Independent Health
Dedicated to Making a Difference

Independent Health's Medicare Passport Advantage (PPO) *offered by* Independent Health

Annual Notice of Changes for 2023

Important plan information

H3344_C8702_M H3344_005 Passport Advantage PPO

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

Independent Health's Medicare Passport Advantage (PPO) *offered by* Independent Health

Annual Notice of Changes for 2023

You are currently enrolled as a member of Independent Health's Medicare Passport Advantage (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 6 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.independenthealth.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Independent Health's Medicare Passport Advantage (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Independent Health's Medicare Passport Advantage (PPO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 716-250-4401 or 1-800-665-1502 for additional information. (TTY users should call: 711.) Hours are October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m. and April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
- Verbal translation of written materials is available via free interpreter services. For those with special needs, accessibility to benefit information or alternate formats (e.g., large print) of written materials are available upon request.
- **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 Independent Health's Medicare Passport Advantage (PPO)

- Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.
- When this document says “we,” “us,” or “our”, it means Independent Health. When it says “plan” or “our plan,” it means Independent Health's Medicare Passport Advantage (PPO).
- Out-of-network/non-contracted providers are under no obligation to treat Independent Health's Medicare Passport Advantage (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Independent Health's Medicare Passport Advantage (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$99	$99
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $6,900 From network and out-of-network providers combined: $11,300	From network providers: $6,900 From network and out-of-network providers combined: $11,300
Doctor office visits	**In-Network** Primary care visits: $0 copayment per visit Specialist visits: $35 copayment per visit **Out-of-Network** Primary care visits: 40% Coinsurance per visit Specialist visits: 40% Coinsurance per visit	**In-Network** Primary care visits: $0 copayment per visit Specialist visits: $35 copayment per visit **Out-of-Network** Primary care visits: 40% Coinsurance per visit Specialist visits: 40% Coinsurance per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**In-Network** $275 copayment per day, Days 1-6 $0 copayment per day, Days 7-90, per benefit period. $1,925 annual copay maximum applies. Unlimited days for Medicare covered stays. **Out-of-Network** 40% coinsurance	**In-Network** $250 copayment per day, Days 1-6 $0 copayment per day, Days 7-90, per benefit period. $1,925 annual copay maximum applies. Unlimited days for Medicare covered stays. **Out-of-Network** 40% coinsurance
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: **$150** for drugs on Tiers 3, 4 and 5 in-network and out-of-network Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription • Drug Tier 2: You pay $15 per prescription • Drug Tier 3: You pay $47 per prescription • Drug Tier 4: You pay 40% of the total cost • Drug Tier 5: You pay 30% of the total cost There is no deductible for select insulins. You pay a $35 copay for select insulins.	Deductible: **$150** for drugs on Tiers 3, 4 and 5 in-network and out-of-network Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription • Drug Tier 2: You pay $15 per prescription • Drug Tier 3: You pay $47 per prescription • Drug Tier 4: You pay 40% of the total cost • Drug Tier 5: You pay 30% of the total cost There is no deductible for select insulins. You pay a $35 copay for select insulins.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$99**	**$99**
Optional Supplemental Dental Package 1 (This premium will be added to your monthly plan premium)	$25	$24
Optional Supplemental Dental Package 2 (This premium will be added to your monthly plan premium)	Not Applicable	$40

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

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

Cost	2022 (this year)	2023 (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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,900	$6,900 Once you have paid $6,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$11,300	$11,300 Once you have paid $11,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at www.IndependentHealth.com/Medicare. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Accidental/Medical Dental	**In-Network and Out-of-Network:** You pay a $65 copay for this benefit in an urgent care setting. You pay a $90 copay for this benefit in an emergency room setting.	**In-Network and Out-of-Network:** You pay a $60 copay for this benefit in an urgent care setting. You pay a $95 copay for this benefit in an emergency room setting.
Additional Telehealth Services	**In-Network:** You pay a $15 copay for Physical Therapy, Occupational Therapy or	**In-Network:** You pay a $20 copay for Physical Therapy, Occupational Therapy or

Cost	2022 (this year)	2023 (next year)
	Speech Therapy. You pay a $65 copay for telehealth visit for urgent care. **Out-of-Network:** You pay 40% coinsurance for this benefit.	Speech Therapy. You pay a $60 copay for telehealth visit for urgent care. **Out-of-Network:** You pay 40% coinsurance for this benefit.
Air Ambulance	**In-Network:** You pay a 20% coinsurance for this benefit. **Out-of-Network:** You pay a 20% coinsurance for this benefit.	**In-Network:** You pay a $250 copay for this benefit. **Out-of-Network:** You pay a $250 copay for this benefit.
Chronic Condition Management Personal Emergency Response System	This benefit is not covered.	**In-Network and Out-of-Network:** This program provides eligible members with a Personal Emergency Response System through NationsResponse in partnership with ADT at no cost. Eligibility for the program include, but are not limited to, specific chronic conditions and participation with our Care For You program. Eligible members will have access to emergency alert devices, two-way connectivity to round-the-clock monitoring centers and scheduled wellness checks by ADT

Cost	2022 (this year)	2023 (next year)
		Companion agents. Eligible members have three PERS units to choose from: ADT On-The-Go (4G) ADT Medical Alert Plus (4G) ADT Medical Alert Basic
Emergency Care	**In-Network and Out-of-Network:** You pay a $90 copay for this benefit.	**In-Network and Out-of-Network:** You pay a $95 copay for this benefit.
Health Education	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** You pay nothing. You must use plan approved services.	**In-Network:** You pay $10 per class for certain community fitness classes. You pay nothing for other Health Education services. **Out-of-Network:** You pay $10 per class for certain community fitness classes. You pay nothing for other Health Education services. You must use plan approved services.
Hearing Aids (all types)	**In-Network and Out-of-Network:** You pay a $499 minimum copay for each hearing aid from a provider in the national	**In-Network and Out-of-Network:** You pay a $499 minimum copay for each hearing aid from a provider in the

Cost	2022 (this year)	2023 (next year)
	Start Hearing network. You pay a $2799 maximum copay for each hearing aid from a provider in the national Start Hearing network.	national Start Hearing network. You pay a $2199 maximum copay for each hearing aid from a provider in the national Start Hearing network. Starkey Economy = $499 Copayment Starkey Low = $699 Copayment Starkey Select = $999 Copayment Starkey Advanced = $1,499 Copayment Starkey Premium = $2,199 Copayment
In-Home Fall Risk Assessment	This benefit is not covered.	**In-Network and Out-of-Network:** You pay nothing for this benefit. You must use our plan approved provider for this service.
Inpatient Medical Rehab	**In Network:** You pay a $275 copayment for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** 40% coinsurance per stay.	**In Network:** You pay a $250 copayment for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** 40% coinsurance per stay.

Cost	2022 (this year)	2023 (next year)
Inpatient Psychiatric Stay	**In Network:** You pay a $275 copayment for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** 50% coinsurance per stay.	**In Network:** You pay a $250 copayment for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** 50% coinsurance per stay.
Inpatient Substance Abuse Services	**In-Network:** You pay a $275 copayment per day for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** You pay 50% coinsurance per day.	**In-Network:** You pay a $250 copayment per day for days 1-6. You pay a $0 copayment for days 7-90. **Out-of-Network:** You pay a 50% coinsurance per day.
Medicare-Covered Inpatient Hospital	**In Network:** You pay a $275 copayment for days 1-6. You pay a $0 copayment for days 7-90. Unlimited days for Medicare-covered stays. There is a $1,925 out-of-pocket limit every year. **Out-of-Network:** 40% coinsurance per stay.	**In Network:** You pay a $250 copayment for days 1-6. You pay a $0 copayment for days 7-90. Unlimited days for Medicare-covered stays. There is a $1,925 out-of-pocket limit every year. **Out-of-Network:** 40% coinsurance per stay.

Cost	2022 (this year)	2023 (next year)
Observation Services	**In-Network:** You pay a $275 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.	**In-Network:** You pay a $250 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.
Occupational Therapy Services	**In-Network:** You pay a $15 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.	**In-Network:** You pay a $20 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.
OTC Items	**In-Network and Out-of-Network:** You pay nothing for this benefit. There is a $25 allowance every quarter. The allowance does not accumulate quarter to quarter or plan year to plan year. You must purchase OTC items from the NationsOTC catalogue.	**In-Network and Out-of-Network:** You pay nothing for this benefit. There is a $25 allowance every quarter. The allowance accumulates quarter to quarter. The allowance does not carry over plan year to plan year. You must purchase OTC items from the NationsOTC catalogue.

Cost	2022 (this year)	2023 (next year)
Preventive Dental	**In-Network:** You pay $20 copay for this benefit. This benefit is administered by Healthplex. **Out-of-Network:** You pay $20 copay, plus 50% coinsurance for this benefit.	**In-Network:** You pay $0 copay for this benefit. This benefit is administered by LIBERTY Dental Plan. **Out-of-Network:** You pay $0 copay for this benefit. You will be covered up to the In-Network contractual payment amount for out-of-network services. Balance billing may apply.
Skilled Nursing Facility (SNF) Medicare-covered stay	**In Network:** You pay a $0 copayment for days 1-20. You pay a $188 copayment for days 21-100. **Out-of-Network:** 40% coinsurance per stay.	**In Network:** You pay a $0 copayment for days 1-20. You pay a $196 copayment for days 21-100. **Out-of-Network:** 40% coinsurance per stay.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	**In-Network:** You pay a $30 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.	**In-Network:** You pay a $25 copay for this benefit. **Out-of-Network:** You pay a 40% coinsurance for this benefit.

Cost	2022 (this year)	2023 (next year)
Urgently Needed Services	**In-Network and Out-of-Network:** You pay a $65 copay for this benefit.	**In-Network and Out-of-Network:** You pay a $60 copay for this benefit.
Worldwide Emergency Coverage	You pay a $90 copay for this benefit. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.	You pay a $95 copay for this benefit. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.
Worldwide Emergency Transportation	You pay a $250 copay for ground ambulance services. You pay a 20% coinsurance for air ambulance services. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.	You pay a $250 copay for ground ambulance and air ambulance services. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.
Worldwide Urgent Coverage	You pay a $65 copay for this benefit. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.	You pay a $60 copay for this benefit. There is a $10,000 plan benefit limit per occurrence for unforeseen care outside the United States and its territories.

Benefit	2022	2023
Comprehensive Dental Package Option 1	$25 monthly premium in addition to your monthly plan premium and Medicare Part B premium. $3,000 total annual coverage limit. On January 1, April 1, July 1 and October 1, $750 will be added to your coverage limit to bring the total annual coverage limit to $3,000. $750 of the annual coverage limit is earned each quarter. 50% coinsurance on all covered services. Dental implants are not covered. No annual deductible. Administered by Healthplex.	$24 monthly premium in addition to your monthly plan premium and Medicare Part B premium. $3,000 total annual coverage limit. On January 1, April 1, July 1 and October 1, $750 will be added to your coverage limit to bring the total annual coverage limit to $3,000. $750 of the annual coverage limit is earned each quarter. 50% coinsurance on all covered services. Dental implants are not covered. No annual deductible. Administered by LIBERTY Dental Plan.
Comprehensive Dental Package Option 2	This dental package is not offered.	$40 monthly premium in addition to your monthly plan premium and Medicare Part B premium. $4,000 total annual coverage limit. On January 1, April 1, July 1 and October 1, $1,000 will be added to your coverage limit to bring the total annual coverage limit to $4,000.

Benefit	2022	2023
		$1,000 of the annual coverage limit is earned each quarter. 50% coinsurance on all covered services, including covered dental implants. No annual deductible. Administered by LIBERTY Dental Plan.

Section 1.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

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 you haven’t received this insert by September 30, 2022, please call Member Services and ask for the “LIS Rider.”

There are four “drug payment stages.”

The information below shows the changes 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.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible.	The deductible is **$150** During this stage, you pay $0 cost sharing for drugs on Tier 1 and $15 cost sharing for drugs on Tier 2 and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.	The deductible is **$150** During this stage, you pay $0 cost sharing for drugs on Tier 1 and $15 cost sharing for drugs on Tier 2 and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.

Changes to Your Cost sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Preferred Generic:** You pay $0 per prescription **Tier 2 – Generic:** You pay $15 per prescription	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Preferred Generic:** You pay $0 per prescription **Tier 2 – Generic:** You pay $15 per prescription

Stage	2022 (this year)	2023 (next year)
costs for a long-term supply; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Tier3 – Preferred Brand:** You pay $47 per prescription **Tier 4 –Non-Preferred Drug:** You pay 40% of the total cost **Tier 5 – Specialty Tier:** You pay 30% of the total cost Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	**Tier 3 – Preferred Brand:** You pay $47 per prescription **Tier 4 – Non-Preferred Drug:** You pay 40% of the total cost **Tier 5 – Specialty Tier:** You pay 30% of the total cost Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Member Services number at 716-250-4401 or 1-800-665-1502 for additional information. (TTY users should call: 711.) Hours are October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m. and April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Independent Health's Medicare Passport Advantage (PPO)

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 Independent Health's Medicare Passport Advantage (PPO).

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 plans for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read *Medicare & You 2022*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 6.2).

As a reminder, Independent Health Benefits Corporation 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 Independent Health's Medicare Passport Advantage (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Independent Health's Medicare Passport Advantage (PPO).
- 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 so.

- – *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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time.** You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Note: If you're in a drug management program, you may not be able to change plans.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HIICAP 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 HIICAP at 1-800-701-0501. You can learn more about HIICAP by visiting their website (www.aging.ny.gov).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York has a program called New York State Elderly Pharmaceutical Insurance Coverage Program (EPIC) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.

- **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 New York State Department of Health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:
  HIV Uninsured Care Programs, Empire Station
  Empire Station
  P.O. Box 2052
  Albany, NY 12220-0052
  1-800-542-2437 or adap@health.ny.gov.

SECTION 6 Questions?

Section 6.1 – Getting Help from *Independent Health's Medicare Passport Advantage*

Questions? We're here to help. Please call Member Services at 1-800-665-1502 or 716-250-4401. (TTY only, call 711). We are available for phone calls:

Hours of operation (Eastern time)

October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m.
April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.

Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the 2023 *Evidence of Coverage* for Independent Health's Medicare Passport Advantage (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the Evidence of Coverage is located on our website at www.IndependentHealth.com/Medicare. 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 www.IndependentHealth.com/Medicare. As a reminder, our website has the most up-to-date information about our provider network (*Physician/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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

H3344_C8702_M H3344_005 Passport Advantage PPO

INDEPENDENT HEALTH'S

Evidence of Coverage (EOC)

Your EOC will not be mailed to you this year. Your EOC will be available no later than October 15th. You can access your EOC one of three ways.

1. **Visit IndependentHealth.com/Medicare and click on "2023 Medicare Plans"**

   - Refer to the front of your Annual Notice of Change (ANOC) booklet to find the name of your plan.
   - Find your plan name and click "Learn More".
   - Under "Plan Details" click on "Annual Notice of Change/Evidence of Coverage."

   You can download and save the document or print a copy for your records.

2. **Create a secure account to view your EOC online:**
   - Visit IndependentHealth.com/Register.
   - Have your member ID card handy during setup, as you will need to provide your member ID number to register.
   - Choose a username and password – and then use it to sign into your account whenever you visit us online.
   - Once you have registered and logged in, click on "Documents" to view your ANOC and EOC.

   Plus, once you have registered, you can select **Go Paperless** to receive your ANOC and EOC electronically moving forward, instead of receiving them in the mail. To let us know you would like to go paperless, follow these steps:

   - Once you are logged in to your online account, select "Manage Preferences" from the "Go Paperless" section on your account home.
   - Under "Paperless Preferences" select "Electronic".

   Please note that you always have the option to change your preferences in the future.

3. **If you prefer to receive a copy of your EOC by mail, please contact Member Services:**
   (716)250-4401 or 1-800-665-1502 (TTY users call 711)

   October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.

   April1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

   Or email us at: medicareservice@servicing.independenthealth.com

Independent Health

INDEPENDENT HEALTH'S

Medicare Advantage Provider Directories and Prescription Drug Formularies

At Independent Health, we're dedicated to helping you get the right care, at the right time, and in the right setting. That's why we offer a comprehensive network of health care providers, giving you choice and flexibility as to where you receive care.

To help you understand who participates in our network, we've compiled the names of our health care providers and wellness partners into the following directories and listings:

- Independent Health's Medicare Advantage Physician/Provider Directory
- Independent Health's Medicare Advantage Pharmacy Directory
- Liberty Dental® Dental Directory (for routine/preventive dental providers)
- EyeMed® "Insight Network" Directory (for routine/refractive eye exam providers)
- SilverSneakers® Fitness Program participating facility listing
- Start Hearing participating network provider listing
- Independent Health's Medicare Advantage Part D Formulary (Drug List)

All of this information is available online at **www.independenthealth.com/Medicare**.

If you prefer to receive a copy by mail, please contact Member Services:

PHONE: (716) 250-4401 or 1-800-665-1502; (TTY users call 711)

October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.

April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

EMAIL:medicareservice@servicing.independenthealth.com

For the most up-to-date information on our provider listings, call Member Services or use our "Find a Doctor" tool online at **www.independenthealth.com/findadoc.** This tool gives you the option to search for providers or facilities by name, location or specialty, and print your results.

Independent Health

If you have a question about covered drugs, please call 1-800-665-1502 or visit www.independenthealth.com/MedicareFormularies to access our online formulary. If you would like a formulary mailed to you, you may call the number above, request one at the website link provided above, or email medicareservice@servicing.independenthealth.com.

Language Assistance Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-665-1502 (TTY: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-665-1502 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-665-1502 (TTY: 711)
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-665-1502 (телетайп TTY: 711).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-665-1502 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-665-1502 (TTY: 711) 번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-665-1502 (TTY: 711).
Yiddish	אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-665-1502 (TTY: 711).
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-665-1502 (TTY: 711)।
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-665-1502 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-665-1502 (رقم هاتف الصم والبكم: 117).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-665-1502 (TTY: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-665-1502 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-665-1502 (TTY: 711).
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-665-1502 (TTY: 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-665-1502 (TTY: 711).

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

Y0042_C7100_C

Independent Health

Notice of Nondiscrimination

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Independent Health's Member Services Department. If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 711, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.