Independent Health

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

Annual Notice of Changes for 2025

You are currently enrolled as a member of Independent Health's Medicare Passport Access (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Independent Health's Medicare Passport Access (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, 2025.** This will end your enrollment with Independent Health's Medicare Passport Access (PPO).
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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. This call is free.
- 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 Access (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 Access (PPO).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Independent Health's Medicare Passport Access (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$10	$19
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: $7,500 From network and out-of-network providers combined: $12,500	From network providers: $6,750 From network and out-of-network providers combined: $10,100
Doctor office visits	**In-Network** Primary care visits: $0 copayment per visit Specialist visits: $40 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: $40 copayment per visit **Out-of-Network** Primary care visits: 40% Coinsurance per visit Specialist visits: 40% Coinsurance per visit

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	**In-Network:** $325 copayment per day, Days 1-5 $0 copayment per day, Days 6-90, per benefit period. Unlimited days for Medicare covered stays. $1,625 annual copayment maximum applies **Out-of-Network:** 40% coinsurance per admission.	**In-Network:** $320 copayment per day, Days 1-5 $0 copayment per day, Days 6-90, per benefit period. Unlimited days for Medicare covered stays. $1,600 annual copayment maximum applies **Out-of-Network:** 40% coinsurance per admission.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $250 on Tiers 3, 4, and 5 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription • Drug Tier 2: You pay $17 per prescription • Drug Tier 3: You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: You pay 48% of the total cost You pay $35 per month supply of each covered insulin product on this tier.	Deductible: $450 on Tiers 3, 4, and 5 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: You pay $0 per prescription • Drug Tier 2: You pay $20 per prescription • Drug Tier 3: You pay $47 per prescription You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: You pay 50% of the total cost

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 5: You pay 29% of the total cost Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.	You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: You pay 27% of the total cost Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$10**	**$19**

- 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 6 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	2024 (this year)	2025 (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.	$7,500	$6,750 Once you have paid $6,750 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.

Cost	2024 (this year)	2025 (next 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.	$12,500	$10,100 Once you have paid $10,100 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

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.

Updated directories are 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, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *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 2025 *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	2024 (this year)	2025 (next year)
Ambulance Services- Medicare-covered Air Ambulance	**In-Network:** You pay $275 Copay for evaluation, treatment or transportation by air ambulance. **Out-of-Network:** You pay $275 Copay for evaluation, treatment or transportation by air ambulance.	**In-Network:** You pay 20% Coinsurance for evaluation, treatment or transportation by air ambulance. **Out-of-Network:** You pay 20% Coinsurance for evaluation, treatment or transportation by air ambulance.
Dental Services- Medicare covered	**In-Network**: You pay $100 copay for Medicare-covered dental services in an Emergency Room. **Out-of-Network**: You pay 40% coinsurance for Medicare-covered Dental Services.	**In-Network**: You pay $125 copay for Medicare-covered dental services in an Emergency Room. **Out-of-Network**: You pay 40% coinsurance for Medicare-covered Dental Services.
Emergency Care	**In-Network and Out-of-Network:** You pay a $100 copay for this benefit.	**In-Network and Out-of-Network:** You pay a $125 copay for this benefit.
Hearing Aids	**In-Network and Out-of-Network:** You pay a minimum $499 Copay for Hearing Aids. You pay a maximum $2,199 Copay for Hearing Aids.	**In-Network and Out-of-Network:** You pay a minimum $499 Copay for Hearing Aids. You pay a maximum $1,949 Copay for

Cost	2024 (this year)	2025 (next year)
	Benefit is limited to preferred hearing aids through a provider in the Start Hearing Network. Loss and damage warranty claims subject to $125 deductible per ear.	Hearing Aids. Benefit is limited to preferred hearing aids through a provider in the Start Hearing Network. Loss and damage warranty claims subject to $250 deductible per ear.
Help with Certain Chronic Conditions	**In-Network:** If a member has been diagnosed with diabetes: $0 copayment for an office visit with an endocrinologist. If you have been diagnosed with lower back pain: $0 copayment for initial evaluation with a physical therapist $0 copayment for first physical therapy session. If you have been diagnosed with depression: $0 copayment for first visit with a participating mental health provider. **Out-of-Network:** Lab work: 40% coinsurance. Physical Therapy: 40% coinsurance. Outpatient mental health: 40% coinsurance.	**In-Network:** $40 per visit with an endocrinologist regardless of diagnosis. $25 per visit for physical therapy regardless of diagnosis. $35 per visit for outpatient mental health regardless of diagnosis. **Out-of-Network:** Lab work: 40% coinsurance. Physical Therapy: 40% coinsurance. Outpatient mental health: 40% coinsurance.
Inpatient Hospital	**In-Network:** You pay a $325 copayment for days 1-5. You pay a $0	**In-Network:** You pay a $320 copayment for days 1-5. You pay a $0

Cost	2024 (this year)	2025 (next year)
	copayment for days 6-90. There is a $1,625 out-of-pocket limit Every Year. Unlimited number of days for Medicare-covered hospital stays. **Out-of-Network:** 40% coinsurance per stay.	copayment for days 6-90. There is a $1,600 out-of-pocket limit Every Year. Unlimited number of days for Medicare-covered hospital stays. **Out-of-Network:** 40% coinsurance per stay.
Inpatient Medical Rehab	**In-Network:** You pay a $325 copay for days 1-5. You pay a $0 copay for days 6-90. **Out-of-Network:** 40% coinsurance per stay.	**In-Network:** You pay a $320 copay for days 1-5. You pay a $0 copay for days 6-90. **Out-of-Network:** 40% coinsurance per stay.
Medicare-covered Diabetic Supplies	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Diabetic Supplies.	**In-Network:** You pay a minimum 0% Coinsurance for Medicare-covered Diabetic Supplies. You pay a maximum 20% Coinsurance for supplies used with a non-therapeutic continuous glucose monitor. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Diabetic Supplies.
Medicare-covered Diagnostic Radiological Services	**In-Network**: You pay $225 Copay for this Medicare-covered Diagnostic Radiological Services.	**In-Network**: You pay $200 Copay for this Medicare-covered Diagnostic Radiological Services.

Cost	2024 (this year)	2025 (next year)
	Out-of-Network: You pay 40% Coinsurance for this Medicare-covered Diagnostic Radiological Services.	**Out-of-Network**: You pay 40% Coinsurance for this Medicare-covered Diagnostic Radiological Services.
Medicare-covered Occupational Therapy Services	**In-Network:** You pay $30 Copay for Medicare-covered Occupational Therapy Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Occupational Therapy Services.	**In-Network:** You pay $25 Copay for Medicare-covered Occupational Therapy Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Occupational Therapy Services.
Medicare-covered Physical Therapy and Speech Therapy Services	**In-Network:** You pay $30 Copay for Medicare-covered Physical Therapy and Speech Therapy Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Physical Therapy and Speech Therapy Services.	**In-Network:** You pay $25 Copay for Medicare-covered Physical Therapy and Speech Therapy Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered Physical Therapy and Speech Therapy Services.
Medicare-covered X-Ray Services	**In-Network:** You pay $35 Copay for Medicare-covered X-Ray Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered X-Ray Services.	**In-Network:** You pay $30 Copay for Medicare-covered X-Ray Services. **Out-of-Network:** You pay a 40% Coinsurance for Medicare-covered X-Ray Services.

Cost	2024 (this year)	2025 (next year)
Observation Services	**In-Network:** You pay $325 Copay for Observation Services. **Out-of-Network:** You pay a 40% Coinsurance for Observation Services.	**In-Network:** You pay $320 Copay for Observation Services. **Out-of-Network:** You pay a 40% Coinsurance for Observation Services.
Over-The-Counter (OTC) Items	**In-Network:** You pay nothing for this benefit. There is a $25 allowance every three months. You must use NationsOTC. **Out-of-Network:** You must use NationsOTC.	**In-Network:** You pay nothing for this benefit. There is a $45 allowance every three months. You must use NationsOTC. **Out-of-Network:** You must use NationsOTC.
Skilled Nursing Facility (SNF) Medicare-covered stay	**In-Network:** You pay a $0 copayment for days 1-20. You pay a $203 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 $214 copayment for days 21-100. **Out-of-Network:** 40% coinsurance per stay.
Teladoc- Behavioral Health	**In-Network and Out-of-Network**: Not covered through Teladoc.	**In-Network and Out-of-Network**: $0 copay for behavioral health services through Teladoc. See Chapter 4 of the Evidence of Coverage for details on how to access this benefit.
Worldwide Emergency Coverage	You pay a $100 copay for this benefit. There is a $10,000	You pay a $125 copay for this benefit. There is a $10,000 plan benefit limit

Cost	2024 (this year)	2025 (next year)
	plan benefit limit per occurrence for unforeseen care.	per occurrence for unforeseen care.
Worldwide Emergency Transportation	You pay a $275 copay for Worldwide Emergency Transportation by air ambulance or ground ambulance. There is a $10,000 plan benefit limit per occurrence for unforeseen care.	You pay a $275 copay for Worldwide Emergency Transportation by ground ambulance. You pay a 20% coinsurance for Worldwide Emergency Transportation by air ambulance. There is a $10,000 plan benefit limit per occurrence for unforeseen care.

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, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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 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, 2024, please call Member Services and ask for the LIS Rider.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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 doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is **$250**. During this stage, you pay $0 cost sharing for drugs on Tier 1 and $17 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 **$450**. During this stage, you pay $0 cost sharing for drugs on Tier 1 and $20 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	2024 (this year)	2025 (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.** 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. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply is: **Tier 1 – Preferred Generic:** You pay $0 per prescription. **Tier 2 – Generic:** You pay $17 per prescription. You pay $17 per month supply of each covered insulin product on this tier. **Tier 3 – Preferred Brand:** You pay $47 per prescription. **Tier 4 – Non-Preferred Drug:**	Your cost for a one-month supply is: **Tier 1 – Preferred Generic:** You pay $0 per prescription. **Tier 2 – Generic:** You pay $20 per prescription. You pay $20 per month supply of each covered insulin product on this tier. **Tier 3 – Preferred Brand:** You pay $47 per prescription. **Tier 4 – Non-Preferred Drug:**

Stage	2024 (this year)	2025 (next year)
	You pay 48% of the total cost. **Tier 5 – Specialty Tier:** You pay 29% of the total cost. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	You pay 50% of the total cost. **Tier 5 – Specialty Tier:** You pay 27% of the total cost. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Cost	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug

Cost	2024 (this year)	2025 (next year)
		coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at (800) 665-1502 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Independent Health's Medicare Passport Access (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 Access (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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 the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 Access (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 Access (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 4 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 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 6 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.
- **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. To be eligible for the ADAP operating in your State, 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 New York State Department of Health. For information on eligibility criteria, covered drugs, how to enroll in the program or if

you are currently enrolled how to continue receiving assistance, call
HIV Uninsured Care Programs
Empire Station
P.O. Box 2052
Albany, NY 12220-0052
1-800-542-2437 or adap@health.ny.gov.

Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-800-665-1502 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Independent Health's Medicare Passport Access (PPO)

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 *2025 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 2025. For details, look in the 2025 *Evidence of Coverage* for Independent Health's Medicare

Passport Access (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 (*Provider Directory*) and our *List of Covered Drugs (Formulary/Drug List).*

Section 7.2 – 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 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 (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.

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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 "2025 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 "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, click on LOG IN, and then click on Get Started to create a secure account.
   - 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, go to "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 Delivery" select the checkboxes for the documents you wish to access electronically and save your paperless preferences.

   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 Customer Service:**

   (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'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
- 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 Customer Service:

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.

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 1-800-665-1502. 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 1-800-665-1502. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-665-1502。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 1-800-665-1502。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 1-800-665-1502. 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 1-800-665-1502. 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 1-800-665-1502 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 1-800-665-1502. 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 1-800-665-1502 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 1-800-665-1502. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-665-1502. 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 1-800-665-1502 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 1-800-665-1502. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-800-665-1502. 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 1-800-665-1502. 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 1-800-665-1502. 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、1-800-665-1502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。

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.

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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 Customer Service 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 Customer Service 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 Customer Service 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.

Independent Health's Medicare Passport Access (PPO) Member Services

Method	Member Services – Contact Information
CALL	**1-800-665-1502 or 716-250-4401** Calls to this number are free. 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. After business hours and on Saturdays, Sundays, and holidays please leave a message. Callers should include their name, phone number and the time they called, and a representative will return their call no later than one business day after they leave a message. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**Call 711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
FAX	***716-631-1039***
WRITE	511 Farber Lakes Drive, Buffalo, NY 14221 medicareservice@servicing.independenthealth.com
WEBSITE	www.independenthealth.com/medicare

New York HIICAP - HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	HIICAP Hot Line: 1-800-665-1502
TTY	**Dial 711**
WRITE	Health Insurance Information, Counseling, and Assistance Program New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	www.aging.ny.gov