*i*Care Family Care Partnership (HMO D-SNP) offered by Independent Care Health Plan (*i*Care)

Annual Notice of Changes for 2023

You are currently enrolled as a member of *i*Care Family Care Partnership. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs.***

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 web site at www.iCareHealthPlan.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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 web site 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 web site.

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 *i*Care Family Care Partnership.
   - 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 *i*Care Family Care Partnership.
   - Look in Section 2, page 14 to learn more about your choices.
   - 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 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 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) web site at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *i*Care Family Care Partnership

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

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Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for *i*Care Family Care Partnership in several important areas. **Please note this is only a summary of costs**.

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	2022 (this year)	2023 (next year)
Monthly plan premium	$0	$0
Doctor office visits	Primary care visits: $0 per visit. Specialist visits: $0 per visit.	Primary care visits: $0 per visit. Specialist visits: $0 per visit.
Inpatient hospital stays	$0	$0
Part D Prescription Drug Coverage (See Section 1.5 for details.)	**Prescription Drug Savings Benefit** is covered because you qualify for "Extra Help." You 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.	**$0 Rx Co-pay** is covered because you qualify for "Extra Help." You will pay the following: Deductible: **$0** There are no co-payments during the Initial Coverage, Gap and Catastrophic Stages. 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 a 1-month and 3-month supply. Drug Tier 5 is limited to a 1-month supply.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$0 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.	$0 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.

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 unless it is paid for you by Medicaid.)	$0	$0 There is no change for the upcoming benefit year.

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (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.** 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) count toward your maximum out-of-pocket amount. You do not pay a plan premium or pay for prescription drugs so, there is nothing to count toward your maximum out-of-pocket amount.	$0	$0 There is no change for the upcoming benefit year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our web site at www.iCareHealthPlan.org. You may also call Customer Service 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/Pharmacy 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 Provider/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 a part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – 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 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)
Prescription Drugs	**Prescription Drug Savings Benefit:** $0 co-pay for all Medicare covered prescription drugs for all formularies, on all tiers. Benefit begins in the Deductible Stage (when applicable) and continues through the Initial Coverage Stage, only. Because you are eligible for "Extra Help" you qualify for this benefit. 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 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.	**$0 Rx Co-Pay:** $0 co-pay for all Medicare covered Part D prescription drugs on all tiers and through all stages. You qualify because you are eligible for "Extra Help." For more details about covered drugs see the Formulary. For additional details about this benefit, see Changes to Part D Prescription Drug Coverage within this document.
Because you are a member of *i*Care Family Care Partnership and receive Medicaid assistance with your Medicare cost-sharing amounts, you are not responsible for paying any out-of-pocket costs for covered Part A and Part B services in 2022 or 2023. For additional details please refer to the Evidence of Coverage.		

Cost	2022 (this year)	2023 (next year)
Diabetes Self-Management Training	$0 co-pay 20% co-insurance	$0 co-pay 0% co-insurance
Additional Drug Coverage For select Erectile Dysfunction drugs.	Additional Drug Coverage – select Erectile Dysfunction drugs, is not covered.	Covered at Tier 1 co-pay of $0. Maximum of 6 tablets every 30 days.
Emergency Services For Medicare covered Emergency room visits. Contact the plan after you receive emergency care.	If you are admitted to the hospital within *three (3) days* for the same condition that brought you to the emergency room, you have a co-pay of $0 per visit for Medicare covered emergency room visits.	If you are admitted to the hospital *within 24 hours* for the same condition that brought you to the emergency room, you have a co-pay of $0 per visit for Medicare covered emergency room visits.
Cardiac and Pulmonary Rehabilitation Services	Benefits/services listed under this category include: • Medicare covered Cardiac Rehabilitation Services • Medicare covered Intensive Cardiac Rehabilitation Services • Medicare covered Pulmonary Rehabilitation Services	Benefit/services listed under this category include: • Medicare covered Cardiac Rehabilitation Services • Medicare covered Intensive Cardiac Rehabilitation Services • Medicare covered Pulmonary Rehabilitation Services • Medicare covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services.
Weight Watchers	Weight Watchers meetings are covered for 13 weeks with the option to extend upon Care Team approval.	Weight Watchers is not covered.
Healthy Foods	$50 allowance amount per month for Healthy Foods Card	See Healthy Options Allowance.

Cost	2022 (this year)	2023 (next year)
Healthy Foods continued	for members to spend at participating retailers toward the purchase of approved healthy foods.	
Over-the-Counter Benefit (Non-Medicare Covered) There is no supplemental premium, co-pay, deductible or co-insurance for this benefit.	$40 every month to spend on approved over-the-counter items at participating retailers, online or through a catalog. Purchase using a pre-paid benefits card. Balance re-sets annually.	See Healthy Options Allowance.
Healthy Options Allowance	Healthy Options Allowance is not covered.	$150 loaded on a prepaid card every month to use toward the purchase of food, over-the-counter (OTC) products, and home supplies from a national network of retailers. The card may also be used to pay for non-medical transportation, general supports for living (such as rent assistance, internet, and utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year or upon disenrollment from the plan.
Dental Services (Non-Medicare Covered Supplemental Benefit) There is no supplemental premium, co-pays, deductible or co-insurance for this benefit.	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.	We provide Supplemental Dental services under Medicare Part C for preventive and comprehensive dental services limited to a total of $4,000 per calendar year.

Cost	2022 (this year)	2023 (next year)
Dental Services (Non-Medicare Covered Supplemental Benefit) continued There may be limits on how much the plan will provide.	**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.	**$0 co-pay for Preventive Care:** • Oral Exams — up to three (3) per calendar year: include emergency diagnostic exam up to 1 per year, and periodic oral exam up to 2 per year. • Prophylaxis (Cleaning): Up to six (6) per calendar year: include periodontal maintenance up to 4 per year, and prophylaxis (cleaning) up to 2 per year. • Fluoride Treatment: Up to two (2) per calendar year. • Dental X-Rays include bitewing x-rays and intraoral x-rays up to 1 set(s) per year, and panoramic film or diagnostic x-rays up to 1 every 5 years. **$0 co-pay for Comprehensive Care**: • Non-routine Services: Two (2) visits included every year. • Diagnostic Services: One (1) visit included every three (3) years. • Restorative Services: Include fillings up to unlimited per year, re-cementation of crown and re-cementation of dentures up to 1 every 5 years, crown up to 1 per tooth per lifetime.

Cost	2022 (this year)	2023 (next year)
Dental Services (Non-Medicare Covered Supplemental Benefit) continued	Prior authorization *is not* required for Comprehensive Care.	• Endodontics: Include root canal, root canal retreatment up to 1 per tooth per lifetime. • Periodontics include scaling and root planning (deep cleaning) up to 1 per quadrant every 3 years, scaling for moderate inflammation up to 1 every 3 years. • Extractions: Surgical extractions are covered; Unlimited per year. • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Include partial dentures and complete dentures up to 1 set(s) every 5 years, denture adjustment, denture reline, denture repair, denture rebase, tissue conditioning up to 1 per year, occlusal adjustments up to 1 every 3 years, oral surgery up to 2 per year, bridges up to 1 every 5 years. Prior authorization *is* required for Comprehensive Care.
Vision Services (Non-Medicare Covered) There is no supplemental premium, co-pay, deductible 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 $300 per calendar year for: • Eye exam • Contact fitting • Contact lenses	This plan provides a supplemental benefit under Medicare Part C for: $0 co-pay for routine exam up to one (1) per year. $50 combined maximum benefit coverage amount per year for routine exam. $400 combined maximum benefit coverage amount per

Cost	2022 (this year)	2023 (next year)
Vision Services (Non-Medicare Covered) continued There is no supplemental premium, co-pay, deductible or co-insurance for this benefit. There may be limits on how much the plan will provide.	• One (1) pair of eyeglasses (lenses and/or frames) upgrades combined. Prior authorization *is not* required.	year for contact lenses or eyeglasses — lenses and frames, fitting for eyeglasses — lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to one (1) pair per year. Maximum benefit coverage amount is limited to one time use per year. Prior authorization *is* required.

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 Customer Service for more information.

Changes to Prescription Drug Costs

Note: Because you are in a program that helps pay for your drugs ("Extra Help"), the information about costs for Part D prescription drugs does 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 if you didn't receive this insert with this packet, please call Customer Service 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	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

Stage	2022 (this year)	2023 (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 that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 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.	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, if	Because you qualify to receive "Extra Help," you will pay a $0 co-pay for all Medicare covered Part D prescription drugs on all tiers. Your cost for a one-month supply filled at a network pharmacy: **Preferred Generic** You pay $0 co-pay per prescription. **Generic** You pay $0 co-pay per prescription. **Preferred Brand** You pay $0 co-pay per prescription. **Non-Preferred Drug** You pay $0 co-pay per prescription. **Specialty Tier** You pay $0 co-pay per prescription.

Stage	2022 (this year)	2023 (next year)
	applicable, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660 if applicable, 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. Call Customer Service for more information.

Important Message About What You Pay for Insulin — You won't pay more than $0 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in *i*Care Family Care Partnership

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 Family Care Partnership.

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 2023 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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 Family Care Partnership.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *i*Care Family Care Partnership.
- 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 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.

  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.

If you are changing plans, you must also contact your local Aging and Disability Resource Center (ADRC). Please see Chapter 2 in the *Evidence of Coverage* for the telephone numbers of the ADRCs. You can also use the following link to find an ADRC in your area: https://www.dhs.wisconsin.gov/adrc/consumer/index.htm**.**

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, 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.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Wisconsin, the SHIP is called the Wisconsin State Health Insurance Assistance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Wisconsin SHIP at 1-800-242-1060, 1-855-677-2783 or 1-800-926-4862 (for people under age 60). You can learn more about the Wisconsin SHIP by visiting their web site: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

For questions about your Wisconsin Medicaid benefits, contact the Wisconsin Department of Health Services (DHS), 1-800-362-3002 (TTY users should call WI Relay 711) Monday – Friday from 8:00 am to 6:00 pm. You can also contact your local Aging and Disability Resource Center (ADRC). To find a location near you visit https://www.dhs.wisconsin.gov/adrc/consumer/index.htm or you can refer the Evidence of Coverage, Chapter 2 for contact information. 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 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).

SECTION 6 Questions?

Section 6.1 – Getting Help from *i*Care Family Care Partnership

Questions? We're here to help. Please call Customer Service at 1-800-777-4376 (TTY only, call 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. – 5:00 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 *i*Care Family Care Partnership. 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 web site at www.iCareHealthPlan.org. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Web site

You can also visit our web site at www.iCareHealthPlan.org. As a reminder, our web site 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 Web site

Visit the Medicare web site (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 web site (https://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.

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 (DHS) at 1-800-362-3002. TTY users should call the Wisconsin Relay System at 711.You can also visit the Medicaid web site at https://www.dhs.wisconsin.gov/medicaid/index.htm.

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, exclude or treat people differently because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion or language.

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 you have been discriminated against by Independent Care Health Plan, you may file a complaint, also known as 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.

- Grievance and Appeal Coordinator
  1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212
  1-800-777- 4376 x1076 (TTY: 1-800-947-3529)
  Fax: 414-918-7589
  Advocate@iCareHealthPlan.org
- 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: 07/20/2022

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-777-4376. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-777-4376. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Hmong: Peb muaj kev pab txhais lus dawb los teb cov lus nug uas koj muaj txog peb txoj kev npaj khomob lossis tshuaj. Yog xav tau ib tug neeg txhais lus, hu rau peb ntawm 1-800-777-4376. Ib tug neeg uas hais lus Askiv / thiab lwm yam lus tuaj yeem pab koj. Qhov no yog ib qho kev pab dawb.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-777-4376。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-777-4376。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-777-4376. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-777-4376. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-777-4376 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-777-4376. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-777-4376 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-777-4376. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1 800-777-4376 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-777-4376 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-777-4376. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-777-4376. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-777-4376. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-777-4376. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-777-4376にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。