eternalHealth Give Back (PPO) offered by eternalHealth

Annual Notice of Changes for 2025

You are currently enrolled as a member of eternalHealth Give Back (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.eternalHealth.com.You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

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

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including 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 eternalHealth Give Back (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with eternalHealth Give Back (PPO).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Services number at 1-(800) 680-4568 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8 p.m. local time seven days a week from October 1st to March 31st. From April 1st to September 30th the hours are 8:00 a.m. to 8:00 p.m. local time from Monday through Friday. This call is free.
- If you need information in a different language or format (such as braille, audio, or large print) – or you need any help at all – call us at 1-800-680-4568 (TTY 711).
- **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 eternalHealth Give Back (PPO)

- eternalHealth is an HMO/HMO-POS and PPO organization with a Medicare contract. Enrollment in eternalHealth depends on contract renewal.
- When this document says "we," "us," or "our," it means eternalHealth. When it says "plan" or "our plan," it means eternalHealth Give Back (PPO).

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 eternalHealth Give Back (PPO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Part B premium reduction	You receive a $80 reduction in your monthly Part B premium.	You receive a $70 reduction in your monthly Part B premium.
Maximum out-of-pocket amounts This is the most you will pay out of pocket for your covered Part A and Part B Services. (See Section 2.2 for details.)	From network providers: $6,500 From network and out-of-network providers combined: $10,000	From network providers: $6,500 From network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network:** Primary care visits: $0 per visit Specialist visits: $0 per visit **Out-of-Network** Primary care visits: $0 per visit Specialist visits: $20 per visit	**In-Network:** Primary care visits: $0 per visit Specialist visits: $0 per visit **Out-of-Network** Primary care visits: $0 per visit Specialist visits: $20 per visit
Inpatient hospital stays	**In-Network:** $430 per day, days 1-4 $0 per day for days 5-90	**In-Network:** $395 per day for days 1-5 $0 per day for days 6-90

Cost	2024 (this year)	2025 (next year)
	$0 per day for days 91+ **Out-of-Network** 40% coinsurance per stay	$0 per day for days 91+. **Out-of-Network** 30% coinsurance per stay
Part D prescription drug coverage (See Section *[edit section number as needed]* 2.5 for details.)	Deductible: $300 except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $5 • 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: 30% You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs You pay nothing.	Deductible: $300 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $5 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 29% You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 29% You pay $35 per month supply of each covered insulin product on this tier. 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 (You must also continue to pay your Medicare Part B premium.)	$0	$0 There is no change to your premium for 2025.

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

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

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

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription	$6,500	$6,500 Once you have paid $6,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for

Cost	2024 (this year)	2025 (next year)
drugs do not count toward your maximum out-of-pocket amount.		the rest of the calendar year. There is no change to your in-network maximum out-of-pocket for 2025.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$10,000	$10,000 Once you have paid $10,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year. There is no change to your combined maximum out-of-pocket for 2025.

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.eternalHealth.com. 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* at www.eternalHealth.com 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* at www.eternalHealth.com 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)
Ambulatory surgical center (ASC) services	**In-Network:** You pay a $250 copay for ASC services. There is a $0 copay for diagnostic colonoscopies. **Out-of-Network** You pay 30% of the total cost for ASC services.	**In-Network:** You pay a $250 copay for ASC services. There is a $0 copay for diagnostic colonoscopies. **Out-of-Network** You pay 20% of the total cost for ASC services.
Cardiac rehabilitation services	**In-Network:** You pay a $20 copay per visit. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network** You pay a $50 copay per visit.

Cost	2024 (this year)	2025 (next year)
Chiropractic services	**In-Network:** You pay a $15 copay for Medicare-covered chiropractic services. Referral is required. **Out-of-Network** You pay 30% of the total cost for Medicare-covered chiropractic services.	**In-Network:** You pay a $20 copay for Medicare-covered chiropractic services. Referral is not required. **Out-of-Network** You pay a $50 copay for Medicare-covered chiropractic services.
Comprehensive dental – Medicare-covered	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay a $0 copay per visit.	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay a $50 copay per visit.
Diagnostic radiological services	**In-Network:** You pay a $150-$350 copay per service. $150 copay for ultrasounds and $350 copay for all others. **Out-of-Network** You pay 30% of the total cost per service.	**In-Network:** You pay a $150-$300 copay per service. $150 copay for ultrasounds and $300 copay for all others. **Out-of-Network** You pay 20% of the total cost per service.

Cost	2024 (this year)	2025 (next year)
Diabetic supplies	**In-Network:** You pay 0%-20% of the total cost. 0% for preferred manufacturers, 20% for all others. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay 0%-20% of the total cost. 0% for preferred manufacturers, 20% for all others. **Out-of-Network** You pay 20% of the total cost.
Diabetic therapeutic shoes/inserts	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 20% of the total cost.
Dialysis services	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 20% of the total cost.
Durable medical equipment	**In-Network:** You pay 20% of the total cost. Referral is required for DME under $500. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay 20% of the total cost. No referral is required. **Out-of-Network** You pay 20% of the total cost.

Cost	2024 (this year)	2025 (next year)
Health and wellness programs – Fitness	**In-Network:** You pay a $0 copay for this benefit. OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos and home kits. **Out-of-Network** You pay 50% of the total cost when outside the OnePass network. Member must pay out of pocket and submit for reimbursement.	**In-Network:** You pay a $0 copay for this benefit. OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos, a personalized online brain training program for improved cognitive health. Members may also choose to receive a home kit if they prefer working out at home. There are three kits offered. 1. Fit Kit: resistance band, exercise tubing, door anchor, exercise cards specific to balance, coordination, agility, strength, cardio and flexibility. 2. Yoga Kit: DVA with two, 20-minute videos + yoga mat, yoga block, yoga strap. 3. Dance Kit: Zumba Gold dance kit includes quick start and 20-minute express DVD. Members also have access to a digital MSK program through their fitness benefit. **Out-of-Network** You pay 50% of the total cost when outside the OnePass network. Member must pay out of pocket and submit for reimbursement.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital care	**In-Network:** You pay $430 per day for days 1-4 You pay $0 per day for days 5-90 You pay $0 per day for days 91+ Authorization is required for elective inpatient admissions. **Out-of-Network** You pay 40% of the total cost per admission.	**In-Network:** You pay $395 per day for days 1-5 You pay $0 per day for days 6-90 You pay $0 per day for days 91+ Prior Authorization is required in-network. **Out-of-Network** You pay 30% of the total cost per admission.
Inpatient services in a psychiatric hospital	**In-Network:** You pay $430 per day for days 1-4 You pay $0 per day for days 5-90 You pay $0 per day for days 91+ Authorization may be required. **Out-of-Network** You pay 40% of the total cost per admission.	**In-Network:** You pay $395 per day for days 1-5 You pay $0 per day for days 6-90 You pay $0 per day for days 91+ Prior Authorization is required in-network. **Out-of-Network** You pay 30% of the total cost per admission.
Intensive cardiac rehabilitation services	**In-Network:** You pay a $20 copay per visit. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network** You pay a $50 copay per visit.

Cost	2024 (this year)	2025 (next year)
Meals program – post hospitalization	Meals program – post hospitalization is not covered.	**In-Network:** You pay a $0 copay for this program. After a discharge from an inpatient stay at a hospital, you may be eligible to have up to two weeks (28 meals) of fully prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, our care management team will coordinate your meal benefit. (Meals must be ordered by an eternalHealth care manager). If the criteria are met, meals are prepared and delivered to your home by a plan approved vendor at no cost to you. **Out-of-Network** You pay a $0 copay for this program. Meals must be ordered by an eternalHealth care manager through Plan approved vendor.
Medicare-covered preventive services	**In-Network:** You pay a $0 copay for Medicare-covered preventive services. **Out-of-Network** You pay 30% of the total cost for Medicare-covered preventive services.	**In-Network:** You pay a $0 copay for Medicare-covered preventive services. **Out-of-Network** You pay a $0 copay for Medicare-covered preventive services.

Cost	2024 (this year)	2025 (next year)
Medicare Part B drugs	**In-Network:** You pay 0%-20% of the total cost of Medicare Part B drugs. **Out-of-Network** You pay 30% of the total cost for Medicare Part B drugs.	**In-Network:** You pay 0%-20% of the total cost of Medicare Part B drugs. 20% coinsurance for Part B drugs unless a lesser copay is required by the IRA. **Out-of-Network** You pay 20% of the total cost for Medicare Part B drugs.
Medicare-covered eye exams	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay 50% of the total cost per visit.	**In-Network:** You pay a $25 copay per visit. **Out-of-Network** You pay a $50 copay per visit.
Medicare-covered eyewear	**In-Network:** You pay a $0 copay for Medicare-covered eyewear. **Out-of-Network** You pay 50% of the total cost for Medicare-covered eyewear.	**In-Network:** You pay a $0 copay for Medicare-covered eyewear. **Out-of-Network** You pay for a $0 copay for Medicare-covered eyewear.

Cost	2024 (this year)	2025 (next year)
Medicare-covered hearing exams	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay 50% of the total cost per visit.	**In-Network:** You pay a $25 copay per visit. **Out-of-Network** You pay a $50 copay per visit.
Mental health specialty services – Individual and Group sessions	**In-Network:** You pay a $0-$40 copay per visit. $0 copay for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs. **Out-of-Network:** You pay a $50 copay per visit.	**In-Network:** You pay a $0-$25 copay per visit. $0 copay for brief office visits (up to 15 minutes) for the sole purpose of monitoring or changing drugs. **Out-of-Network:** You pay a $50 copay per visit.
Occupational therapy services	**In-Network:** You pay a $30 copay per visit. Referral is required. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay a $20 copay per visit. Referral is not required. **Out-of-Network** You pay a $50 copay per visit.
Opioid treatment program services	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $45 copay per visit. **Out-of-Network** You pay a $50 copay per visit.

Cost	2024 (this year)	2025 (next year)
Other health care professional	**In-Network:** You pay a $0-$35 copay per visit. $0 copay for PCP related services and $35 copay for specialist related services. **Out-of-Network** You pay a $55 copay per visit.	**In-Network:** You pay a $0-$35 copay per visit. $0 copay for PCP related services and $35 copay for specialist related services. **Out-of-Network** You pay a $50 copay per visit.
Outpatient blood services	**In-Network:** You pay a $0 copay for outpatient blood services. **Out-of-Network** You pay 30% of the total cost for Medicare-covered outpatient blood services. You pay 50% of the total cost for non-Medicare-covered outpatient blood services.	**In-Network:** You pay a $0 copay for outpatient blood services. **Out-of-Network** You pay 20% of the total cost for outpatient blood services.

Cost	2024 (this year)	2025 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network:** You pay a $0-$40 copay for Medicare-covered diagnostic procedures and tests. $0 copay in an office setting and $40 at a free-standing lab facility. **Out-of-Network** You pay 30% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 30% of the total cost for Medicare-covered lab services. You pay 30% of the total cost per outpatient x-ray.	**In-Network:** You pay a $0-$20 copay for Medicare-covered diagnostic procedures and tests. $0 copay in an office setting and $20 at a free-standing lab facility. **Out-of-Network** You pay 20% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 20% of the total cost for Medicare-covered lab services. You pay 20% of the total cost per outpatient x-ray.
Outpatient hospital observation services	**In-Network:** You pay a $350 copay for observations services. Prior Authorization is required for in-network observation services. **Out-of-Network** You pay 40% of the total cost for observation services.	**In-Network:** You pay a $350 copay for observations services. Prior Authorization is not required for in-network observation services. **Out-of-Network** You pay 20% of the total cost for observation services.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital services	**In-Network:** You pay a $350 copay for outpatient hospital services. There is a $0 copay for diagnostic colonoscopies. **Out-of-Network** You pay 40% of the total cost for outpatient hospital services.	**In-Network:** You pay a $350 copay for outpatient hospital services. There is a $0 copay for diagnostic colonoscopies. **Out-of-Network** You pay 20% of the total cost for outpatient hospital services.
Over the Counter items	**In-Network and Out-of-Network** There is no coinsurance, copayment, or deductible for OTC benefits. You receive an allowance of $30 per calendar quarter to use toward Medicare-approved OTC items. If the cost of the Medicare-approved OTC items exceeds the benefit limit of $30 per calendar quarter, you are responsible for all additional costs.	**In-Network and Out-of-Network** There is no coinsurance, copayment, or deductible for OTC benefits. You receive an allowance of $45 on your eternalPlus Benefits card per calendar quarter to use toward Medicare-approved OTC items. Unused balances at the end of each quarter will not be carried over to the next quarter. If your order total exceeds your quarterly amount, you may use a credit card to pay the remaining balance.
Physical therapy and Speech-language pathology services	**In-Network:** You pay a $30 copay per visit. A referral is required. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $20 copay per visit. A referral is <u>not</u> required. **Out-of-Network** You pay a $50 copay per visit.

Cost	2024 (this year)	2025 (next year)
Podiatry services	**In-Network:** You pay a $35 copay for Medicare-covered podiatry services. **Out-of-Network** You pay 30% of the total cost for Medicare-covered podiatry services.	**In-Network:** You pay a $25 copay for Medicare-covered podiatry services. **Out-of-Network** You pay a $50 copay for Medicare-covered podiatry services.
Preventive & comprehensive dental services – non-Medicare-covered	**In-Network and Out-of-Network** You pay a $0 copay for this benefit. eternalHealth will pay as much as $3,500 per year for Non-Medicare Covered preventative & comprehensive dental services. This benefit is accessed by using your OTC/Dental Card.	**In-Network and Out-of-Network** You pay a $0 copay for this benefit. eternalHealth will pay as much as $2,500 per year for Non-Medicare Covered preventative & comprehensive dental services. This benefit is accessed by using your eternalPlus Benefits card.
Prosthetics and medical supplies	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 30% of the total cost.	**In-Network:** You pay 20% of the total cost. **Out-of-Network** You pay 20% of the total cost.

Cost	2024 (this year)	2025 (next year)
Psychiatric services - Individual and group sessions	**In-Network:** You pay a $0-$40 copay per visit. $0 copay for office visits up to 15 minutes for medication monitoring. $40 Copay for all other visits. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $0-$25 copay per visit. $0 copay for office visits up to 15 minutes for medication monitoring. $25 Copay for all other visits. **Out-of-Network** You pay a $50 copay per visit.
Pulmonary rehabilitation services	**In-Network:** You pay a $15 copay per visit. **Out-of-Network:** You pay 30% of the total cost per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay a $50 copay per visit.
Routine vision services	**In-Network and Out-of-Network:** Unlimited	**In-Network and Out-of-Network:** One routine eye exam per year. One pair of eyewear/contact lenses per year.
Routine hearing services	**In-Network and Out-of-Network:** Unlimited	**In-Network and Out-of-Network:** One routine hearing exam per year. Hearing aids are limited to two per year – one per ear per year.

Cost	2024 (this year)	2025 (next year)
Supervised exercise therapy (SET) services	**In-Network:** You pay a $25 copay per visit. **Out-of-Network** You pay 30% of the total cost per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network** You pay a $50 copay per visit.
Therapeutic radiological services	**In-Network:** You pay 20% of the total cost for therapeutic radiological services. **Out-of-Network** You pay 30% of the total cost for therapeutic radiological services.	**In-Network:** You pay a $60 copay for therapeutic radiological services. **Out-of-Network** You pay 20% of the total cost for therapeutic radiological services.
Worldwide emergency coverage	There is no maximum plan benefit coverage amount for worldwide emergency coverage.	There is a $25,000 maximum plan benefit coverage for worldwide emergency coverage.

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.

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 does not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive "Extra Help "and you haven't received this insert by October 1, 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 During this stage, **you pay the full cost** of your Tier 4 - non-preferred drugs and Tier 5 - Specialty drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is $300. During this stage, you pay $0 cost-sharing for drugs on Tier 1, $5 cost-sharing for drugs on Tier 2, and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $0 cost-sharing for drugs on Tier 1, $5 cost-sharing for drugs on Tier 2, $47 cost-sharing for drugs on Tier 3, and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 4 – Non-Preferred drugs, 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 Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. For 2024 you paid a $100 copayment for drugs on Tier 4. For 2025 you will pay 29% coinsurance for drugs on this tier. For information about the costs for a long-term supply or mail-order prescription look in Chapter 6,	**Tier 1 – Preferred Generics:** You pay $0 per prescription. **Tier 2 – Non-Preferred Generics:** You pay $5 per prescription. **Tier 3 – Preferred Brands:** You pay $47 per prescription.	**Tier 1 – Preferred Generics:** You pay $0 per prescription. **Tier 2 - Generics:** You pay $5 per prescription. **Tier 3 – Preferred Brands:** You pay $47 per prescription.

Stage	2024 (this year)	2025 (next year)
Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you.	**Tier 4 – Non-Preferred Drugs:** You pay $100 copay. Your cost for a one-month mail-order prescription is $100 copay. **Tier 5: - Specialty Drugs:** You pay 28% of the total cost. Your cost for a one-month mail-order prescription is 28% of the total cost. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	**Tier 4 – Non-Preferred Drugs:** You pay 29% of the total cost. Your cost for a one-month mail-order prescription is 29% of the total cost. **Tier 5 – Specialty:** You pay 29% of the total cost. Your cost for a one-month mail-order prescription is 29% of the total cost. _____ 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.

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 1-(800) 680-4568 or visit Medicare.gov.
Observation services – Prior Authorization	Prior Authorization is required for in-network observation services.	Prior Authorization is not required for in-network observation services.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in eternalHealth Give Back (PPO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our eternalHealth Give Back (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section *5*), or call Medicare (see Section 7.2).

As a reminder, eternalHealth 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 eternalHealth Give Back (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from eternalHealth Give Back (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into 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 Massachusetts, the SHIP is called Serving Health Insurance Needs of Everyone (SHINE).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE 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 SHINE at 1-(800) 243-4636.You can learn more about SHINE by visiting their website (https://shinema.org).

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.
- **Help from your state's pharmaceutical assistance program.** Massachusetts has a program called Prescription Advantage 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 Massachusetts HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Massachusetts HIV Drug Assistance Program (HDAP) at 1-(617) 502-1700 or toll-free at 1-(800) 228-2714, or write to AccessHealthMA Attn: HDAP, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129. 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-(800) 680-4568 (TTY only 711) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from eternalHealth Give Back (PPO)

Questions? We're here to help. Please call Member Services at 1-(800) 680-4568 (TTY only, call 711.) We are available for phone calls from 8:00 a.m. to 8 p.m. local time seven days a week from October 1st to March 31st. From April 1st to September 30th the hours of operation are 8:00 a.m. to 8:00 p.m. local time from Monday through Friday. 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 eternalHealth Give Back (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.eternalHealth.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.eternalHealth.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our List of Covered Drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 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.