



Annual Notice of Changes 2025

IU Health Plans Medicare \$0 Preferred (HMO)



Health Plans

950 N. Meridian St., Suite 400
Indianapolis, IN 46204-1202

IU Health Plans Member Advocates: 800.455.9776 (TTY/TDD 711)

Oct. 1 to March 31 – 8 am to 8 pm, seven days a week

April 1 to Sept. 30 – 8 am to 8 pm, Monday – Friday

iuhealthplans.org

IU Health Plans Medicare \$0 Preferred (HMO) offered by Indiana University Health Plans NFP, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of IU Health Plans Medicare \$0 Preferred (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 iuhealthplans.org. You may also call our Customer Solutions Center 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 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 IU Health Plans Medicare \$0 Preferred (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 IU Health Plans Medicare \$0 Preferred (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 Customer Solutions Center at 800.455.9776 for additional information. (TTY/TDD users should call 711.) Hours are October 1 to March 31, 8:00 am - 8:00 pm, seven days a week. April 1 to September 30, 8:00 am - 8:00 pm, Monday through Friday. Calls to these numbers are free. Outside of normal business hours, you may leave a voicemail or send an inquiry to IUHPMedicare@IUHealth.org which will be responded to within one business day.
- This information is available in alternate formats, including braille, large print, audio and data CD. Please call our Customer Solutions Center at the number listed above and at the back of this document if you need plan information in another format.
- **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 IU Health Plans Medicare \$0 Preferred (HMO)

- Indiana University Health Plans is an HMO/HMO-POS with a Medicare contract. Enrollment in IU Health Plans Medicare depends on the plan's contract renewal with Medicare.
- When this document says "we," "us," or "our," it means Indiana University Health Plans NFP, Inc. When it says "plan" or "our plan," it means IU Health Plans Medicare \$0 Preferred (HMO).

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 IU Health Plans Medicare \$0 Preferred (HMO) 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	\$0
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 1.2 for details.)	\$3,400	\$4,155
Doctor office visits	Primary care visits: You pay a \$0 copay per visit Specialist visits: You pay a \$35 copay per visit	Primary care visits: You pay a \$0 copay per visit Specialist visits: You pay a \$30 copay per visit
Inpatient hospital stays	You pay a \$345 copay per day, Days 1 - 6. Day 7 and beyond has no copayment. You have unlimited days of coverage.	You pay a \$395 copay per day, Days 1 - 6. Day 7 and beyond has no copayment. You have unlimited days of coverage.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: \$0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$3 Standard cost sharing / \$0 Preferred cost sharing • Drug Tier 2: \$12 Standard cost sharing / \$12 Preferred cost sharing	Deductible: \$0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: \$0 Standard cost sharing • Drug Tier 2: \$3 Standard cost sharing

Cost	2024 (this year)	2025 (next year)
	• Drug Tier 3: \$47 Standard cost sharing / \$37 Preferred cost sharing ◦ You pay \$35 copay per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 Standard cost sharing / \$100 Preferred cost sharing • Drug Tier 5: 33% Standard cost sharing / 33% Preferred cost sharing • Drug Tier 6: \$0 Standard cost sharing / \$0 Preferred cost sharing Catastrophic Coverage: • During this payment stage, the plan plays the full cost for your covered Part D drugs. You pay nothing.	• Drug Tier 3: \$47 Standard cost sharing ◦ You pay \$35 copay per month supply of each covered insulin product on this tier. • Drug Tier 4: 50% Standard cost sharing • Drug Tier 5: 33% Standard cost sharing • Drug Tier 6: \$0 Standard cost sharing Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

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	\$0	\$0
(You must also continue to pay your Medicare Part B premium.)		

Cost	2024 (this year)	2025 (next year)
Part B premium reduction	\$100	\$70
Optional supplemental benefits monthly plan premium	Dental Enhanced 1000 - \$23	Dental Enhanced 1000 - \$29.90
	Dental Enhanced 1500 - \$28	Dental Enhanced 1500 - \$33.80
	<i>Benefits available through Delta Dental</i>	<i>Benefits available through Delta Dental</i>

- 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	\$3,400	\$4,155
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 \$4,155 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 iuhealthplans.org. You may also call our Customer Solutions Center 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/Pharmacy Directory at iuhealthplans.org 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 Provider/Pharmacy Directory at iuhealthplans.org 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 our Customer Solutions Center 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)
Authorization	Preventive colonoscopies in an outpatient hospital setting do not require a prior authorization.	Preventive colonoscopies do not require prior authorization unless performed in an outpatient hospital setting.
Dental	Our plan pays up to \$1,000 per year for covered preventive and comprehensive services.	Our plan pays up to \$1,500 per year for covered preventive and comprehensive services. Please refer to the <i>Evidence of Coverage</i> for additional details.

Cost	2024 (this year)	2025 (next year)
Diagnostic Radiological Services	You pay 20% of the cost.	You pay 0% of the cost for diagnostic mammograms and 20% of the cost for all other services.
Emergency Services	You pay a \$90 copay.	You pay a \$125 copay.
Eye Exams	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Fitness Benefit	You pay a \$0 copay for multi-facility access and can choose one of eleven home fitness kits per benefit year.	You pay a \$0 copay for single-facility access and can choose one of three home fitness kits per benefit year.
Hearing Exams	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Inpatient Hospital - Acute	You pay a \$345 copay per day for days 1 - 6.	You pay a \$395 copay per day for days 1 - 6.
Inpatient Hospital Psychiatric	You pay a \$345 copay per day for days 1 - 6.	You pay a \$380 copay per day for days 1 - 6.
Mental Health Specialty Services - Individual & Group Sessions	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Occupational Therapy Services	You pay a \$20 copay per visit.	You pay a \$15 copay per visit.
Opioid Treatment Program Services	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Optional supplemental benefits (Available for an extra monthly premium. See Section 1.1 for details.)	You pay an extra monthly premium for select comprehensive dental services. You do have implant coverage. You have a \$25 annual deductible.	You pay an extra monthly premium for select comprehensive dental services. You <u>do not</u> have implant coverage. You have a \$50 annual deductible. Please refer to the <i>Evidence of Coverage</i> for additional details.

Cost	2024 (this year)	2025 (next year)
Other Health Care Professional (Acupuncture for chronic low back pain and other services)	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Outpatient Substance Abuse - Individual & Group Sessions	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Outpatient X-Ray Services	You pay a \$25 copay.	You pay a \$15 copay.
Over-the-Counter (OTC) Items	You receive a quarterly allowance of \$80. Your unused balance does not roll over to the next quarter.	You receive a quarterly allowance of \$40. Your unused balance will roll over to the next quarter.
Physical Therapy and Speech-Language Pathology Services	You pay a \$20 copay per visit.	You pay a \$15 copay per visit.
Physician Specialist Services	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Podiatry Services	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Psychiatric Services - Individual & Group Sessions	You pay a \$35 copay per visit.	You pay a \$30 copay per visit.
Skilled Nursing Facility	You pay a \$203 copay per day for days 21 - 100.	You pay a \$214 copay per day for days 21 - 100.
Worldwide Emergency Coverage	You pay a \$90 copay.	You pay a \$125 copay.
Worldwide Urgent Coverage	You pay a \$90 copay.	You pay a \$125 copay.

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 our Customer Solutions Center 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 our Customer Solutions Center or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included 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 didn't receive this insert with this packet, please call our Customer Solutions Center 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 4 (Non-Preferred Drug), your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. The tier name for Tier 4 is changing from Non-Preferred Brand to Non-Preferred Drug. Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
Stage 2: 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 a \$100 copayment for drugs on Tier 4 (Non-Preferred Brand). For 2025 you will pay 50% coinsurance for drugs on Tier 4 (Non-Preferred Drug). We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply is: Tier 1 (Preferred Generic): <i>Standard cost sharing:</i> You pay \$3 per prescription. Your cost for a one-month mail-order prescription is \$3. <i>Preferred cost sharing:</i> You pay \$0 per prescription. Tier 2 (Non-Preferred Generic): <i>Standard cost sharing:</i> You pay \$12 per prescription. Your cost for a one-month mail-order prescription is \$12. <i>Preferred cost sharing:</i> You pay \$12 per prescription. Tier 3 (Preferred Brand): <i>Standard cost sharing:</i> You pay \$47 per prescription. <i>Preferred cost sharing:</i> You pay \$37 per prescription.	Your cost for a one-month supply at a network pharmacy with standard cost sharing: Tier 1 (Preferred Generic): You pay \$0 per prescription. Your cost for a one-month mail-order prescription is \$0. Tier 2 (Non-Preferred Generic): You pay \$3 per prescription. Your cost for a one-month mail-order prescription is \$3. Tier 3 (Preferred Brand): You pay \$47 per prescription.

Stage	2024 (this year)	2025 (next year)
	You pay \$35 copay per month supply of each covered insulin product on this tier.	You pay \$35 copay per month supply of each covered insulin product on this tier.
	<i>Tier 4 (Non-Preferred Brand):</i> <i>Standard cost sharing:</i> You pay \$100 per prescription. Your cost for a one-month mail-order prescription is \$100. <i>Preferred cost sharing:</i> You pay \$100 per prescription.	<i>Tier 4 (Non-Preferred Drug):</i> You pay 50% of the total cost. Your cost for a one-month mail order prescription is 50% of the total cost.
	<i>Tier 5 (Specialty Tier):</i> <i>Standard cost sharing:</i> You pay 33% of the total cost. <i>Preferred cost sharing:</i> You pay 33% of the total cost.	<i>Tier 5 (Specialty Tier):</i> You pay 33% of the total cost.
	<i>Tier 6 (Select Care):</i> <i>Standard cost sharing:</i> You pay \$0 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.	<i>Tier 6 (Select Care):</i> You pay \$0 per prescription.
	Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap 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 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.

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)
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 844.432.0695 (TTY/TDD users should call 711) or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in IU Health Plans Medicare \$0 Preferred (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 IU Health Plans Medicare \$0 Preferred (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 Indiana's State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Indiana University Health Plans NFP, 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 IU Health Plans Medicare \$0 Preferred (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from IU Health Plans Medicare \$0 Preferred (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact our Customer Solutions Center 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/TDD 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 Indiana, the SHIP is called the 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's 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's State Health Insurance Assistance Program at 800.452.4800. (TTY/TDD users should call 866.846.0139). You can learn more about Indiana's State Health Insurance Assistance Program by visiting their website at 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, 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/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 800.772.1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY/TDD users should call 800.325.0778; or
 - Your State Medicaid Office.
- **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. 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 the Indiana State Department of Health, HIV/STD Viral Hepatitis Division, 2 N. Meridian St., Suite 6C, Indianapolis, IN 46204, Phone: 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 844.432.0695 (TTY/TDD users should call 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from IU Health Plans Medicare \$0 Preferred (HMO)

Questions? We're here to help. Please call our Customer Solutions Center at 800.455.9776. (TTY/TDD only, call 711). We are available for phone calls October 1 to March 31, 8:00 am - 8:00 pm, seven days a week. April 1 to September 30, 8:00 am - 8:00 pm, Monday through Friday. Calls to these numbers are free. Outside of normal business hours, you may leave a voicemail or send an inquiry to IUHPMedicare@IUHealth.org which will be responded to within one business day.

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 IU Health Plans Medicare \$0 Preferred (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 iuhealthplans.org. You may also call our Customer Solutions Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at iuhealthplans.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy 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/TDD 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/TDD users should call 1-877-486-2048.

Notice of nondiscrimination and accessibility requirements

Discrimination is against the law

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law.

Indiana University Health Plans:

- 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 IU Health Plans Member Advocates at **800.455.9776 (TTY/TDD 711)**. Language assistance available.

IU Health Plans Member Advocates hours: Oct. 1 to March 31, 8 am to 8 pm, seven days a week. April 1 to Sept. 30, 8 am to 8 pm, Monday – Friday.

If you believe that IU Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, IU Health Plans, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204; **800.455.9776 (TTY/TDD 711)**; Fax 317.963.9801; **IUHPlansCompliance@iuhealth.org**. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the IU Health Plans Civil Rights Coordinator 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:

U.S. Department of Health and Human Services

200 Independence Ave., SW
Room 509F, HHH Building
Washington, DC 20201

T 800.368.1019

T 800.537.7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.



Health Plans

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 800.455.9776. 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 800.455.9776. 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 800.455.9776。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 800.455.9776。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 800.455.9776. 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 800.455.9776. 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 800.455.9776 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 800.455.9776. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.



Health Plans

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 800.455.9776 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 800.455.9776. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية لإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 800.455.9776. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे सवास य या दवा की योजना वेबोमें आपकेकसी भी पर न केजवाब देने केकेहमारे पास मुफ्त दुभाकिया स्थाएँ उपब्ध हैं. एक दुभाकिया परापत करने के किए, बस हमें 800.455.9776 पर फोन करें कोई वयकति जो कहनदी बोिता 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 800.455.9776. 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 800.455.9776. 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 800.455.9776. 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 800.455.9776. 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、800.455.9776 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。



Health Plans



Health Plans

Thank you for trusting IU Health Plans
to be your healthcare partner.

950 N. Meridian St., Suite 400
Indianapolis, IN 46204-1202

iuhealthplans.org

If you have questions, we're here to help.

Please call our IU Health Plans Member Advocates toll free at **800.455.9776 (TTY/TDD 711)**.

Language assistance is available.

IU Health Plans Member Advocates hours

Oct. 1 to March 31 – 8 am to 8 pm, seven days a week

April 1 to Sept. 30 – 8 am to 8 pm, Monday – Friday

You may receive assistance through alternate technology after hours, on weekends and holidays;
or visit **iuhealthplans.org**.