Provider Partners Texas Community Plan (HMO I-SNP) offered by Provider Partners Health Plans

Annual Notice of Changes for 2023

You are currently enrolled as a member of *Provider Partners Texas Community Plan*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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.pphealthplan.com*.You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

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

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

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

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

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

- If you don't join another plan by December 7, 2022, you will stay in *Provider Partners Texas Community Plan*.
- *To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.*

Additional Resources

- Please contact our Member Services number at *1-800-405-9681* for additional information. (TTY users should call *711*.) Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31: 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.
- This document is available for free in *Spanish.*
- This material may be available in an alternate format (e.g., braille, large print, etc)
- **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 *Provider Partners Texas Community Plan*

- *Provider Partners Texas Community Plan is a Health Maintenance Organization (HMO)Special Needs Plan (SNP) with a Medicare contract. Enrollment in Provider Partners Medicare Community Plan depends on contract renewal.*
- When this document says "we," "us," or "our," it means *Provider Partners Health Plans.*
  When it says "plan" or "our plan," it means *Provider Partners Texas Community Plan*.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for *Provider Partners Texas Community Plan* in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	*$25.10*	*$25.00*
Deductible	*$233*	*$226*
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.)	*$7,550*	*$8,300*
Doctor office visits	Primary care visits: *20% of the total cost* per visit Specialist visits: *20% of the total cost* per visit	Primary care visits: *0% of the total cost* per visit Specialist visits: *20% of the total cost* per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	$1,556 deductible for each benefit period. Days 1–60 $0 copay for each benefit period. Days 61–90: $389 copay per day of each benefit period. Days 91 and beyond: $778 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs	$1,600 deductible for each benefit period. Days 1–60 $0 copay for each benefit period. Days 61–90: $400 copay per day of each benefit period. Days 91 and beyond: $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs
Part D prescription drug coverage (See Section *1*.5 for details.)	Deductible: *$480* *Coinsurance as applicable* during the Initial Coverage Stage: • Drug Tier 1: *25%*	Deductible: *$505* *Coinsurance as applicable* during the Initial Coverage Stage: • Drug Tier 1: *25%*

SECTION 1 Changes to Benefit and Cost 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.)	*$25.10*	*$25.00*

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

Section 1.2 – Changes to Your Maximum Out-of-Pocket 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 services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays 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*	*$8,300* Once you have paid *$8,300* out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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

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

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

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	*2022 (this year)*	*2023 (next year)*
Additional Telehealth Services	*Comprehensive Dental, Eye Exams, Eyewear, and Hearing Exams were not covered under the Additional Telehealth Services Benefits.*	*You pay 20% coinsurance for the Medicare-covered benefits that may have Additional telehealth benefits available below: Comprehensive Dental, Eye Exams, Eyewear, and Hearing Exams are covered under the Additional Telehealth Services Benefit.*
Ambulatory Surgical Center (ASC) Services	*Prior authorization is required.*	*No prior authorization is required.*

Cost	*2022 (this year)*	*2023 (next year)*
Deductible	*The total cost of in-Network Medicare-covered Eye Exams, Eyewear and Hearing Exams did not count towards the Deductible.*	*The total cost of in-Network Medicare-covered Eye Exams, Eyewear and Hearing Exams do count towards the Deductible.*
Durable Medical Equipment (DME)	*Prior authorizations are required for billed charges in excess of $500.*	*Prior authorizations are required for billed charges in excess of $750.*
Emergency Services	*You pay 20% of the total cost (up to $90 maximum) per visit.*	*You pay 20% of the total cost (up to $95 maximum) per visit.*
Home and Bathroom Safety Devices and Modifications	*Home and Bathroom Safety Devices and Modifications are not covered.*	*You pay $0 for a $300 allowance for Home and Bathroom Safety Devices and Modifications outside of the Over the Counter (OTC) benefit every year. For more information, please see Chapter 4 of the Evidence of Coverage.*
Other Health Care Professional Services	*You pay 20% of the total cost for Medicare-covered benefits.*	*You pay 0% for facility visits by Nurse Practitioners that are required by the plan Model of Care. You pay 20% for all other visits.*
Outpatient Diagnostic and Therapeutic Radiological Services	*Prior authorization required for high tech radiological services, including but not limited to MRI, MRA, PET, CTA, and SPECT scans.*	*Prior authorization is required for Nuclear Medicine Scans. Prior authorization is not required on Therapeutic Radiological Service.*

Cost	*2022 (this year)*	*2023 (next year)*
Outpatient Diagnostic Procedures, Tests and Lab Services	*Prior authorization is required.*	*No prior authorization is required.*
Podiatry Services	*You pay $0 coinsurance for up to 6 routine foot care visits every year.*	*You pay $0 copay for up to 6 routine foot care visits every year.*
Primary Care Physician Services	*You pay 20% of the total cost for Medicare-covered benefits*	*You pay 0% of the total cost for Medicare-covered benefits.*
Prosthetics/ Medical Supplies	*Prior authorizations are required for billed charges in excess of $500.*	*Prior authorizations are required for billed charges in excess of $750.*
Special Supplemental Benefits for the Chronically Ill	*You pay $0 for the companion support program which provides emotional support and socialization by pairing a member with a compatible companion or K9 companion. This can include one on one support or in a group setting. Companion visits are limited to 1 hour a month.*	*Special Supplemental Benefits for the Chronically Ill/ Companion support is not covered.*
Urgently Needed Services	*You pay 20% of the total cost (up to $65 maximum) per visit.*	*You pay 20% of the total cost (up to $60 maximum) per visit.*

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by *October 15*, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	The deductible is $480.	The deductible is $505.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Tier 1*:** You pay 25% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: ***Tier 1*:** You pay 25% of the total 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 6, Section 5 of your *Evidence of Coverage*.	Once your total drug costs have reached $*4,430* you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $*4,660* you will move to the next stage (the Coverage Gap Stage).

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

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

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Service Areas covered	*The Plan's service area includes the following counties: Anderson, Angelina, Bandera, Bexar, Cherokee, Concho, Delta, Denton, Ector, El Paso, Falls, Fannin, Freestone, Goliad, Gregg, Grimes, Guadalupe, Hardin, Hood, Hopkins, Howard, Jefferson, Jim Wells, Karnes, Limestone, Madison, Medina, Navarro, Orange, Palo Pinto, Refugio, Robertson, Runnels, Smith, Somervell, Titus, Trinity, Tyler, Upshur, Wise, and Young.*	*The Plan's service area will add the following counties for the 2023 contract year: Brazos, Brown, Burnet, Collingsworth, Comanche, Dallas, Gray, Hall, Harris, Hutchinson, Kaufman, Lubbock, McLennan, Matagorda, Maverick, Moore, Nacogdoches, Potter, Randall, Sabine, San Saba, Tarrant, Uvalde, Val Verde, Victoria, and Wichita.*

Part D Address/ Fax Changes	*Coverage Decisions for Part D prescription drugs were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd, Suite 201, Twinsburg OH 44087* *Part D Appeals were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd, Suite 201, Twinsburg OH 44087 Attention: Part D Appeals* *Part D Complaints/ Grievances were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd, Suite 201, Twinsburg OH 44087 Attention: Grievance Department Fax: 1-877-503-7231* *Pharmacy Payment Requests were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd, Suite 201, Twinsburg OH 44087* *Claims were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd, Suite 201, Twinsburg, OH 44087*	*Coverage Decisions for Part D prescription drugs are to be mailed to: Elixir C/O Provider Partners Health Plans 8921 Canyon Falls Blvd. Suite 100 Twinsburg, OH 44087* *Part D Appeals are to be mailed to: Elixir C/O Provider Partners Health Plans 8921 Canyon Falls Blvd. Suite 100 Twinsburg, OH 44087 Attn: Appeals Department* *Part D Complaints/ Grievances are to be mailed to: Elixir C/O Provider Partners Health Plans 8921 Canyon Falls Blvd. Suite 100 Twinsburg, OH 44087 Attn: Grievance Department Fax: 1-866-250-5178* *Pharmacy Payment Requests are to be mailed to: Elixir C/O Provider Partners Health Plans 8935 Darrow Rd. P.O. Box 1208 Twinsburg, OH 44087* *Claims are to be mailed to: Elixir C/O Provider Partners Health Plans 8921 Canyon Falls*

Description	2022 (this year)	2023 (next year)
	Direct Member Reimbursements were to be mailed to: Elixir C/O Provider Partners Health Plans 2181 E. Aurora Rd. Suite 201, Twinsburg, OH 44087 Attention: Direct Member Reimbursement	*Blvd. Suite 100 Twinsburg, OH 44087* *Direct Member Reimbursements are to be mailed to: Elixir C/O Provider Partners Health Plans 8935 Darrow Rd. P.O. Box 1208 Twinsburg, OH 44087 Attention: DMR Department*

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Provider Partners Texas Community 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 *Provider Partners Texas Community Plan.*

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 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. If you do not enroll in a Medicare drug plan, please see Section 2.1 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 5 or call Medicare (see Section 7.2). As a reminder, *Provider Partners Health Plans* 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 *Provider Partners Texas Community Plan*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Provider Partners Texas Community Plan*.
- 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, 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 Community 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 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 *Texas* the SHIP is called *Health Information, Counseling, and Advocacy Program (HICAP).*

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *Health Information, Counseling, and Advocacy Program (HICAP)* 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 *Health Information, Counseling, and Advocacy Program (HICAP) at 800-252-9240*. You can learn more about *Health Information, Counseling, and Advocacy Program (HICAP)* by visiting their website https://www.hhs.texas.gov/services/health/medicare.

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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** *Texas* has 2 programs called *Kidney Health Care (KHC) and Texas HIV Medication Program* that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *800-255-1090 or 737-255-4300*.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Provider Partners Texas Community Plan*

Questions? We're here to help. Please call Member Services at *1-800-405-9681*. (TTY only, call *711*). We are available for phone calls Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31: 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30. 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 *Provider Partners Texas Community 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.pphealthplan.com*. 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.pphealthplan.com*. 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 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (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.