Hamaspik Medicare Choice
(HMO D-SNP)
2024 Summary of Benefits

HAMASPIK, INC.

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Hamaspik Medicare Choice (HMO D-SNP)
Summary of Benefits 2024

Introduction

This document is a brief summary of the benefits and services covered by Hamaspik Medicare Choice. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of Hamaspik Medicare Choice. Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage.*

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If you have questions, call Hamaspik Medicare Choice Member Services at 1-888-426-2774. (TTY users, call 711.) Our staff are available 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1, 2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free.
For more information, visit www.hamspik.com.

A. Disclaimers

This is a summary of health services covered by Hamaspik Medicare Choice for January 1, 2024 through December 31, 2024. This is only a summary. Read the Evidence of Coverage for the full list of benefits. If you don't have an Evidence of Coverage, call Hamaspik Medicare Choice Member Services at the number at the bottom of this page. You can also find a copy of the Evidence of Coverage, and many other member resources, on our website at www.hamaspik.com.

- Hamaspik Medicare Choice is an HMO D-SNP with a Medicare contract, and a Medicaid Advantage Plus (MAP) Plan with a New York State Medicaid contract. Enrollment in Hamaspik Medicare Choice depends on contract renewal.
- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2025.
- The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
- For more information about Medicare, you can read the Medicare & You 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 access it online at the Medicare website (www.medicare.gov) or request a copy 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.
- This document is available for free in Spanish. Este EOC esta disponible en espanol. Por favor, llame a servicios para miembros.
- You can also get this document for free in other formats, such as large print, braille, or audio.
- Please contact Member Services at 1-888-426-2774 if you would like to receive a document in a different language or format. Member Services will document in your care management record if you have made a request, for future mailings and communications. If you would like to change your request at any time, please call Member Services.

B. Frequently Asked Questions

Frequently Asked Questions (FAQ)	Answers
What is a Medicaid Advantage Plus (MAP/HMO) + Dual Eligible Special Needs Plan (D-SNP) plan? Our MAP/HMO plan is called Hamaspik Medicare Choice.	Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has care managers and member services staff to help you manage all of your providers and services. They all work together to provide the care you need. Our MAP plan is called Hamaspik Medicare Choice.
Will I get the same Medicare and Medicaid benefits in Hamaspik Medicare Choice	If you are coming to Hamaspik Medicare Choice from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get almost all of your covered Medicare and Medicaid benefits directly from Hamaspik Medicare Choice. When you enroll in Hamaspik Choice, you and your Care Team will work together to develop an individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that Hamaspik Medicare Choice does not normally cover, you can get a temporary supply, and we will help you to transition to another drug or get an exception for Hamaspik Medicare Choice to cover your drug if medically necessary.

Frequently Asked Questions (FAQ)	Answers
Can I use the same health care providers I use now?	That is often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) work with Hamaspik Medicare Choice and have a contract with us, you can keep going to them. • Providers with an agreement with us are “in-network.” You must use the providers in Hamaspik Choice’s network • If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you can use providers outside of Hamaspik Choice’s network. To find out if your providers are in the plan’s network, call Member Services at the numbers listed at the bottom of this page, or read the Hamaspik Choice’s *Provider and Pharmacy Directory*. You can also visit our website at www.hamaspik.com for the most current listing. If Hamaspik Choice is new for you, we will work with you to develop an individualized plan of care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2023, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. “Continuous Behavioral Health Episode of Care” means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2023 by the same provider for the treatment of the same or related behavior.

Frequently Asked Questions (FAQ)	Answers
What is a Care Manager?	A Care Manager is your main contact person at our plan. This person helps you manage all of your providers and services and make sure you get what you need. Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager. (Please see **Section E.** Benefits covered outside of Hamaspik Medicare Choice on page 31.**)**
What are Managed Long Term Services and Supports (MLTSS)?	Managed Long Term Services and Supports (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.
What happens if I need a service but no one in Hamaspik Medicare Choice's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, Hamaspik Medicare Choice will cover services provided by an out-of-network provider.

If you have questions, call Member Services at 1-888-426-2774 or TTY 711. Our hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1,2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free. For more information, visit www.hamspik.com.

Frequently Asked Questions (FAQ)	Answers
Where is Hamaspik Medicare Choice available?	The service area for this plan includes the following counties in New York. • Bronx • Dutchess • Kings (Brooklyn) • Nassau • New York (Manhattan) • Orange • Putnam • Queens • Richmond (Staten Island) • Rockland • Sullivan • Ulster • Westchester You must live in one of these counties to join Hamaspik Medicare Choice.
What is prior authorization?	Prior authorization means that you must get approval from Hamaspik Medicare Choice before from Hamaspik Medicare Choice will cover a specific service, item, or drug or out-of-network provider. from Hamaspik Medicare Choice may not cover the service, item or drug if you don't get prior approval. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first. Hamaspik Medicare Choice can provide you with a list of services or procedures that require you to get prior authorization from Hamaspik Medicare Choice before the service is provided. Refer to Chapter 3, of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in Chapter 4 of the *Evidence of Coverage* to learn which services require a prior authorization.

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Frequently Asked Questions (FAQ)	Answers
Do I pay a monthly amount (also called a premium) under Hamaspik Medicare Choice?	No. You will not pay any monthly premiums to Hamaspik Medicare Choice for your health coverage. Additionally, Medicaid will pay your Medicare Part B premium for you.
Do I pay a deductible as a member of Hamaspik Medicare Choice	No. You do not pay deductibles in Hamaspik Medicare Choice
What is the maximum out-of-pocket amount that I will pay for medical services as a member of Hamaspik Medicare Choice.	There is no cost sharing (copays or deductibles) for medical services in from Hamaspik Medicare Choice so your annual out-of-pocket costs will be $0.
Do I have a coverage gap for drugs?	No. Because you have Medicaid you will not have a coverage gap stage for your drugs.
Are there any other costs in joining Hamaspik Medicare Choice that I should be aware of?	When the DSS reviews your financial information for purposes of determining your Medicaid eligibility, it may determine that you must "spend-down" a portion of your monthly income in order to meet the income requirements for eligibility for Medicaid. If Medicaid determines that you must "spend-down" a certain amount, you must pay this amount to Hamaspik CHOICE each month. If this requirement applies to you, we will send you an invoice this month.

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C. Overview of services

The following table is a quick overview of what services you may need and rules about the benefits

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital care	$0	Except in an emergency, your health care provider must tell the plan of your hospital admission. Authorization is required except when admission is the result of an emergency or urgent care services.
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon	$0	Authorization is required for Medicare-covered outpatient hospital services and Medicare-covered observation services
	Ambulatory surgical center (ASC) services	$0	Authorization is required for Ambulatory surgical center services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to use an outpatient health care provider	Doctor visits (including visits to Primary Care Providers and specialists)	$0	You do not need a referral or an authorization for visits to a PCP or specialist. Additional telehealth services are available for primary care physician and physician specialist services. Telehealth services allow members to access health care services remotely while your provider manages your care.
(This service is continued on the next page)	Visits to treat an injury or illness	$0	You do not need a referral or an authorization for visits to a PCP or specialist. Additional telehealth services are available for primary care physician and physician specialist services. Telehealth services allow members to access health care services remotely while your provider manages your care.

You want to use a health care provider (continued)	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	$0	Hamaspik Medicare CHOICE covers a broad range of preventive health services that are covered by Medicare, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, • Fecal occult blood test, Flexible sigmoidoscopy • Depression screening. • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Other Medicare-Covered Preventive Services • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco related • Vaccines, including Flu shots, Hepatitis B shots, and Pneumococcal shots disease) (continued on next page)

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to use a health care provider (continued)			You are covered for other Medicare-covered screenings including: • EKG following a Welcome Visit • Glaucoma Screening • Diabetes Self-Management Training • Barium Enemas • Digital Rectal Exams Any additional preventive services approved by Medicare during the contract year will be covered.
	Wellness visits, such as a physical	$0	There is no coinsurance, copayment, or deductible for the annual wellness visit.
	"Welcome to Medicare" preventive visit (one time only)	$0	The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care	Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs)	$0	You may use any emergency room or CPEP if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network. You are also covered for up to $50,000 in worldwide emergency and urgent care, including emergency transportation, when you travel outside the United States and its territories. Contact the plan for details.
	Urgent care	$0	Urgent care is not emergency care. You do not need prior authorization and you do not have to be in-network. You are also covered for up to $50,000 in worldwide emergency and urgent care, including emergency transportation, when you travel outside the United States and its territories. Contact the plan for details.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests	Lab tests, such as blood work	$0	Authorization is not required for routine lab tests.
	X-rays or other pictures, such as CAT scans You are covered for Medicare-covered: • X-Ray services • Diagnostic Radiological services • Therapeutic Radiological services	$0	Authorization is required for diagnostic procedures, non-lab tests, and genetic testing procedures.
	Screenings, such as tests to check for cancer	$0	See the detailed list of covered health care screenings on pages 10-11. Authorization is not required for these services.
You need hearing/ auditory services (continued on next page)	Hearing screenings (including routine hearing exams)	$0	Covered services include diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment. You are also covered for a routine hearing exam, performed by an audiologist. Authorization is not required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Hearing aids (as well as fittings and associated accessories and supplies)	$0	You are covered for Medicare-covered hearing exams, and you are also covered for: • A routine hearing exam, performed by an audiologist • Hearing Aids fitting and dispensing • Hearing aid products, including hearing aids, earmolds, and special fittings • Hearing aid checks following dispensing • Conformity evaluations • Hearing aid repairs

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	$0	You are covered for Medicare and Medicaid covered dental benefits. Covered services include: • Cleaning (once every six months) • Oral exam (once every six months) • X-ray(s) • Basic restorative services, such as fillings, extractions, and dentures'' • Other restorative dental services (such as root canals or dental implants) are covered when they are needed to ease a medical problem; Authorization is not required for cleanings, exams, x-rays, and basic restorative dental care. Authorization is required for other restorative dental services.
You need eye care (continued on next page)	Vision services (including annual eye exams)	$0	You are covered for all Medicare- and Medicaid covered vision care. You are also covered for a routine eye exam once every two years. Authorization is not required.

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (continued)	Glasses or contact lenses	$0	You are covered for eyewear, up to $200 every two years. Covered eyewear includes: • Contact lenses (One pair of contact lenses every two years) • Eyeglasses (lenses and frames) One pair every two years • Upgrades
	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	$0	You are covered for all Medicare- and Medicaid covered vision care. Authorization is not required.
You have a mental health condition (continued on next page)	Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment Center's (ATC), Inpatient addition rehabilitation, Inpatient Medically Supervised Detox, or critical access hospital)	$0	You are covered for acute inpatient hospitalization, regardless of the admitting diagnosis or treatment. Except in an emergency, authorization is required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued) (Continued on the next page)	Adult outpatient mental health care • Continuing Day Treatment (CDT) • Partial hospitalization	$0	Authorization is required for these services.
	Adult outpatient rehabilitative mental health care • Assertive Community Treatment (ACT) • Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) • Personalized Recovery Oriented Services (PROS)	$0	Authorization is not required for these services. Members who need ACT services must have their eligibility determined by the Single Point of Access (SPOA) program in the county where they reside.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services: • Psychosocial Rehabilitation (PSR) • Community Psychiatric Supports and Treatment (CPST) • Empowerment services – peer supports • Family Support and Training (FST)	$0	Eligibility for CORE services is determined by the State Department of Health. For members who are eligible, authorization is not required for these services.
	Adult mental health crisis services • Comprehensive Psychiatric Emergency Program (CPEP) • Mobile Crisis and Telephonic Crisis Services • Crisis Residential Programs	$0	Authorization is not required for these services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care) Note: This is not a complete list of the plan's expanded outpatient mental health services. Call Member Services at the numbers listed at the bottom of this page. Also, please see Chapter 4 of the Evidence of Coverage for more information.)	$0	Services may be provided by any OMH licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws. Additional telehealth services are available for these services. Telehealth services allow members to access health care services remotely while your provider manages your care.
You are having a mental health or substance use crisis	Mobile Crisis services (assessment by telephone or mobile crisis team response); short-term residential crisis stabilization (for mental health crises)	$0	Any approved mobile crisis or licensed crisis residence provider in New York State. Authorization is not required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition or a substance use disorder	CORE Services (which are person-centered, recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence). (**Note:** For more information about CORE Services and to determine whether you are eligible for them, call Member Services at the numbers listed at the bottom of this page. Also, please see Chapter 4 of the Evidence of Coverage for more information.	$0	CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services. Authorization is not required for these services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a substance use disorder	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment) (**Note:** This is not a complete list of the plan's expanded substance use disorder services. Call Member Services at the numbers listed at the bottom of this page for more information. Also, please see Chapter 4 of the Evidence of Coverage.)	$0	When you receive inpatient services, your health care provider must tell the plan of your hospital admission, except in an emergency. Some outpatient substance abuse services may be provided by telehealth. Telehealth services allow members to access health care services remotely while your provider manages your care.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Authorization is required.
	Nursing home (Residents of a Long-term care facility)	$0	Authorization is required.
	Custodial care (long-term care in a Nursing Facility)	$0	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission. Authorization is required.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	$0	You are covered for Medicare and Medicaid covered therapy services. Authorization is required.
You need help getting to health services	Emergency transportation	$0	You are covered for Ground Ambulance Services and Air Ambulance Services. Authorization is not required for emergency transportation.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (Continued on the next page)	Medicare Part B prescription drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment)	$0	Read the *Evidence of Coverage* for more information on these drugs.
	Medicare Part D prescription drugs **Note:** All drugs including generic and brand name drugs are on a single tier. **Important Message About What You Pay for Vaccines** – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs* (Formulary). Our plan covers most Part D vaccines at no cost to you.	$0	There may be limitations on the types of drugs covered. Refer to Hamaspik Medicare Choice's Formulary (for example, *List of Covered Drugs*) at www.hamaspik.org for more information. Hamaspik Medicare Choice may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Hamaspik Medicare Choice for certain drugs. You may receive an extended day supply (for up to 90 days) of your drugs at certain retail pharmacies, or by using the mail order service. Contact member services for more information. (continued on next page)

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Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the Hamaspik Medicare Choice website and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare.
	Over-the-counter (OTC) drugs	$0	Hamaspik Medicare Choice covers a maximum of $180.00 per month for Over-the-Counter health products. The types of products that may be purchased using this benefit are approved by CMS.
	Diabetes medications	$0	For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose (for example: blood glucose monitors and blood glucose test strips, lancets and lancet devices) • Prescribed diabetes medications.

You need foot care	Podiatry services (including routine exams)	$0	Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs
	Orthotic services	$0	Authorization is required.
You need durable medical equipment (DME) or supplies	Wheelchairs, nebulizers, crutches, roll about knee walkers, walkers, and oxygen equipment and supplies, for example (Note: This is not a complete list of covered DME or supplies. Call Member Services at the numbers listed at the bottom of this page for more information, or see Chapters 3 and 4 of your Evidence of Coverage.)	$0	Authorization is required.
You need interpreter services	Spoken language interpreter	$0	Please contact Member Services for assistance.
	Sign language interpreter	$0	Please contact Member Services for assistance.

Other covered services	Acupuncture	$0	Covered services include: • Up to 12 visits in 90 days are covered for members with chronic low back pain. An additional eight sessions will be covered for those patients demonstrating an improvement. • An additional 20 visits per year are covered for other health conditions not covered by Medicare. Authorization is required.
	Plan Care coordination	$0	All members are assigned to a care manager for ongoing assistance with all of their health care services.
	Chiropractic services	$0	Covered services include manual manipulation of the spine to correct subluxation. Authorization is required.
	Diabetic supplies	$0	Covered services include: blood glucose monitors, blood glucose test strips, lancet devices and lancets.

Other covered services (continued)	Early and Periodic Screening Diagnosis and Treatment (EPSDT) (including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services)	$0	EPSDT is for members under 21 years of age.
	Family planning	$0	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service.
	Hospice care	$0	You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal illness are paid for by Original Medicare, not Hamaspik Medicare Choice.
	Mammograms	$0	No authorization is needed. (See pages 10-11 for a list of all Medicare covered preventive services.)

Other covered services (continued)	Managed Long Term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); social adult day care; and non-medical transportation)	$0	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility, and allows them to get necessary care in a residential or community setting. MLTSS is available to all members; specific service authorization, including amount, is indicated in the member's individualized approved Plan of Care.
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting)	$0	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. Authorization is required, based on the member's individualized approved Plan of Care.
	Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care)	$0	Authorization is required, based on the member's individualized approved Plan of Care

Other covered services (continued)	Prosthetic services	$0	Authorization is required.
	Services to help manage your disease	$0	Your care manager will provide you with education and assistance to help you manage your chronic illnesses and other health care concerns.

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read Hamaspik Medicare Choice's *Evidence of Coverage*. If you have questions, you can also call Hamaspik Medicare Choice Member Services at the numbers listed at the bottom of this page.

D. Additional services Hamaspik Medicare Choice covers

The list of services on the following page is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other covered services. Please also see Chapter 4 of the *Evidence of Coverage* for more information about these services.

Additional services Hamaspik Medicare Choice covers	Your costs
Fitness Benefits which include: • Participation in any of our contracted gyms and fitness centers throughout the service area and nationally. Some fitness centers offer low-impact classes focused on improving muscular strength, endurance, mobility,flexibility, balance, agility, and coordination. • Exercise classes, through live on-line classes and thousands of on-line videos. • One home fitness kit per year, from a selection of wearable fitness trackers, weights, or yoga equipment. • Personal fitness coaching, conducted by phone.	$0
Special Supplemental Benefits for the Chronically Ill Eligible members may use a portion of the monthly allowance for OTC health products for the purchase of the following: • $60.00 per month may be used for the purchase of food and produce, and • $60.00 per month may be used to cover the cost of your household utilities (such as your electric, gas, water, or phone bills If you have been diagnosed with three or more chronic conditions, you may be eligible for the "healthy food and produce" benefit. Eligibility will be determined based on information provided by your physician(s) and your annual Health Risk Assessment.	$0
Nursing Hotline, available 24 hours per day, 7 days per week when the Hamaspik Medicare Choice offices are closed.	$0
Worldwide Emergency and Urgent Care Coverage. You are covered for a maximum of $50,000 per year.	$0

If you have questions, call Member Services at 1-888-426-2774 or TTY 711. Our hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1,2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free. For more information, visit www.hamspik.com.

E. Benefits covered outside of Hamaspik Medicare Choice

This is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other services not covered by Hamaspik Medicare Choice but available through Medicaid fee-for-service.

Other services covered directly by Medicaid fee-for-service	Your costs
CSS (Community Support Services)	$0
Health Home (HH) and Health Home Plus (HH+) Care Management services	$0
Certified Community Behavioral Health Clinics (CCBHC)	$0
Crisis Intervention Services for Youth ages 18-20	$0

F. Services that Hamaspik Medicare Choice, Medicare, and Medicaid do not cover

The services listed on the next page are not covered by our plan. This is not a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other excluded services.

Services Hamaspik Medicare Choice, Medicare, and Medicaid do not cover
Personal and comfort items
Cosmetic surgery if not medically necessary
Private room in a hospital (except when medically necessary)
Personal items in your room at a hospital or skilled nursing facility (such as a telephone or television)
Services of a provider that is not part of the plan, unless the plan sends you to that provider or gives you an authorization in advance
Naturopath services (natural or alternative treatments)
Reversal of sterilization procedures and/or non-prescription contraceptive supplies
Services considered not medically necessary, according to Original Medicare or Medicaid standards

G. Your rights and responsibilities as a member of the plan

As a member of Hamaspik Medicare Choice, you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you cannot be refused medically necessary treatment. You can use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, read the *Evidence of Coverage.*

Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex (including sex stereotypes and gender identity), age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
  - Ask for and get information in other formats (for example, large print, braille, audio) free of charge
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers
  - Have your questions and concerns answered completely and courteously
  - Apply your rights freely without any negative effect on the way Hamaspik Medicare Choice or your provider treats you
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  - Hamaspik Medicare Choice
  - Description of the services we cover
  - How to get services

If you have questions, call Member Services at 1-888-426-2774 or TTY 711. Our hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1,2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free. For more information, visit www.hamspik.com.

- How much services will cost you
- Names of health care providers and Care Managers
- Your rights and responsibilities

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call 1-888-426-2774 if you want to change your PCP.
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment as far as the law allows, even if your health care provider advises against it
  - Stop taking medicine, even if your health care provider advises against it
  - Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. <Plan name> will pay for the cost of your second opinion visit.
  - Make your health care wishes known in an advance directive
- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call <phone number> if you need help with this service

  - Have your *Evidence of Coverage* and any printed materials from <plan name> translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
  - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation

- **You have the right to emergency and urgent care when you need it**. This means you have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
  - Use an out-of-network urgent or emergency care provider, when necessary

- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.
  - Have privacy during treatment

- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - Access an easy process to voice your concerns, and to expect follow-up by <plan name>
  - File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers
  - Ask for a State Appeal (State Fair Hearing)
  - Get a detailed reason why services were denied

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Your responsibilities include, but are not limited to, the following:

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
  - Treat your health care providers with dignity and respect
  - Keep appointments, be on time, and call in advance if you're going to be late or have to cancel
- **You have the responsibility to give information about you and your health.** You should:
  - Tell your health care provider your health complaints clearly and provide as much information as possible
  - Tell your health care provider about yourself and your health history
  - Tell your health care provider that you are a Hamaspik Medicare Choice
  - Talk to your PCP, Care Manager, or other appropriate person about seeking the services of a specialist before you go to a hospital (except in cases of emergency)
  - Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
  - Notify Hamaspik Medicare Choice Member Services if there are any changes in your personal information, such as your address or phone number
- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
  - Partner with your Care Team and work out treatment plans and goals together
  - Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health
- **You have the responsibility to obtain your services from** Hamaspik Medicare Choice You should:
  - Get all your health care from Hamaspik Medicare Choice except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless Hamaspik Medicare Choice provides a prior authorization for out-of-network care

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- Not allow anyone else to use your Hamaspik Medicare Choice Member ID Card to obtain healthcare services
- Notify Hamaspik Medicare Choice when you believe that someone has purposely misused Hamaspik Medicare benefits or services

For more information about your rights, you can read Hamaspik Medicare Choice's *Evidence of Coverage*. If you have questions, you can also call Hamaspik Medicare Choice Member Services at the numbers listed at the bottom of this page.

H. How to file a complaint or appeal a denied service

If you have you have a complaint or think Hamaspik Medicare Choice should cover something we denied, call Hamaspik Medicare Choice at 1-888-426-2774. (TTY users, call 711.) You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of Hamaspik Medicare Choice's Evidence of Coverage. You can also call Hamaspik Medicare Choice Member Services at the numbers listed at the bottom of this page.

If you would like to file a grievance or appeal, please send it to:

Hamaspik Medicare Choice
Attn: Grievance and Appeals
58 Route 59, Suite #1
Monsey, NY 10952

If you have a complaint or think Hamaspik Medicare Choice should cover something we denied, call Hamaspik Medicare Choice at 1-888-426-2774 You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read Chapter 8 of Hamaspik Medicare Choice's *Evidence of Coverage*. You can also call Hamaspik Medicare Choice Member Services at the numbers listed at the bottom of this page.

If you have questions, call Member Services at 1-888-426-2774 or TTY 711. Our hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1,2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free. For more information, visit www.hamspik.com.

You (or someone on your behalf, may also file a complaint directly to Medicare or the New York State Department of Health.

- To file your complaint with Medicare, please call 1-800-MEDICARE, or 1-800-633-4227.
- To file your complaint with the New York State Department of Health, please call 1-866-712-7197.

I. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest. If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

- Call us at Member Services. Phone numbers are listed at the bottom of this page.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Or, call the New York State Medicaid Fraud Hotline 1-877-87 FRAUD.

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-426-2774. (TTY, call 711.) Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-426-2774. (TTY 711.) Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-426-2774。(TTY 711) 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-426-2774。(TTY 711) 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-426-2774. (TTY 711) Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-426-2774. (TTY 711) Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-426-2774 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí . (TTY 711)

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-426-2774. (TTY 711) Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-426-2774 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다. (TTY 711)

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-426-2774. (TTY 711) Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-2774-426-888. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية (TTY 711) .

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-426-2774 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है. **(TTY 711)**

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-426-2774. (TTY 711) Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-426-2774. (TTY 711) Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-426-2774. (TTY 711) Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-426-2774. (TTY 711) Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、[1-888-426-2774] にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。 (TTY 711)

If you have questions, call Member Services at 1-888-426-2774 or TTY 711. Our hours are 7 days a week, from 8:00 am to 8:00 pm, October 1, 2023, through March 31, 2024. From April 1,2024, through September 30, 2024, our Member Service Department will be available Monday through Friday, 8:00 am to 8:00 pm. The call is free. For more information, visit www.hamspik.com.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Hamaspik Medicare Choice Member Services at 888-426-2774.

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TTY number: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

If you have questions about your health:

Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.

If your PCP's office is closed, you can also call Hamaspik Medicare Choice Nurse Hotline. A nurse will listen to your problem and tell you how to get care. (Examples include convenience care, urgent care, emergency room). Contact the Nurse Hotline at: 888-426-2774. (TTY users, call 711.) Calls to these numbers are free.

If you need immediate behavioral health care, call the Behavioral Health Crisis Line at 988.
Calls to this number are free.