## *Mount Carmel MediGold No Premium (HMO) offered by Mount Carmel Health Plan, Inc.*

# Annual Notice of Changes for 2025

You are currently enrolled as a member of Mount Carmel MediGold No Premium (HMO). 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.thpmedicare.org/mount-carmel/for-members/plan-documents. 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 Mount Carmel MediGold No Premium (HMO).
- 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 Mount Carmel MediGold No Premium (HMO).
- 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 1-800-240-3851 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This information is available in braille, large print or audio.
- **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 Mount Carmel MediGold No Premium (HMO)

- Mount Carmel MediGold (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Mount Carmel MediGold depends on contract renewal.
- When this document says "we," "us," or "our," it means Mount Carmel Health Plan, Inc.. When it says "plan" or "our plan," it means Mount Carmel MediGold No Premium (HMO).

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# *Annual Notice of Changes* for 2025
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## Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Mount Carmel MediGold No Premium (HMO) in several important areas. **Please note this is only a summary of costs**.

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium may be higher than this amount. See Section 1.1 for details. | $0 | $0 |
| **Maximum out-of-pocket amount** <br> 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.) | $4,500 | $4,500 |
| **Doctor office visits** | Primary care visits: $0 copay per visit <br> Specialist visits: $35 copay per visit | Primary care visits: $0 copay per visit <br> Specialist visits: $35 copay per visit |
| **Inpatient hospital stays** | $325 copay per day for days 1-5; $0 copay per day for days 6-90 | $325 copay per day for days 1-5; $0 copay per day for days 6-90 |
| **Part D prescription drug coverage** <br> (See Section 1.5 for details.) | Deductible: $0 <br> Copayment/Coinsurance during the Initial Coverage Stage: <br>• Drug Tier 1: $0 copay <br>• Drug Tier 2: $5 copay | Deductible: $0 <br> Copayment/Coinsurance during the Initial Coverage Stage: <br>• Drug Tier 1: $0 copay <br>• Drug Tier 2: $5 copay |

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| | • Drug Tier 3: $45 copay<br>You pay $35 copay per month supply of each covered insulin product on this tier. | • Drug Tier 3: 25% of the total cost<br>You pay $35 copay per month supply of each covered insulin product on this tier. |
| | • Drug Tier 4: $95 copay<br>You pay $35 copay per month supply of each covered insulin product on this tier. | • Drug Tier 4: 50% of the total cost<br>You pay $35 copay per month supply of each covered insulin product on this tier. |
| | • Drug Tier 5: 33% of the total cost<br>You pay $35 copay per month supply of each covered insulin product on this tier. | • Drug Tier 5: 33% of the total cost<br>You pay $35 copay per month supply of each covered insulin product on this tier. |
| | Catastrophic Coverage:<br>• During this payment stage, the plan pays the full cost for your covered Part D drugs.<br>• You may have cost sharing for drugs that are covered under our enhanced benefit. | Catastrophic Coverage:<br>• During this payment stage, you pay nothing for your covered Part D drugs **and for excluded 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**<br>(You must also continue to pay your Medicare Part B premium.) | $0 | $0<br>There is no change for the upcoming benefit year. |
| **Monthly premium for optional supplemental benefits: Dental Silver** | $16 | $16<br>There is no change for the upcoming benefit year. |
| **Monthly premium for optional supplemental benefits: Dental Gold** | $36 | $37 |
| **Monthly Part B premium reduction** | Not applicable in 2024. | $13.50 |

- 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 Amount

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

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $4,500 | $4,500<br>There is no change for the upcoming benefit year.<br>Once you have paid $4,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. |

## Section 1.3 – Changes to the Provider 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.thpmedicare.org/mount-carmel/. 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* www.thpmedicare.org/mount-carmel/find-a-provider 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.thpmedicare.org/mount-carmel/find-a-provider 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) |
|---|---|---|
| **Emergency Care** | **In- and Out-of-Network**<br>You pay $90 copay for each visit for Medicare-covered emergency care services. | **In- and Out-of-Network**<br>You pay $110 copay for each visit for Medicare-covered emergency care services. |
| **Fitness Benefit** | **In-and Out-of-Network**<br>You pay $0 copay for the fitness benefit. Benefit includes physical fitness. | **In-and Out-of-Network**<br>You pay $0 copay for the fitness benefit. Benefit includes memory fitness and physical fitness. |
| **Skilled Nursing Facility (SNF) Care** | **In-Network**<br>For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $203 copay per day for days 21-56; $0 copay per day for days 57-100. | **In-Network**<br>For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $214 copay per day for days 21-55; $0 copay per day for days 56-100. |
| **Supplemental Vision/Hearing Allowance** | **In-and Out-of-Network**<br>You received $1,000 /year on your Flex Card to apply towards out-of-pocket costs for covered Vision/Hearing services. | **In-and Out-of-Network**<br>You will receive $500 /year on your Flex Card to apply towards out-of-pocket costs for covered Vision/Hearing services. For a complete description of Vision/Hearing services, please refer to Chapter 4, Section 2.1 of your *Evidence of Coverage.* |

| Cost | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Transportation Services (routine)** | | |
| | **In-Network**<br>You pay $0 copay for routine transportation services (unlimited round trips to plan-approved health-related locations) using taxi, rideshare services, van, and medical transport. Other modes include any special transport requirements for medically fragile or physically/mentally challenged members, using the considerations identified on the members medical needs documentation. | **In-Network**<br>You pay $0 copay for routine transportation services (unlimited round trips to plan-approved health-related locations) using taxi, rideshare services, van, and medical transport. Excluding Stretcher rides, other modes include any special transport requirements for medically fragile or physically/mentally challenged members, based on the members medical needs documentation. |
| **Worldwide Emergency / Urgently Needed Care Services** | | |
| | You pay $90 copay for each emergency care visit outside of the United States and its territories.<br>You pay $90 copay for each urgently needed care visit outside of the United States and its territories. | You pay $110 copay for each emergency care visit outside of the United States and its territories.<br>You pay $110 copay for each urgently needed care visit outside of the United States and its territories. |

## 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 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** | Because we have no deductible, this payment stage does not apply to you. | Because we have no deductible, this payment stage does not apply to you. |

### Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 3 and Tier 4, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

| Stage | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>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 is:<br>**Tier 1 (Preferred Generic):**<br>You pay $0 copay per prescription. | Your cost for a one-month supply is:<br>**Tier 1 (Preferred Generic):**<br>You pay $0 copay per prescription. |

| Stage | 2024 (this year) | 2025 (next year) |
|---|---|---|
| For 2024 you paid a $45 copay for drugs on Tier 3. For 2025 you will pay a 25% coinsurance for drugs on this tier.<br><br>For 2024 you paid a $95 copay for drugs on Tier 4. For 2025 you will pay a 50% coinsurance for drugs on this tier.<br><br>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.<br>Most adult Part D vaccines are covered at no cost to you. | **Tier 2 (Generic):**<br>You pay $5 copay per prescription.<br><br>**Tier 3 (Preferred Brand):**<br>You pay $45 copay per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is $45 copay.<br><br>**Tier 4 (Non-Preferred Drug):**<br>You pay $95 copay per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is $95 copay.<br><br>**Tier 5 (Specialty Tier):**<br>You pay 33% of the total cost per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br><br>_____<br><br>Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage). | **Tier 2 (Generic):**<br>You pay $5 copay per prescription.<br><br>**Tier 3 (Preferred Brand):**<br>You pay 25% of the total cost per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is 25% of the total cost.<br><br>**Tier 4 (Non-Preferred Drug):**<br>You pay 50% of the total cost per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br>Your cost for a one-month mail-order prescription is 50% of the total cost.<br><br>**Tier 5 (Specialty Tier):**<br>You pay 33% of the total cost per prescription.<br>You pay $35 copay per month supply of each covered insulin product on this tier.<br><br>_____<br><br>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 and 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

| Description | 2024 (this year) | 2025 (next year) |
|---|---|---|
| **Dental Benefit Brand Change** | MediGold Dental | Your dental plan is administered by Dental Benefit Providers, Inc. Same dental provider, new branding. |
| **Fitness Services** | SilverSneakers®<br><br>$0 copay for SilverSneakers® fitness membership. Benefit includes physical fitness. | One Pass®<br><br>$0 copay for the fitness benefit. Benefit includes memory fitness and physical fitness. |

| 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 1-866-785-5714, option 2 or visit Medicare.gov. |
| **Member Rewards** | All members who receive either an Annual Wellness Visit or In-Home Assessment can earn a **$25** member reward. Qualifying members can also earn **$25** rewards for completing eligibility-based screenings such as breast cancer screening, colorectal cancer screening, diabetes care eye exam, and diabetes care A1c. One reward per service per calendar year. Member rewards are loaded to the Member Rewards wallet on the Flexible Benefit Card after the member submits the required service attestation. | All members who receive either an Annual Wellness Visit or In-Home Assessment can earn a **$50** member reward. One reward per service per calendar year. Member rewards are loaded to the Member Rewards wallet on the Flexible Benefit Card after the member submits the required service attestation (eligibility-based rewards for breast cancer screening, colorectal cancer screening, diabetes care eye exam, and diabetes care A1c are discontinued/no longer offered after 2024). |
| **Vision Benefit Brand Change** | MediGold Vision | Your vision plan is administered by Spectera, Inc. Same vision provider, new branding. |

# SECTION 3 Deciding Which Plan to Choose

## Section 3.1 – If you want to stay in Mount Carmel MediGold No Premium (HMO)

**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 Mount Carmel MediGold No Premium (HMO).

## 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, Mount Carmel Health Plan, Inc. offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Mount Carmel MediGold No Premium (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Mount Carmel MediGold No Premium (HMO).
- 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 Ohio, the SHIP is called Ohio Senior Health Insurance Information Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Ohio Senior Health Insurance Information 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 Ohio Senior Health Insurance Information Program at 1-800-686-1578. You can learn more about Ohio Senior Health Insurance Information Program by visiting their website (https://insurance.ohio.gov/consumers/medicare/01-oshiip).

## 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.

- **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 Ohio HIV Drug Assistance Program (OHDAP). 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 Ohio HIV Drug Assistance Program (OHDAP) at 1-800-777-4775. 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 1-866-785-5714, option 2 or visit Medicare.gov.

# SECTION 7 Questions?

## Section 7.1 – Getting Help from Mount Carmel MediGold No Premium (HMO)

Questions? We're here to help. Please call Member Services at 1-800-240-3851. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., 7 days a week. 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 Mount Carmel MediGold No Premium (HMO). 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.thpmedicare.org/mount-carmel/for-members/plan-documents. 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.thpmedicare.org/mount-carmel/. 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.

## Notice of Nondiscrimination

Mount Carmel MediGold complies with applicable Federal civil rights laws and does not discriminate on age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law.

Mount Carmel MediGold does not exclude people or treat them differently because of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law. Mount Carmel MediGold:

- 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 Member Services.

If you believe that Mount Carmel MediGold has failed to provide these services or discriminated in any other way on the basis of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law), you can file a grievance with: Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor - Health Plan, Columbus, OH 43219, 1-800- 240-3851 (TTY 711), 1-833-802-2200 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Daniel Hayes, Member Services Manager, 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/complaints/index.html*

# 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711)。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 1-800-240-3851 (TTY 711)。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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711) 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711)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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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 1-800-240-3851 (TTY 711). 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、1-800-240-3851 (TTY 711). 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。