ERISA

Important Notice from Hamaspik Care about
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Hamaspik Care Sponsored Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **Hamaspik Care** has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th through December 7th.**

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while you are covered under the **Hamaspik Care** Sponsored Health Plan, your **Hamaspik Care** Sponsored Health Plan may be affected. Your employer sponsored coverage cannot be cancelled due to your Medicare enrollment (See the COBRA Note below.). Medicare and your employer sponsored coverage will coordinate benefits so that you will not receive duplicate benefits.
The Medicare, Who Pays First handbook available from your Medicare representative or on line https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf, has detail on how Medicare coordinates benefits.

Typically, your employer sponsored coverage will pay its benefits without regard to payments that may be made by Medicare. In these cases, your employer sponsored coverage is considered 'primary' and Medicare is 'secondary' coverage. Medicare will only pay after the primary employer sponsored coverage has paid its benefits. Your Medicare coverage will have no effect on your employer sponsored coverage cost sharing such as copayments, deductibles, exclusions or other plan limits.

HOWEVER, there are three instances where Medicare is primary and your employer sponsored coverage is secondary. In these cases Medicare will pay its benefits without regard to payments that may be made under the employer sponsored coverage. The employer sponsored coverage will coordinate benefits so that it does not duplicate benefits paid by Medicare. This will reduce the benefits paid by your employer sponsored coverage. These three instances are when:

- your employer employs less than 20 employees
- your coverage is from a former employer, a retiree plan or COBRA coverage
- you are disabled and the employer sponsored coverage is due to another person working for the employer (examples when allowed – the coverage is under your spouse, your domestic partner, your dependent or grandchild), and the employer has less than 100 employees. When the employer has 100 or more employees then Medicare is secondary.

Notes:

1. If you have end stage renal disease then the employer sponsored coverage is primary for the first 30 months and Medicare is primary after that 30 month period has expired.)

2. If you are enrolled in Medicare prior to electing COBRA, then your Medicare enrollment cannot be used to limit or deny COBRA. If you enroll in Medicare after you elect COBRA then the Medicare enrollment is a terminating event for your COBRA coverage.

If you do decide to join a Medicare drug plan and drop your current **Hamaspik Care** Sponsored Health Plan, be aware that you and your dependents will have to wait for the next Open Enrollment period, if any are offered by your Employer, or HIPAA Special Enrollment Right be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **Hamaspik Care** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below at the bottom of this Notice for further information or to receive the contact information for someone at the insurance company, third party administrator or service provider who administers the prescription drug program for the **Hamaspik Care** Sponsored Health Plan.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Hamaspik Care** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	February 6, 2020
Name of Entity/Sender:	Hamaspik Homecare
Contact—Position/Office:	
Address:	5 Perlman Drive Spring Valley, NY 10977
Phone Number:	855-426-2774

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CREDITABLE COVERAGE DISCLOSURE TO CMS GUIDANCE

INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Regulations to implement Medicare prescription drug coverage were published January 28, 2005 (70 Fed. Reg. 4193 (2005)). This guidance pertains to Section 1860D-13 of the MMA and 42 CFR §423.56(e).

Under those provisions, most entities that currently provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" (Disclosure to CMS). Disclosure to CMS is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed at 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage. Meanwhile, entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure to CMS requirement. See 42 CFR 423.56(e).

Per 42 CFR §423.56(e), CMS will provide additional information concerning the disclosure to CMS, including the required form and manner of disclosure. This guidance provides such additional information concerning those rules, including the form, manner, and timing of providing the disclosure to CMS.

OVERVIEW OF REGULATORY REQUIREMENTS

Creditable Coverage Definition and Determination

Per 42 CFR §423.56(a), drug coverage is defined as creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. See 70 Fed. Reg. 4225 (2005).

This determination is identical to the first step (the "gross test") in calculating actuarial equivalence for purposes of 42 CFR §423.884, which applies when an employer or union applies for the Retiree Drug Subsidy (RDS). The gross test does not consider the extent to which the coverage is financed by the beneficiary or by the entity. See 42 C.F.R. §423.884(d)(5)(ii)(A).

For plans with multiple benefits options, the regulation requires that entities apply the gross test separately for each benefit option. See 42 CFR §423.884(d)(5)(iv). A "benefits option" is defined at 42 CFR §423.882 as a particular benefit design, category of benefits, or cost sharing arrangement offered within a group health plan, such as different categories of benefits and different plan design options

under a given type of coverage (e.g., HMO, PPO, Indemnity). Benefit options are referenced on the disclosure to CMS Form as "Options".

For purposes of the disclosure to CMS, we require a separate Disclosure to CMS Form for each type of coverage sponsored by an entity (e.g., Medicaid, SPAP, employer plan, church Plan, Standardized Medigap Plan, Pre-standardized Medigap Plan).

III. POLICY GUIDANCE

Clarifications and other guidance relating to the above requirements follow.

Creditable Coverage Disclosure to CMS Form from Entity to CMS

Per 42 CFR §423.56(e), all entities described in 42 CFR §423.56(b) must disclose to CMS whether the prescription drug coverage that is offered to a Medicare Part D eligible individual is creditable or non - creditable.

Form and Manner of Creditable Coverage Disclosure to CMS from Entity

An entity is required to provide a disclosure to CMS through completion of the Disclosure to CMS Form (Form CMS 10198) posted on the CMS Creditable Coverage Web Page at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

This method of transmission is convenient, takes little time to complete, and is the sole method for compliance with the requirement, unless the entity has no internet access.

Required data fields on the Disclosure to CMS Form must be populated to generate a disclosure to CMS. For detailed descriptions of these data fields and instructions about how to complete the Disclosure to CMS Form, please reference the Disclosure to CMS Form Instructions which are posted on the CMS website at: https://www.cms.gov/CreditableCoverage.

Who Must Provide the Disclosure to CMS Form

The Disclosure to CMS Form must be provided to CMS by certain entities listed at 42 CFR §423.56(b) that are not excluded at §423.56(e). These entities include the following:

1. Group health plans, including those offered by employers; union/Taft-Hartley plans; church plans; federal, state, and local government plans; and other group-sponsored plans;
2. Government sponsored plans, including Medicaid; State Pharmaceutical Assistance Programs (SPAPs); State High Risk Pools;
3. Military coverage, including the United States Department of Veterans Affairs (VA) coverage and TRICARE;
4. Individual health insurance;
5. Indian Health Service; Tribe or other Tribal Organizations; Urban Indian Organizations; and
6. Medigap (Medicare Supplement) plans, including standardized plans H, I or J; pre- standardized plans; waiver state plans; and plans with innovative benefits.

The entities exempted under 42 CFR §423.56(e) include PDPs, MA PDs, and PACE or cost based HMOs or CMPs that provide "qualified Part D coverage" as defined in 42 CFR §423.100.

Per 42 CFR §423.884(c)(2)(iv), a Plan Sponsor must provide an attestation that its prescription drug coverage is at least actuarially equivalent to the standard prescription drug coverage under Part D as part of the application for the Retiree Drug Subsidy (RDS). Therefore, because the actuarial equivalence standard includes the creditable coverage standard, a sponsor approved for the RDS is exempt from filing the Disclosure to CMS Form with respect to those qualified covered retirees for which the Sponsor is claiming the RDS. The sponsor's RDS application serves as its Disclosure to CMS under 42 CFR §423.56(e). For example: If a plan option has 100 retired beneficiaries and the plan claims RDS for 97 of them, the plan must report the 3 non RDS participants on the Disclosure to CMS Form, in addition to reporting the non RDS participants on other plan options.

Timing of Creditable Coverage Disclosure to CMS Form from Entity

The Disclosure to CMS Form must be submitted to CMS annually and upon any change that affects whether the drug coverage is creditable.

At a minimum, the Disclosure to CMS Form must be provided at the following times:

1. For Plan Years that end in 2006, the Disclosure to CMS Form must be provided no later than March 31, 2006;
2. For Plan Years that end in 2007 and beyond, the Disclosure to CMS Form must be provided within 60 days after start of Plan Year for which the entity is providing the Disclosure to CMS Form;
3. Within 30 days after the termination of the prescription drug plan; and
4. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Additional Guidance

CMS may release Questions and Answers relating to Creditable Coverage issues from time to time under the Questions link on the CMS website at: https://www.cms.gov/.

IV. CONTACT FOR FURTHER INFORMATION

Visit the CMS website link related to creditable coverage issues at:
https://www.cms.gov/CreditableCoverage.