¡Care Medicare Plan (HMO D-SNP) offered by Independent Care Health Plan (¡Care)

Annual Notice of Changes for 2022

You are currently enrolled as a member of *¡*Care Medicare Plan. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you.

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Sections 1.3 and 1.4 for information about our *Provider/Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

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

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices.

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2 to learn more about your choices.

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

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

- If you don't join another plan by December 7, 2021, you will be enrolled in *i*Care Medicare Plan.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in Section 2, page 16 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in *i*Care Medicare Plan.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at 1-800-777-4376 for additional information. (TTY users should call 711). Hours are 24 hours a day, 7 days a week. Office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.
- Please contact Customer Service or our Member Advocate/Member Rights Specialist at 1-800-777-4376 ext. 1076 or should you require plan materials in another format such as braille or large print.
- **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 *i*Care Medicare Plan

- Independent Care Health Plan (*i*Care), which insures *i*Care Medicare Plan (HMO D-SNP), is an HMO with a Medicare contract. Enrollment in *i*Care Medicare Plan depends on contract renewal. The plan also has a written agreement with the Wisconsin Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means Independent Care Health Plan (*i*Care). When it says "plan" or "our plan," it means *i*Care Medicare Plan.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for *i*Care Medicare Plan in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.iCareHealthPlan.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0 or $40.70	$0 or $42.30
Deductible	$0 or $203 per year for in-network services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	This is the 2021 cost-sharing amount and may change for 2022. *i*Care Medicare Plan will provide an updated rate as soon as it is released. $0 or $203 per year for in-network services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Doctor office visits	Primary care visits: 0% or 20% co-insurance per visit. Specialist visits: 0% or 20% co-insurance per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.	Primary care visits: 0% or 20% co-insurance per visit. Specialist visits: 0% or 20% co-insurance per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	In 2021, the amounts for each benefit period are $0 or: • $1,484 Deductible for each benefit period. • Days 1–60: $0 co-insurance for each benefit period. • Days 61–90: $371 co-insurance per day of each benefit period. • Days 91 and beyond: $742 co-insurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond Lifetime reserve days: all costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	These are 2021 cost-sharing amounts and may change for 2022. *i*Care Medicare Plan will provide updated rates as soon as they are released. In 2021, the amounts for each benefit period are $0 or: • $1,484 Deductible for each benefit period. • Days 1–60: $0 co-insurance for each benefit period. • Days 61–90: $371 co-insurance per day of each benefit period. • Days 91 and beyond: $742 co-insurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond Lifetime reserve days: all costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	**Prescription Drug Savings Benefit** is not covered.	**Prescription Drug Savings Benefit** is covered because you qualify for "Extra Help". You will pay the following: Deductible: $0 Co-payment during the Initial Coverage Stage: For **retail and mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$0** • Drug Tier 4: **$0** • Drug Tier 5: **$0** Cost shares apply to 30 and 90-day supply. Drug Tier 5 is limited to a 30-day supply.
Maximum out-of-pocket amount 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)	$7,550 In-network If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,450 In-network If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Annual Notice of Changes for 2022
Table of Contents

Section 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 or $40.70	$0 or $42.30

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

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

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B co-pays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as co-pays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550 In-Network Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	$3,450 In-Network Once you have paid $3,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.iCareHealthPlan.org. Also on our website is a request form to ask us to send you a *Provider/Pharmacy Directory*. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) and pharmacies are in our network**.

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

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

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.iCareHealthPlan.org. Also on our website is a request form to ask us to send you a *Provider/Pharmacy Directory*. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.* A copy

of the *Evidence of Coverage* is located on our website at www.iCareHealthPlan.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Supplemental Dental Services (Non-Medicare Covered Supplemental Benefit) There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit. There may be limits on how much the plan will provide.	We provide Supplemental Dental services under Medicare Part C for preventive and comprehensive (combined) dental services for: **Preventive Care** • Oral Exams: Up to 2 per calendar year. • Prophylaxis (Cleaning): Up to 2 per calendar year. • Fluoride Treatment: Up to 2 per calendar year. • Dental X-rays: X-rays are limited to either 1 panoramic or 1 full set per calendar year. **Comprehensive Care** • Diagnostic Services: Up to 2 visits per calendar year.)	We provide Supplemental Dental services under Medicare Part C for preventive and comprehensive dental services limited to a total of $2,500 per calendar year. **Preventive Care** • Oral Exams: Up to two (2) per calendar year. • Prophylaxis (Cleaning): Up to two (2) per calendar year. • Fluoride Treatment: Up to two (2) per calendar year. • X-Rays are limited to either 1 panoramic, 1 full set, or 1 bitewing set per calendar year. **Comprehensive Care** • Diagnostic Services — Up to two (2) visits per calendar year. • Restorative Services — Simple restorations are limited to Amalgams/Resins, one (1) restoration per tooth, per calendar year. • Extractions — Simple extractions only. No surgical extractions. • Prosthodontics/Oral or Maxillofacial Surgery/Other services: ▪ Crowns — Limited to one (1) per tooth per 60 months. ▪ Basic Partials and basic dentures are covered, one (1) every 60 months. No coverage for repair. ▪ No coverage for oral/maxillofacial surgery.

Cost	2021 (this year)	2022 (next year)
Vision Services (Non-Medicare Covered – Supplemental Benefit) There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit. There may be limits on how much the plan will provide.	This plan provides a supplemental benefit under Medicare Part C limited to a total of $250 per calendar year for: • Contact fitting • Contact lenses • The purchase of one (1) set of eyeglass lenses and frames; and/or upgrades	This plan provides a supplemental benefit under Medicare Part C limited to a total of $300 per calendar year for: • Eye exam • Contact fitting • Contact lenses • One (1) pair of eye glasses (lenses and/or frames)/upgrades combined
Meal Benefit — Post In-patient Hospital Stay (Non-Medicare Covered Supplemental Benefit) There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit.	If you are transitioning from an inpatient hospital or skilled nursing facility, you are eligible for one (1) meal per day for a maximum of seven (7) days (7 meals provided).	If you are transitioning from an inpatient hospital stay or skilled nursing facility, you are eligible for up to 14 days of meals (maximum 28 meals provided — two (2) meals per day).
Non-Emergency Transportation **(Non-Medicare Covered Supplemental Benefit)** There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit.	Non-Emergency Transportation is **not** covered.	The *i*Care transportation benefit provides members with non-emergency transportation to and from plan approved locations for up to 24 one-way trips annually, up to 25 miles.

Cost	2021 (this year)	2022 (next year)
Healthy Foods Card There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit.	Healthy foods is **not** covered.	$50.00 allowance amount per month for Healthy Foods Card for members to spend at participating retailers toward the purchase of approved healthy foods.
Special Supplemental Benefits for the Chronically Ill **Flexible Care Assistance** There is no supplemental premium, co-pays, deductibles or co-insurance to participate.	Special Supplemental Benefits for the Chronically Ill Flexible Care Assistance is **not** covered.	Flexible Care Assistance is available to chronically ill members diagnosed with Cancer, COPD, CHF, and/or Diabetes, who are participating with care management services and meet program criteria. Eligible members may receive medical expenses assistance, primarily health related, and non-primarily health related additional benefits to address specific needs based on the individual's unique situations. Benefits are limited up to $500 per year and must be coordinated and authorized by a care manager. There is no coinsurance, copayment, or deductible to participate.
Wellness and Health Care Planning (WHP) Services There is no supplemental premium, co-pays, deductibles or co-insurance for this benefit.	WHP is **not** covered.	As an *i*Care member, you have access to an online advance care planning resource on icarehealthplan.org. This resource helps you to create an advance directive where you can combine the elements of a living will, medical power of attorney, do not attempt resuscitation, and an organ donation form.

Cost	2021 (this year)	2022 (next year)
Prescription Drug Savings Benefit	Prescription Drug Savings Benefit is **not** covered.	**$0** copay for all Medicare covered prescription drugs for all formularies, on all tiers. Benefit begins in the Deductible Stage (when applicable) and continues through Initial Coverage Stage, only. To qualify, members must be eligible for "Extra Help". If the total amount of prescription drugs covered under this benefit reaches $4,430, you will then pay the "Extra Help" cost-share amount. For more details, please refer to the separate insert we sent to you, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"). For more details about covered drugs see the Comprehensive Formulary (Drug List). For additional details about this benefit, see *Changes to Part D Prescription Drug Coverage* within this document.

Cost	2021 (this year)	2022 (next year)
Inpatient Mental Health Care	In 2021, the amounts for each benefit are $0 or: • $1,484 deductible for each benefit period. • Days 1–60: $0 co-insurance per day of each benefit period. • Days 61–90: $371 co-insurance per day of each benefit period. • Days 91 and beyond: $742 co-insurance per each "lifetime reserve days" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: all costs. 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.	These are 2021 cost-sharing amounts and may change for 2022. *i*Care Medicare Plan will provide updated rates as soon as they are released. In 2021, the amounts for each benefit are $0 or: • $1,484 deductible for each benefit period. • Days 1–60: $0 co-insurance per day of each benefit period. • Days 61–90: $371 co-insurance per day of each benefit period. • Days 91 and beyond: $742 co-insurance per each "lifetime reserve days" after day 90 for each benefit period (up to 60 days over your lifetime). • Beyond lifetime reserve days: all costs. • 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.
Please note: Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility for Original Medicare Services.		

Cost	2021 (this year)	2022 (next year)
Skilled Nursing Facility (SNF)	Plan covers up to 100 days each benefit period. Three day prior hospital stay is required. In 2021 the amounts for each benefit period are $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $185.50 co-insurance per day of each benefit period. Days 101 and beyond: all costs.	These are 2021 cost-sharing amounts and may change for 2022. *i*Care Medicare Plan will provide updated rates as soon as they are released. Plan covers up to 100 days each benefit period. Three day prior hospital stay is required. In 2021 the amounts for each benefit period are $0 or: • Days 1–20: $0 for each benefit period. • Days 21–100: $185.50 co-insurance per day of each benefit period. Days 101 and beyond: all costs.
Please note: Depending on your level of Medicaid eligibility, you may not have any cost sharing responsibility for Original Medicare Services.		

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In most cases, formulary exceptions are approved for a period of one year. When your formulary exception is approved, we send you a letter with the dates of approval. The approval may extend into the next year if the date on the approval extends into the next calendar year. A new formulary exception request will need to be submitted when your current exception expires.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included 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. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

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

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Generic Drugs, including brand drugs treated as generic):** Depending on your income and institutional status, you pay either: $0 or $1.30 or $3.70 co-pay per prescription. **Tier 2 (Brand Drugs):** Depending on your income and institutional status, you pay either: $0 or $4.00 or $9.20 co-pay per prescription. **Tier 3 (Specialty Drugs):** Depending on your income and institutional status, you pay either: $0 or $1.30 or $3.70 co-pay; or $0 or $4.00 or $9.20 co-pay per prescription. Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Because you qualify for "Extra Help", you will pay $**0** for all Medicare covered prescription drugs for all formularies, on all tiers. Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic** *Standard cost sharing:* You pay $0 per prescription. **Generic** *Standard cost sharing:* You pay $0 per prescription. **Preferred Brand** *Standard cost sharing:* You pay $0 per prescription. **Non-Preferred Drug** *Standard cost sharing:* You pay $0 per prescription. **Specialty Tier** *Standard cost sharing:* You pay $0 per prescription. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**. For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in *i*Care Medicare Plan

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 *i*Care Medicare Plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 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.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6).

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

As a reminder, Independent Care Health Plan and its parent company, Humana, offers other Medicare health plans *AND/OR* Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *i*Care Medicare Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *i*Care Medicare Plan.
- To **change to Original Medicare without a prescription drug plan**, you must either:

- Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 6 of this booklet).
- – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called Wisconsin Board of Aging & Long-Term Care.

The Wisconsin Board of Aging & Long-Term Care is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The Wisconsin Board of Aging & Long-Term Care 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 the Wisconsin Board of Aging & Long-Term Care at 1-800-242-1060 or call 1-855-677-2783 for questions about Medicare Part D and other prescription drug coverage options. You can learn more about the Wisconsin Board of Aging & Long-Term Care by visiting their website (http://longtermcare.wi.gov/).

For questions about your Wisconsin Medicaid benefits, contact the Wisconsin Department of Health Services at 1-800-362-3002 (TTY:711), Monday – Friday, 8:00 a.m. to 6:00 p.m. (central

time with the exception of state-observed holidays). Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.

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.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and co-insurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Wisconsin has a program called SeniorCare 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 (the name and phone numbers for this organization are in Section 4 of this booklet).
- **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 AIDS/HIV Drug Assistance Program (ADAP) and the Insurance Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 608-261-6952, 608-267-6875, or 1-800-991-5532.

SECTION 6 Questions?

Section 6.1 – Getting Help from *i*Care Medicare Plan

Questions? We're here to help. Please call Customer Service at 1-800-777-4376 (TTY: 711). We are available for phone calls 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. to 5:00 p.m., or visit www.iCareHealthPlan.org. Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for *i*Care Medicare Plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.iCareHealthPlan.org.You may also call Customer Service to ask us to mail you an *Evidence of Coverage*. A notice which explains how to get a copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.iCareHealthPlan.org. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid *OR* your Medicaid managed care plan you can call the Wisconsin Department of Health Services at 1-800-362-3002. TTY users should call 1-888-701-1251.

SECTION 7 Legal Notices

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan:

- 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 Customer Service at 1-800-777-4376 (TTY: 1-800-947-3529), 24 hours a day, 7 days a week (Office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.).

If you believe that Independent Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, or sex, you can file a grievance with the Grievance and Appeal Coordinator,1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, 1-800-777-4376 x1076 (TTY: 1-800-947-3529), F: 414-918-7589, or advocate@icarehealthplan.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, the Grievance and Appeal Coordinator 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 *https://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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Last update: 08/24/2020

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-800-777-4376 (TTY: 1-800-947-3529).

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。1-800-777-4376 (TTY: 1-800-947-3529).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-4376 (TTY: 1-800-947-3529).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-777-4376 (رقم هاتف الصم والبكم: 1-800-947-3529).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-4376 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-4376 (TTY: 1-800-947-3529) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-4376 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-777-4376 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-4376 (ATS: 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-777-4376 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-777-4376 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-777-4376 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-4376 (TTY: 1-800-947-3529).

Notes

Use this page to write down questions you may have for the plan. Or use it to write notes. Call us at 1-800-777-4376 (TTY: 711) with your questions or visit www.iCareHealthPlan.org.