Imperial Traditional (HMO) offered by Imperial Health Plan of California, Inc. (HMO) (HMO C-SNP)

Annual Notice of Changes for 2025

You are currently enrolled as a member of *Imperial Traditional (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 *www.imperialhealthplan.com*. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you by logging into the member portal using your user name and password. 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.

OMB Approval 0938-1051 (Expires: August 31, 2026)

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 *Imperial Traditional (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 *Imperial Traditional (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

- This document is available for free in *Spanish.*
- Please contact our Member Services number at 1-800-838-8271 for additional information. (TTY users should call *711*.) Hours are October 1 through March 31 Monday – Sunday, from 8:00 a.m. – 8:00 p.m. except holidays or April 1 through September 30 Monday - Friday, from 8:00 a.m. – 8:00 p.m. except holidays. This call is free.
- This document may be available in other formats such as braille, large print or other alternate formats. For additional information, call our Member Services Department at the phone number listed above.
- **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 *Imperial Traditional (HMO)*

- *Imperial Health Plans of California, Inc. is an (HMO) (HMO SNP) plan with a Medicare Contract. Enrollment in Imperial Health Plan (HMO) (HMO SNP) depends on contract renewal.*
- When this document says "we," "us," or "our", it means *Imperial Health Plan of California, Inc. (HMO) (HMO C-SNP)*. When it says "plan" or "our plan," it means *Imperial Traditional (HMO)*.

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *Imperial Traditional (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 most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	*$1,349*	*$1,499*
Doctor office visits	Primary care visits: *$0* per visit Specialist visits: *$0* per visit	Primary care visits: *$0* per visit Specialist visits: *$0* per visit
Inpatient hospital stays	Medicare covers the first 2 days of your hospital stay. If you stay in the hospital longer than 2 days, you pay a $150 copay per day for days 1-5 and $0 copay for days 6 through 90. Our plan provides a maximum of 60 Lifetime Reserve days. You pay a $670 copay per day for days 1 – 60.	Medicare covers the first 2 days of your hospital stay. If you stay in the hospital longer than 2 days, you pay: • a $0 copay per day for days 1-3 • a $150 copay for days 4 – 5 • a $0 copay for days 6 - 90 Our plan provides a maximum of 60 Lifetime Reserve days. You pay a $670 copay per day for days 1 – 60.

Cost	2024 (this year)	2025 (next year)

Part D prescription drug coverage
(See Section 1.5 for details.)
	Deductible: *$0*
	Copayment during the Initial Coverage Stage:
	• Drug Tier 1: $0 copay
	• Drug Tier 2: $5 copay
	• Drug Tier 3: $45 copay
	  • You pay $0 per month supply of each covered insulin product on this tier.
	• Drug Tier 4: $90 copay
	• Drug Tier 5: 33% coinsurance
	Catastrophic Coverage:
	• During this payment stage, the plan pays the full cost for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit**. You pay nothing.
		Deductible: *$0*
		Copayment during the Initial Coverage Stage:
		• Drug Tier 1: $0 copay
		• Drug Tier 2: $10 copay
		• Drug Tier 3: $45 copay
		  • You pay $0 per month supply of each covered insulin product on this tier.
		• Drug Tier 4: $90 copay
		  • You pay $0 per month supply of each covered insulin product on this tier.
		• Drug Tier 5: 33% coinsurance
		Catastrophic Coverage:
		• During this payment stage, you pay nothing for your covered Part D drugs **and for excluded drugs that are covered under our enhanced benefit**.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	*$0*	*$0*

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

Section 1.2 – Changes to Your Maximum Out-of-Pocket 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 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.	*$1,349*	*$1,499* Once you have paid *$1,499* out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at *www.imperialhealthplan.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* *www.imperialhealthplan.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* *www.imperialhealthplan.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)
Dental	You pay a $0 copay for covered non-routine services. Your plan covers up to $1000 in non-routine dental services every year.	You pay a $0 copay for covered non-routine services. Your plan covers up to $3000 in non-routine dental services every year.
Emergency Care - Worldwide	The plan covers up to $50,000 per year in Emergency Care received outside of the United States.	The plan covers up to $100,000 per year in Emergency Care received outside of the United States.

Cost	2024 (this year)	2025 (next year)
Health and Fitness	Through the Silver&Fit® Healthy Aging and Exercise Program, you pay a $0 copay for: 1. Fitness Center Membership 2. Home Fitness Kits: You can choose from a variety of home fitness kits. Up to 1 kit each benefit year. You will also have access to numerous resources, including Healthy Aging classes (online or DVD), daily workout classes on Facebook Live and YouTube, Signature Series workout videos for all fitness levels on www.SilverandFit.com, digital workout classes on the Silver&Fit ASHConnect™ mobile app, and a quarterly newsletter.	Through Silver & Fit® you pay a $0 copay for one of the following Home Fitness Kits per year: 1. Fitbit® or Garmin® Wearable Fitness Tracker Kit 2. Dumbbells & Exercise Bands 3. Pilates ball & Towel 4. Yoga Mat & Towel 5. Yoga Strap & Yoga Blocks 6. Swim Goggles & Kickboard 7. Aquatic Resistance Gloves & Pull Float 8. Stability Walking Poles.

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays	Medicare covers the first 2 days of your hospital stay. If you stay in the hospital longer than 2 days, you pay a $150 copay per day for days 1-5 and $0 copay for days 6 through 90. Our plan provides a maximum of 60 Lifetime Reserve days. You pay a $670 copay per day for days 1 – 60.	Medicare covers the first 2 days of your hospital stay. If you stay in the hospital longer than 2 days, you pay: • a $0 copay per day for days 1-3 • a $150 copay for days 4 – 5 • a $0 copay for days 6 - 90 Our plan provides a maximum of 60 Lifetime Reserve days. You pay a $670 copay per day for days 1 – 60.
Inpatient services in a psychiatric hospital	Medicare covers the first 2 days of your hospital stay. During this period, there is $0 copay. If you stay in the hospital longer than 2 days, you pay a $150 copay per day for days 1-5 and $0 copay for days 6 through 90.	Medicare covers the first 2 days of your hospital stay. During this period, there is $0 copay. If you stay in the hospital longer than 2 days, you pay: • a $0 copay per day for days 1-3 • a $150 copay for days 4 – 5 • a $0 copay for days 6 - 90

Cost	2024 (this year)	2025 (next year)
Outpatient Diagnostic Tests	You pay 10% of the total cost for Medicare covered: • Diagnostic tests and procedures • Lab Services You pay a $0 copay for Medicare covered: • Blood sugar/a1c tests • Lipid panels • Diagnostic radiology services (including X-rays, CT, and MRI)	You pay a $0 copay for Medicare covered: • Diagnostic tests and procedures • Lab Services • Blood sugar/a1c tests • Lipid panels • Diagnostic radiology services (including X-rays, CT, and MRI)
Outpatient Hospital and Observation Services	You pay a $200 copay for Medicare covered outpatient hospital and observation services including those provided in an ambulatory surgical center.	You pay a $100 copay for Medicare covered outpatient hospital and observation services including those provided in an ambulatory surgical center.
Over-the-Counter (OTC) Items	You receive a $75 allowance every 3 months for OTC drugs and supplies	You receive a $95 allowance every 3 months for OTC drugs and supplies
Skilled Nursing Facility	You pay a $0 copay per day for days 1-20 and $164.50 per day for days 21-100.	You pay a $0 copay per day for days 1-20 and • $100 per day for days 21-50 • $200 per day for days 51-100

Cost	2024 (this year)	2025 (next year)
Vision	The plan covers up to $250 per year for 1 pair of eyeglasses or contacts.	The plan covers up to $500 per year for 1 pair of eyeglasses or contacts.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are

taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs 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 *September 30,* please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

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**. The costs in this chart are for a one-month (*30*-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply, look in Chapter 6, 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Preferred Generic Drugs – Tier 1:** You pay $0 per prescription **Generic Drugs – Tier 2:** You pay $5 per prescription **Preferred Brand Drugs – Tier 3:** You pay $45 per prescription. You pay $0 per month supply of each covered insulin product on this tier. **Non-Preferred Drug – Tier 4:** You pay $90 per prescription **Specialty Drugs – Tier 5:** You pay 33% of the total cost _____ Once your total drug costs have reached $*5,030,* you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Preferred Generic Drugs – Tier 1:** You pay $0 per prescription **Generic Drugs – Tier 2:** You pay $10 per prescription **Preferred Brand Drugs – Tier 3:** You pay $45 per prescription. You pay $0 per month supply of each covered insulin product on this tier. **Non-Preferred Drug – Tier 4:** You pay $90 per prescription. You pay $0 per month supply of each covered insulin product on this tier. **Specialty Drugs – Tier 5:** You pay 33% 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.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
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 *1-800-838-8271* or visit Medicare.gov.
Mental Health	Call 1-800-838-8271 for assistance.	Call 1-800-838-8200 for assistance.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Imperial Traditional (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 *Imperial Traditional (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 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, *Imperial Health Plan of California, 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 *Imperial Traditional (HMO)*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Imperial Traditional (HMO)*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

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

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

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

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

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In *California*, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *HICAP* 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 *HICAP* at 1-800-434-0222. You can learn more about HICAP by visiting their website https://www.aging.ca.gov/Find_Services_in_My_County/.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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 *California AIDS Drug Assistance Program.* For information on eligibility criteria, covered drugs, or how to enroll in the program, please call *1-833-422-4255.*
- **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 1-800-838-8271 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Imperial Traditional (HMO)*

Questions? We're here to help. Please call Member Services at 1-800-838-8271. (TTY only, call 711). We are available for phone calls October 1 through March 31 Monday – Sunday, from 8:00 a.m. – 8:00 p.m. except holidays or April 1 through September 30 Monday - Friday, from 8:00 a.m. – 8:00 p.m. except holidays. 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 *Imperial Traditional (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.imperialhealthplan.com*. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. 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.imperialhealthplan.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.