Network providers. You pay a $525 copay per day for days 1-5; nothing for additional days per stay for services received from Out-of-Network providers.
Inpatient mental health care (In and Out-of-Network)	You pay a $325 copay per day for days 1-5; nothing for additional days per stay for services received from In-Network providers. You pay 40% of the total cost for services received from Out-of-Network providers.	You pay a $345 copay per day for days 1-5; nothing for additional days per stay for services received from In-Network providers. You pay a $525 copay per day for days 1-5; nothing for additional days per stay for services received from Out-of-Network providers.
Medicare-covered preventive services, other than Part B immunizations (Out-of-Network)	You pay 40% of the total cost.	You pay a $20 copay per visit.

Cost	2020 (this year)	2021 (next year)
Medicare Part B prescription drugs (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost
Opioid treatment program services (Out-of-Network)	You pay 40% of the total cost.	You pay a $60 copay per episode of care.
Outpatient diagnostic tests and therapeutic services and supplies (Out-of-Network)		
• Outpatient diagnostic procedures and tests	You pay 40% of the total cost.	You pay a $40 copay.
• Laboratory tests	You pay 40% of the total cost.	You pay a $10 copay.
• X-rays	You pay 40% of the total cost.	You pay a $40 copay.
• Therapeutic radiology	You pay 40% of the total cost.	You pay 20% of the total cost.
• Diagnostic radiology (ex. MRI/CT)	You pay 40% of the total cost.	You pay a $500 copay.
• Blood services	You pay 40% of the total cost.	You pay 20% of the total cost.
Outpatient hospital observation (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Outpatient mental health care (Out-of-Network)	You pay 40% of the total cost.	You pay a $60 copay per individual visit. You pay a $60 copay per group visit.
Outpatient rehabilitation services (Out-of-Network)	You pay 40% of the total cost.	You pay a $60 copay per visit.

Cost	2020 (this year)	2021 (next year)
Outpatient substance abuse services (Out-of-Network)	You pay 40% of the total cost.	You pay a $60 copay per visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (Out-of-Network)	You pay 40% of the total cost.	You pay a $500 copay per visit.
Partial hospitalization services (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Physician/Practitioner services (Out-of-Network)		
• Primary care and specialty care services for consultation, diagnosis, and treatment	You pay 40% of the total cost.	You pay a $60 copay per visit.
• Virtual care, including consultation your doctor has with other doctors by phone, internet, or electronic health record, e-visits, virtual check-ins, and Medicare-covered preventive services furnished via secure online interactive audio and video technology	You pay 40% of the total cost.	You pay 20% of the total cost for doctor to doctor consultations, e-visits, and virtual check-ins. You pay a $20 copay for Medicare-covered preventive services furnished via secure online interactive audio and video technology.
• Scheduled telephone visits and online clinic visits	You pay 40% of the total cost.	You pay 20% of the total cost.
• Non-routine dental care (Medicare covered)	You pay 40% of the total cost.	You pay 20% of the total cost.

Cost	2020 (this year)	2021 (next year)
• Visits to convenience clinics	You pay 40% of the total cost.	You pay a $60 copay per visit.
Podiatry services (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Prosthetic devices and related supplies (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Pulmonary rehabilitation services (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Routine physical exams (Out-of-Network)	You pay 40% of the total cost.	You pay a $20 copay per visit.
Services to treat kidney disease (Out-of-Network)		
• Kidney disease education services	You pay 40% of the total cost.	You pay a $20 copay per session.
• Self-dialysis training and certain home support services	You pay 40% of the total cost.	You pay 20% of the total cost.
Skilled nursing facility (SNF) care (In and Out-of-Network)	You pay a $0 copay per day for days 1-20; $172 copay per day for days 21-100 per benefit period for services received from In-Network providers. You pay 40% of the total cost per benefit period for services received from Out-of-Network providers.	You pay a $0 copay per day for days 1-20; $184 copay per day for days 21-100 per benefit period for services received from In-Network providers. You pay 20% of the total cost per benefit period for services received from Out-of-Network providers.

Cost	2020 (this year)	2021 (next year)
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (Out-of-Network)		
• Additional sessions beyond Medicare coverage	You pay 40% of the total cost.	You pay 20% of the total cost.
Supervised Exercise Therapy (SET) (Out-of-Network)	You pay 40% of the total cost.	You pay 20% of the total cost.
Vision care (Out-of-Network)		
• Routine eye exam, diagnostic eye exam, and Medicare-covered eyewear	You pay 40% of the total cost.	You pay 20% of the total cost.
• Glaucoma screening for people who are at high risk of glaucoma	You pay 40% of the total cost.	You pay a $20 copay per visit.
Services Requiring Prior Authorization		
• Skilled nursing facility (SNF) care	Services may require prior authorization.	Services do not require prior authorization.
• Home health agency care	Services may require prior authorization.	Services do not require prior authorization.
• Non-routine dental care (Medicare covered)	Services may require prior authorization.	Services do not require prior authorization.

Cost	2020 (this year)	2021 (next year)
• Diabetes self-management training, diabetic services and supplies	Continuous glucose monitors do not require prior authorization.	Continuous glucose monitors require prior authorization.

Section 1.6 – 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.
    - 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.

Exceptions are typically approved for 1 year from the date of the request. An end date of the exception will be communicated to you in the approval letter.

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 haven't received this insert by September 30, 2020, please call Member Services 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 **healthpartnersunitypointhealth.com**. You may also call Member Services 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.

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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic drugs):** You pay $2 per prescription. **Tier 2 (Generic drugs):** You pay $9 per prescription. **Tier 3 (Preferred Brand drugs):** You pay $47 per prescription. **Tier 4 (Non-preferred drugs):** You pay $100 per prescription. **Tier 5 (Specialty drugs):** You pay 31% of the total cost. _____	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic drugs):** You pay $2 per prescription. **Tier 2 (Generic drugs):** You pay $9 per prescription. **Tier 3 (Preferred Brand drugs):** You pay $47 per prescription. You pay $35 for select insulins. **Tier 4 (Non-preferred drugs):** You pay $100 per prescription. **Tier 5 (Specialty drugs):** You pay 33% of the total cost. _____

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	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*.

Our plan offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $35.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in HealthPartners UnityPoint Health Align

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 plan.

Section 2.2 – 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 1.1 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 4), or call Medicare (see Section 6.2).

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, HealthPartners UnityPoint Health 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 our plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from our plan.

- 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 6.1 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 3 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 4 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 Iowa, the SHIP is called Senior Health Insurance Information Program. In Illinois, the SHIP is called Senior Health Insurance Program.

The State Health Insurance Assistance Program (SHIP) 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. State Health Insurance Assistance Program (SHIP) 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 your State Health Insurance Assistance Program (SHIP) at 800-351-4664 (Iowa residents) or 800-252-8966 (Illinois residents). You can learn more about your State Health Insurance Assistance Program by visiting their website (see contact information below).

Method	Senior Health Insurance Information Program (Iowa SHIP) – Contact Information
PHONE	800-351-4664
TTY	800-735-2942 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
ADDRESS	601 Locust Street, 4th Floor Des Moines, IA 50309-3738
WEBSITE	www.shiip.iowa.gov

Method	Senior Health Insurance Program (Illinois SHIP)– Contact Information
PHONE	800-252-8966
TTY	888-206-1327 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
ADDRESS	One Natural Resources Way #100 Springfield, IL 62702-1271
WEBSITE	www2.illinois.gov/aging/ship/pages/default.aspx

SECTION 5 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 Iowa Department of Public Health Bureau of HIV, STD and Hepatitis (Iowa residents) or Illinois Department of Public Health (Illinois residents). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 515-281-7689 (Iowa residents) or 800-243-2437 (Illinois residents).

SECTION 6 Questions?

Section 6.1 – Getting Help from our plan

Questions? We're here to help. Please call Member Services at 888-360-0544. (TTY only, call 711.) We are available for phone calls **Oct. 1 through March 31** from 8 a.m. to 8 p.m. CT, **seven days a week.** You'll speak with a representative. From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

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 our plan. 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 **healthpartnersunitypointhealth.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 **healthpartnersunitypointhealth.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 6.2 – 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.