

MyTruAdvantage Select Plus (HMO) offered by Southeastern Indiana Health Organizations, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of MyTruAdvantage Select Plus (HMO). Next year, there will be changes to the plan's costs and benefits. *Please see page 5 for a Summary of Important Costs, including Premium.*

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at <https://www.mytruadvantage.com/documents-and-forms>. 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 2024 "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 2024* 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, 2023, you will stay in MyTruAdvantage Select Plus (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, 2024**. This will end your enrollment with MyTruAdvantage Select Plus (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our 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. to 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 or large print).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About MyTruAdvantage Select Plus (HMO)

- MyTruAdvantage Select Plus is an HMO plan with a Medicare contract. Enrollment in MyTruAdvantage Select Plus (HMO) 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 Select Plus (HMO).

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**Annual Notice of Changes for 2024
Table of Contents**

Summary of Important Costs for 2024 4

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MyTruAdvantage Select Plus (HMO) in 2024 7

SECTION 2 Changes to Benefits and Costs for Next Year 7

Section 2.1 – Changes to the Monthly Premium 7

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount..... 7

Section 2.3 – Changes to the Provider and Pharmacy Networks..... 8

Section 2.4 – Changes to Benefits and Costs for Medical Services 8

Section 2.5 – Changes to Part D Prescription Drug Coverage 15

SECTION 3 Administrative Changes 20

SECTION 4 Deciding Which Plan to Choose..... 20

Section 4.1 – If you want to stay in MyTruAdvantage Select Plus (HMO) 20

Section 4.2 – If you want to change plans 20

SECTION 5 Deadline for Changing Plans..... 21

SECTION 6 Programs That Offer Free Counseling about Medicare 21

SECTION 7 Programs That Help Pay for Prescription Drugs 22

SECTION 8 Questions?..... 22

Section 8.1 – Getting Help from MyTruAdvantage Select Plus (HMO)..... 22

Section 8.2 – Getting Help from Medicare 23

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for MyTruAdvantage Select Plus (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	\$0 Per Month	\$0 Per Month
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	In-network: \$2,900	In-network: \$2,900
Doctor office visits	Primary care visits: In-network: \$0 per visit Specialist visits: In-network: \$25 per visit	Primary care visits: In-network: \$0 per visit Specialist visits: In-network: \$25 per visit
Inpatient hospital stays	In-network: Days 1-6: \$275 per day \$0 per additional day	In-network: Days 1-6: \$275 per day \$0 per additional day
Part D prescription drug coverage (See Section 2.5 for details.)	There is no deductible for MyTruAdvantage Select Plus (HMO) Copayment during the Initial Coverage Stage: Standard retail cost sharing (in network) for up to a 30-day supply: <ul style="list-style-type: none"> • Drug Tier 1: \$5 • Drug Tier 2: \$15 	There is no deductible for MyTruAdvantage Select Plus (HMO) Copayment during the Initial Coverage Stage: Standard retail cost sharing (in network) for up to a 30-day supply: <ul style="list-style-type: none"> • Drug Tier 1: \$6 • Drug Tier 2: \$15

Cost	2023 (this year)	2024 (next year)
<p>Part D prescription drug coverage - continued (See Section 2.5 for details.)</p>	<ul style="list-style-type: none"> • 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 of 33% of total cost You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 6: \$0 <p>You won't pay more than \$35 for a one-month supply of each Select Insulin product covered by our plan, no matter what cost-sharing tier it's on</p> <p>Preferred retail cost sharing (in-network) for up to a 30-day supply:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 • Drug Tier 2: \$5 • 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 	<ul style="list-style-type: none"> • 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 of 33% of total cost You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 6: \$0 <p>Due to the Inflation Reduction Act (IRA), you won't pay more than \$35 for a one-month supply of each insulin covered under the plan.</p> <p>Preferred retail cost sharing (in-network) for up to a 30-day supply:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 • Drug Tier 2: \$5 • 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

Cost	2023 (this year)	2024 (next year)
	<ul style="list-style-type: none"> • 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 <p>You won't pay more than \$35 for a one-month supply of each Select Insulin product covered by our plan, no matter what cost-sharing tier it's on</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs). 	<ul style="list-style-type: none"> • 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 <p>Due to the Inflation Reduction Act (IRA), you won't pay more than \$35 for a one-month supply of each insulin covered under the plan.</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • 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 Unless You Choose Another Plan, You Will Be Automatically Enrolled in MyTruAdvantage Select Plus (HMO) in 2024

If you do nothing by December 7, 2023, we will automatically enroll you in our MyTruAdvantage Select Plus (HMO). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through MyTruAdvantage Select Plus (HMO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for “Extra Help,” you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium	\$0	\$0
There is no change to your monthly premium. For the 2024 plan year, your premium will remain \$0.		
Optional Enhanced Dental Package Premium (See section 2.4 for additional benefits for next year)	\$25	Optional Enhanced Dental Package not available
(You must also continue to pay your Medicare Part B premium.)		

- 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 2.2 – 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	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount	\$2,900	\$2,900
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.		Once you have paid \$2,900 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 2.3 – Changes to the Provider and Pharmacy Networks

Updated provider and pharmacy directories are located on our website at

- **Provider Directory**
The Provider Directory, or list of providers, is available online at:
<https://www.mytruadvantage.com/documents-and-forms>
- **Pharmacy Directory**
The Pharmacy Directory, or list of pharmacies, is available online at:
<https://www.mytruadvantage.com/documents-and-forms>

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 no changes to our network of providers for next year.

There are changes to our network of pharmacies for next year. **Please review the 2024 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 2.4 – 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	2023 (this year)	2024 (next year)
Added Benefits for 2024		
Updated Plan Service Area	<p><u>Our service area includes these counties in Indiana:</u> Posey, Vanderburgh, and Warrick</p>	<p><u>Our service area includes these counties in Indiana:</u> Bartholomew, Brown, Clay, Hamilton, Hancock, Howard, Jackson, Jennings, Johnson, Madison, Marion, Parke, Posey, Sullivan, Vanderburgh, Vermillion, Vigo, and Warrick</p>

Cost	2023 (this year)	2024 (next year)
<p>MyTruCard – Flex card</p> <p>MyTruCard is NOT a cash card. There are limitations on where and how you may use your card.</p>	<p>MyTruCard is a pre -paid debit card (Mastercard®) MyTruCard <u>was not</u> offered</p> <p>Benefits for Vision <u>are</u> administered through EyeMed Vision.</p> <p>Vision: \$200 allowance for eyeglasses (frames / lenses) eyeglass lenses, eyeglass frames or contacts.</p> <p>\$0 copayment for routine eye exam.</p> <p>Benefits for Over the Counter <u>are</u> administered through CVS Caremark.</p> <p>Over the Counter (OTC): \$75 quarterly allowance</p>	<p>MyTruCard is a pre -paid debit card (Mastercard®) that can be used toward the cost of Vision, and Over the Counter (OTC) services.</p> <p>Benefits for Vision <u>are not</u> administered through EyeMed Vision.</p> <p><u>Vision:</u> \$200 MyTruCard allowance annually for eye exam, eyeglasses (frames / lenses) eyeglass lenses, eyeglass frames or contacts.</p> <p>MyTruCard Flex Card Vision Benefits; can be used wherever the card is accepted.</p> <p>Benefits for Over the Counter <u>are not</u> administered through CVS Caremark</p> <p><u>Over the Counter (OTC):</u> \$75 MyTruCard quarterly allowance</p>

Cost	2023 (this year)	2024 (next year)
Prior Authorization	<p>Prior Authorization <u>is</u> required for the following:</p> <p>Medicare-covered Diagnostic Radiological Services.</p> <p>Medicare-covered Therapeutic Radiological Services.</p> <p>Medicare-covered X-Ray Services</p>	<p>Prior Authorization <u>is not</u> required for the following:</p> <p>Medicare-covered Diagnostic Radiological Services.</p> <p>Medicare-covered Therapeutic Radiological Services.</p> <p>Medicare-covered X-Ray Services</p>
Ambulance Services	<p>We <u>will not</u> waive copayment if admitted to the hospital</p>	<p>We <u>will</u> waive copayment if admitted to the hospital</p>
Changes to Cost Share for 2024		
Worldwide Urgent Coverage Copayment	<p>You pay a Minimum Copayment of \$50 for Worldwide Urgent Coverage per visit.</p> <p>You pay a Maximum Copayment of \$50 for Worldwide Urgent Coverage per visit.</p>	<p>You pay a Minimum Copayment of \$25 for Worldwide Urgent Coverage per visit.</p> <p>You pay a Maximum Copayment of \$25 for Worldwide Urgent Coverage per visit.</p>

Cost	2023 (this year)	2024 (next year)
<p>Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)</p>	<p>Preventive and Comprehensive have a combined maximum benefit of \$1,500 per year.</p> <p>Minimum Coinsurance for X-Rays is 0% of the total cost.</p> <p>Maximum Coinsurance for X-Rays is 50% of the total cost.</p>	<p>All Delta Dental covered services for Preventive and Comprehensive have a \$0 copayment up to the annual allowance of \$2,000 for all services.</p> <p>Minimum Coinsurance for X-Rays is 0% of the total cost.</p> <p>Maximum Coinsurance for X-Rays is 0% of the total cost.</p>
<p>Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)</p>	<p>Maximum Benefit Coverage is combined with Preventive Dental Services (\$1,500).</p>	<p>All Delta Dental covered services for Preventive and Comprehensive have a \$0 copayment up to the annual allowance of \$2,000 for all services.</p>

<p>Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)</p>	<p>In Network 20% of the cost for Medicare-covered dental services</p>	<p>In Network 0% of the cost for Medicare-covered dental services</p>
	<p>Non-Routine Services: Coinsurance for Non-routine services is 50% of the total cost.</p>	<p>Non-Routine Services: Coinsurance for Non-routine services is 0% of the total cost.</p>
	<p>Diagnostic Services: Coinsurance for Diagnostic Services is 50% of the total cost.</p>	<p>Diagnostic Services: Coinsurance for Diagnostic Services is 0% of the total cost.</p>
	<p>Restorative Services: Coinsurance for Restorative Services has a minimum coinsurance of 40% and a maximum coinsurance of 50% of the total cost.</p>	<p>Restorative Services: Coinsurance for Restorative Services has a minimum coinsurance of 0% and a maximum coinsurance of 0% of the total cost.</p>
	<p>Endodontics: Coinsurance for Endodontics is 50% of the total cost.</p>	<p>Endodontics: Coinsurance for Endodontics is 0% of the total cost.</p>
	<p>Periodontics: Coinsurance for Periodontics is 50% the total cost.</p>	<p>Periodontics: Coinsurance for Periodontics is 0% the total cost</p>
	<p>Extractions: Simple extractions only Coinsurance for Extractions is 40% the total cost.</p>	<p>Extractions: Simple extractions only Coinsurance for Extractions is 0% the total cost.</p>
	<p>Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Brush biopsy covered annually at 50% coinsurance of the total cost.</p>	<p>Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Brush biopsy covered annually at 0% coinsurance of the total cost.</p>

Cost	2023 (this year)	2024 (next year)
<p>Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) continued -</p>	<p>Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services is 50% the total cost.</p>	<p>Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services is 0% the total cost.</p>
<p>Enhanced Optional Dental Package</p>	<p>Premium is \$25</p> <p>Annual Coverage Maximum is \$1,500</p> <p>Crowns are covered at 50% coinsurance. Crowns are covered as needed, per dental provider.</p> <p>New full/partial dentures covered at 50% coinsurance. New Full / Partial dentures covered at 1 per 5 years.</p> <p>Benefit payment limited to Delta Dental payment for out-of-network providers. One visit per service, as determined by dental provider.</p>	<p>Not offered in 2024</p>
<p>Medicare Part B Prescription Drugs</p>	<p>20% of the cost for Medicare Part B prescription drugs.</p> <p>Part B Insulins: 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.</p>	<p>0-20% of the cost for Medicare Part B prescription drugs.</p> <p>Part B Insulins: 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.</p>

Section 2.5 – 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 electronically. **You can get the *complete* “Drug List”** by calling Member Services (see the back cover) or visiting our website <https://www.mytruadvantage.com/documents-and-forms>.

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, 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 September 30th, 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	2023 (this year)	2024 (next year)
<p>Stage 1: Yearly Deductible Stage</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>You won't pay more than \$35 for a one-month supply of each Select Insulin product covered by our plan, no matter what cost-sharing tier it's on.</p> <p>Tier 1 (Preferred Generic): <i>Standard Cost Sharing:</i> You pay \$5 per prescription. <i>Preferred Cost Sharing</i> You pay \$0</p> <p>Tier 2 (Generic): <i>Standard Cost Sharing:</i> You pay \$15 per prescription. <i>Preferred Cost Sharing:</i> You pay \$5 per prescription.</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>Due to the Inflation Reduction Act (IRA), you won't pay more than \$35 for a one-month supply of each insulin covered under the plan.</p> <p>Tier 1 (Preferred Generic): <i>Standard Cost Sharing:</i> You pay \$6 per prescription. <i>Preferred Cost Sharing</i> You pay \$0</p> <p>Tier 2 (Generic): <i>Standard Cost Sharing:</i> You pay \$15 per prescription. <i>Preferred Cost Sharing:</i> You pay \$5 per prescription</p>

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage continued-</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Tier 3 (Preferred Brand): <i>Standard cost sharing:</i> You pay \$47 per prescription. <i>Preferred cost sharing:</i> You pay \$37 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4 (Non-Preferred Brand): <i>Standard cost sharing:</i> You pay \$100 per prescription. <i>Preferred cost sharing:</i> You pay \$90 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5 (Specialty Tier): <i>Standard cost sharing</i> You pay 33% of the total cost <i>Preferred cost sharing:</i> You pay 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.</p>	<p>Tier 3 (Preferred Brand): <i>Standard cost sharing:</i> You pay \$47 per prescription. <i>Preferred cost sharing:</i> You pay \$37 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 4 (Non-Preferred Brand): <i>Standard cost sharing:</i> You pay \$100 per prescription. <i>Preferred cost sharing:</i> You pay \$90 per prescription. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5 (Specialty Tier): <i>Standard cost sharing</i> You pay 33% of the total cost <i>Preferred cost sharing:</i> You pay 33% of the total cost You pay \$35 per month supply of each covered insulin product on this tier.</p>

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage continued-</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Tier 6 (Select Care): <i>Standard cost sharing:</i> You pay \$0 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.</p>	<p>Tier 6 (Select Care): <i>Standard cost sharing:</i> You pay \$0 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.</p>
<p>Enhanced Benefit: Erectile Dysfunction (ED)</p>	<p>Not a covered benefit</p>	<p>Generic ED medication will be covered under Tier 1 with a quantity of 6 tablets per month under our Enhanced Benefit options. <i>*The benefit is limited to 1 generic medication.</i></p> <p>Tier 1 (Preferred Generic): <i>Standard Cost Sharing:</i> You pay \$6 per prescription. <i>Preferred Cost Sharing:</i> You pay \$0 per prescription.</p>

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage (continued)</p> <p>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.</p> <p>For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>Most adult Part D vaccines are covered at no cost to you</p> <p>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.”</p>	<p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p> <p>Once you have paid \$7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p> <p>Once you have paid \$8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for 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 these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

There has been a change with your Prescription Benefit Manager:

Description	2023 (this year)	2024 (next year)
Prescription Benefit Manager	CVS Caremark	MedImpact Healthcare Systems, Inc.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in MyTruAdvantage Select Plus (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 MyTruAdvantage Select Plus (HMO).

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2)

As a reminder, MyTruAdvantage Select Plus (HMO) (Southeastern Indiana Health Organization, Inc.) offers other Medicare health plans AND/OR Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts

Step 2: Change your coverage

- **To change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from MyTruAdvantage Select Plus (HMO).

- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from MyTruAdvantage Select Plus (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 5 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, 2024.

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, 2024, 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, 2024.

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 6 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 (www.indianaship.com).

SECTION 7 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. 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, or how to enroll in the program, please call 1-866-588-4948.

SECTION 8 Questions?

Section 8.1 – Getting Help from MyTruAdvantage Select Plus (HMO)

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.

- October 1 – March 31:
 - 7 Days a week, 8:00 a.m. to 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.

Read your 2024 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 2024. For details, look in the *2024 Evidence of Coverage* for MyTruAdvantage Select Plus (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.mytruadvantage.com/documents-and-forms. 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 <https://www.mytruadvantage.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 8.2 – 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 2024*

Read the *Medicare & You 2024* 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)

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 panggagamot. 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 quý vị cần thông dịch viên xin gọi 1-844-425-4280 sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-425-4280번으로 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。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。