MyTruAdvantage Choice Plus (PPO) offered by Southeastern Indiana Health Organization, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of MyTruAdvantage Choice Plus (PPO). 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.MyTruAdvantage.com/information-2025. 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 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 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 MyTruAdvantage Choice Plus (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 MyTruAdvantage Choice Plus (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 1-844-425-4280 for additional information. (TTY users should call 1-800-743-3333 or 711.) This call is free.

  Hours are:
  - October 1 – March 31:
    - 7 Days a week, 8:00 a.m. – 8:00 p.m., Local Time
    - On Thanksgiving and Christmas Day, leave a message and it will be returned within 1 business day.
  - April 1 – September 30:
    - Monday – Friday, 8:00 a.m. – 8:00 p.m., Local Time
    - On weekends and holidays, leave a message and it will be returned within 1 business day.
- Please call Member Services if you would like to receive materials in alternate formats (e.g., braille, large print, audit CD, and data CD).
- **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 MyTruAdvantage Choice Plus (PPO).

- MyTruAdvantage Choice Plus is a PPO plan with a Medicare contract. Enrollment in MyTruAdvantage Choice Plus depends on contract renewal.

- When this document says “we,” “us,” or “our”, it means Southeastern Indiana Health Organization, Inc. When it says “plan” or “our plan,” it means MyTruAdvantage Choice Plus (PPO).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for MyTruAdvantage Choice Plus (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 than this amount. See Section 1.1 for details.	$0 per month	$0 per month
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: $4,000 From network and out-of-network providers combined: $4,000	From network providers: $4,000 From network and out-of-network providers combined: $4,000
Doctor office visits	**Primary care visits:** **In-network**: $0 copayment per visit. **Out-of-network:** $0 copayment per visit. **Specialist visits**: **In-network**: $35 copayment per visit. **Out-of-network**: $35 copayment per visit.	**Primary care visits:** **In-network**: $0 copayment per visit. **Out-of-network:** $0 copayment per visit. **Specialist visits:** **In-network**: $35 copayment per visit. **Out-of-network**: $35 copayment per visit.
Inpatient hospital stays	**In-Network:** Days 1-5: $350 copayment per day Day 6-90: $0 copayment per day **Out-of-Network:** Days 1-5: $350 copayment per day Day 6-90: $0 copayment per day	**In-Network** Days 1-5: $390 copayment per day Day 6-90: $0 copayment per day **Out-of-Network:** Days 1-5: $390 copayment per day Day 6-90: $0 copayment per day

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	There is no deductible for MyTruAdvantage Choice Plus (PPO)	The deductible is $200 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) MyTruAdvantage Select Plus (HMO) except for covered insulin products and most adult Part D vaccines.
	Copayment during the Initial Coverage Stage: Standard retail cost sharing (in-network) for up to a 30-day supply: • Drug Tier 1: $6 • Drug Tier 2: $15 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: Coinsurance is 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Preferred retail cost sharing (in-network) for up to a 30-day supply: • Drug Tier 1: $0 • Drug Tier 2: $5	Copayment during the Initial Coverage Stage: Standard retail cost sharing (in-network) for up to a 30-day supply: • Drug Tier 1: $6 • Drug Tier 2: $15 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: Coinsurance is 28% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: Coinsurance is 30% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Preferred retail cost sharing (in-network) for up to a 30-day supply: • Drug Tier 1: $0 • Drug Tier 2: $5

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 3: $37 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $90 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: Coinsurance is 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.	• Drug Tier 3: $41 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: Coinsurance is 28% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: Coinsurance is 30% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 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.

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 There is no change to your monthly premium. For the 2025 plan year, your premium will remain $0**.** (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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.

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. 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	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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,000	$4,000 Once you have paid $4,000 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

Cost	2024 (this year)	2025 (next year)
		the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$4,000	$4,000 Once you have paid $4,000 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at:

- **Provider Directory**
  The Provider Directory, or list of providers, is available online at:
  www.MyTruAdvantage.com/information-2025

- **Pharmacy Directory**
  The Pharmacy Directory, or list of pharmacies, is available online at:
  www.MyTruAdvantage.com/information-2025

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;* www.MyTruAdvantage.com/information-2025 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)
Cardiac Rehabilitation Services	**In-Network** You pay a $20 copayment per Medicare-covered cardiac rehabilitative visit. **Out-of-Network** You pay 40% of the total cost for Medicare- covered cardiac rehabilitative visit.	**In-Network** You pay a $35 copayment per Medicare-covered cardiac rehabilitative visit. **Out-of-Network** You pay 40% of the total cost for Medicare- covered cardiac rehabilitative visit.
Dental Services	**In-Network and Out-of-Network** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $2,000 for all services.	**In-Network and Out-of-Network** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $2,340 for all services.

Cost	2024 (this year)	2025 (next year)
Diabetes self-management training, diabetic services, and supplies	**In-Network** You pay 15% of the total cost of Medicare-covered therapeutic shoes or inserts. **Out-of-Network** You pay 0% of the total cost of Medicare-covered therapeutic shoes or inserts.	**In-Network** You pay 15% of the total cost of Medicare-covered therapeutic shoes or inserts. **Out-of-Network** You pay 40% of the total cost of Medicare-covered therapeutic shoes or inserts.
Emergency Room	**In-Network and Out-of-Network** You pay a $90 copayment for Medicare-covered emergency department services.	**In-Network and Out-of-Network** You pay a $140 copayment for Medicare-covered emergency department services.
Hearing Services	You pay a $699 or $999 copayment for hearing aids.	You pay: Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00 for hearing aids.
Inpatient hospital care	**In-Network and Out-of-Network** For Medicare-covered hospital stay: Days 1-5:You pay a $350 copayment per day. Day 6-90: You pay a $0 copayment per day.	**In-Network and Out-of-Network** For Medicare-covered hospital stay: Days 1-5: You pay a $390 copayment per day. Day 6-90: You pay a $0 copayment per day.

Cost	2024 (this year)	2025 (next year)
Inpatient services in a psychiatric hospital	**In-Network and Out-of-Network** For Medicare-covered hospital stay: Days 1-5:You pay a $350 copayment per day. Day 6-90: You pay a $0 copayment per day	**In-Network and Out-of-Network** For Medicare-covered hospital stay: Days 1-5: You pay a $390 copayment per day. Day 6-90: You pay a $0 copayment per day
Outpatient Diagnostic and Therapeutic Radiological Services	**In-Network** You pay a $15 copayment for Medicare-covered diagnostic procedures/test. **Out-of-Network** You pay a $15 copayment for Medicare-covered diagnostic procedures/test.	**In-Network** You pay a $25 copayment for Medicare-covered diagnostic procedures/test. **Out-of-Network** You pay a $25 copayment for Medicare-covered diagnostic procedures/test.
Outpatient Hospital Services	**In-Network** You pay a $325 copayment for Medicare-covered outpatient hospital. **Out-of-Network** You pay a $325 copayment for Medicare-covered outpatient hospital.	**In-Network** You pay a $350 copayment for Medicare-covered outpatient hospital. **Out-of-Network** You pay a $350 copayment for Medicare-covered outpatient hospital.

Cost	2024 (this year)	2025 (next year)
***Over-The-Counter (OTC) Benefit**	Benefits for Over-the-Counter (OTC) use MyTruCard, which is a pre-paid debit card (Mastercard®) for the cost of OTC service. Benefits for Over-the-Counter (OTC) are not administered through CVS Caremark. Over-the-Counter (OTC): $75 quarterly allowance.	Benefits for Over-the- Counter (OTC) no longer utilize MyTruCard for the cost of OTC service and will now use your MyTruAdvantage identification card. Benefits for Over-the- Counter (OTC) are administered through CVS Caremark. Over-the-Counter (OTC): $100 quarterly allowance.
Pulmonary Rehabilitation Services	**In-Network** You pay a $15 copayment for Medicare-covered pulmonary rehabilitation services. **Out-of-Network** You pay 40% of the total cost for Medicare-covered pulmonary rehabilitation services.	**In-Network** You pay a $35 copayment for Medicare-covered pulmonary rehabilitation services. **Out-of-Network** You pay 40% of the total cost for Medicare-covered pulmonary rehabilitation services.
Skilled nursing facility (SNF) care	**In-Network** For Medicare-covered stays: Days 1-20: you pay a $0 copayment per admission. Days 21-100: you pay a $188 copayment per day. **Out-of-Network** For Medicare-covered stays: Days 1-58: you pay a $175 copayment per day. Days 59-100: you pay a $0 copayment per day.	**In-Network** For Medicare-covered stays: Days 1-20: you pay a $0 copayment per admission. Days 21-100: you pay a $214 copayment per day. **Out-of-Network** For Medicare-covered stays: Days 1-58: you pay a $175 copayment per day. Days 59-100: you pay a $0 copayment per day.

Supervised Exercise Therapy (SET)	**In-Network** You pay a $20 copayment for Medicare-covered SET services. **Out-of-Network** You pay 40% of the total cost for Medicare-covered SET services.	**In-Network** You pay a $30 copayment for Medicare-covered SET services. **Out-of-Network** You pay 40% of the total cost for Medicare-covered SET services.
Vision Care - MyTruCard –Vision Benefit Card **MyTruCard is NOT a cash card. There are limitations on where and how you may use your card.**	MyTruCard is a pre-paid debit card (Mastercard®) that can be used toward the cost of Vision services. Vision: $200 allowance annually for eye exam, eyeglasses (frames / lenses) eyeglass lenses, eyeglass frames or contacts. MyTruCard Benefit Card Vision Benefits; can be used wherever the card is accepted.	MyTruCard is a pre-paid debit card (Mastercard®) that can be used toward the cost of Vision services. Vision: $250 allowance annually for eye exam, eyeglasses (frames / lenses) eyeglass lenses, eyeglass frames or contacts. MyTruCard Benefit Card Vision Benefits; can be used wherever the card is accepted.

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. **You can get the *complete* "Drug List"** by calling Member Services (see the back cover) or visiting our website www.MyTruAdvantage.com/information-2025.

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 on the same or a lower cost-sharing tier 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 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 30th, 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 Part D drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) 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.	Because we have no deductible, this payment stage does not apply to you.	The deductible is $200 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) During this stage, you pay: **Tier 1 (Preferred Generic):** Standard Cost Sharing: You pay $6 per prescription. Preferred Cost Sharing You pay $0 per prescription. **Tier 2 (Generic):** **Standard Cost Sharing:** You pay $15 per prescription. Preferred Cost Sharing: You pay $0 per prescription. **Tier 6 (Select Care):** Standard cost sharing: You pay $0 per prescription. Preferred Cost Sharing: You pay $0 per prescription.

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	During this stage you pay the cost sharing on the drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) 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.** For 2024 you paid $100 copayment for drugs on Tier 4 (Non-Preferred Brand). For 2025 you will pay a 28% coinsurance for drugs on this tier. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.	Your cost for a one-month supply is: **Tier 1 (Preferred Generic):** *Standard Cost Sharing*: You pay $6 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $6 per prescription. *Preferred Cost Sharing* You pay $0 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $0 per prescription.	Your cost for a one-month supply is: **Tier 1 (Preferred Generic):** *Standard Cost Sharing*: You pay $6 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved to Tier 2. *Preferred Cost Sharing* You pay $0 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved to Tier 2.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 4, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	*Mail-Order Prescription* You pay $2 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $0 per prescription.	*Mail-Order Prescription* You pay $2 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved to Tier 2.
	Tier 2 (Generic): *Standard Cost Sharing:* You pay $15 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved from Tier 1.	**Tier 2 (Generic):** *Standard Cost Sharing:* You pay $15 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $15 per prescription.
	Preferred Cost Sharing: You pay $5 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved from Tier 1.	*Preferred Cost Sharing:* You pay $5 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $5 per prescription.
	Mail-Order Prescription You pay $8 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* Moved from Tier 1.	*Mail-Order Prescription* You pay $8 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* You pay $8 per prescription.
	Tier 3 (Preferred Brand): *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing*: You pay $37 per prescription. *Mail-Order Prescription* You pay $47 per prescription.	**Tier 3 (Preferred Brand):** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing*: You pay $41 per prescription. *Mail-Order Prescription* You pay $47 per prescription.

Stage 2: Initial Coverage Stage	You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Brand):** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $90 per prescription. *Mail-Order Prescription* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 (Specialty Tier):** *Standard cost sharing* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 (Select Care):** *Standard cost sharing*: You pay $0 per prescription. *Preferred cost sharing*: You pay $0 per prescription. *Mail-Order Prescription* You pay $0 per prescription.	You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Brand):** *Standard cost sharing:* You pay 28% coinsurance per prescription. *Preferred cost sharing:* You pay 28% coinsurance per prescription. *Mail-Order Prescription* You pay 28% coinsurance per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 (Specialty Tier):** *Standard cost sharing* You pay 30% of the total cost. *Preferred cost sharing:* You pay 30% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 (Select Care):** *Standard cost sharing*: You pay $0 per prescription. *Preferred cost sharing*: You pay $0 per prescription. *Mail-Order Prescription* You pay $0 per prescription.

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage). Once you have paid $8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	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 Stages

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

Beginning 2025, the Medicare Prescription Payment Plan is going to be offered.

Description	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 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 1-833-502-2904 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in MyTruAdvantageChoice Plus (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 MyTruAdvantage Choice Plus (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 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 2025*

handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, MyTruAdvantage Choice Plus (PPO) (Southeastern Indiana Health Organization, Inc.) 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 MyTruAdvantage Choice Plus (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MyTruAdvantage Choice Plus (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, 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 Indiana, the SHIP is called Indiana 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. Indiana State Health Insurance Assistance Program 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 Indiana State Health Insurance Assistance Program at 1-800-452-4800. You can learn more about Indiana State Health Insurance Assistance Program by visiting their website (https://www.in.gov/ship/).

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.** Indiana has a program called HoosierRx 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 the Indiana State Department of Health, HIV/STD Viral Hepatitis Division. 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 1-866-588-4948. 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 1-844-425-4280 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from *MyTruAdvantage Choice Plus (PPO)*

Questions? We're here to help. Please call Member Services at 1-844-425-4280. (TTY only, call 1-800-743-3333 or 711.) We are available for phone calls. Calls to these numbers are free.

Hours are:

- October 1 – March 31:
  - 7 Days a week, 8:00 a.m. – 8:00 p.m., Local Time
  - On Thanksgiving and Christmas Day, leave a message and it will be returned within 1 business day.
- April 1 – September 30:
  - Monday – Friday, 8:00 a.m. – 8:00 p.m., Local Time
  - On weekends and holidays, leave a message and it will be returned within 1 business day.

Member Services also has free language interpreter services available for non-English speakers.

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 MyTruAdvantage Choice Plus (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.MyTruAdvantage.com/information-2025. 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.MyTruAdvantage.com/information-2025. 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.

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal.

MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 1.844.425.4280 (TTY: 711)

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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 1-844-425-4280. 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 1-844-425-4280. 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 1-844-425-4280。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 1-844-425-4280。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 1-844-425-4280. 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 1-844-425-4280. 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 1-844-425-4280 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 1-844-425-4280. 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 1-844-425-4280 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 1-844-425-4280. 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 1-844-424-4280. 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 1-844-425-4280 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 1-844-425-4280. 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 1-844-425-4280. 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 1-844-425-4280. 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 1-844-425-4280. 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、1-844-425-4280 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。