

Saint Alphonsus Health Plan Choice (PPO) offered by Mount Carmel Health Plan Of Idaho, Inc. (Saint Alphonsus Health Plan)

Annual Notice of Change for 2026

You're enrolled as a member of Saint Alphonsus Health Plan Choice (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Saint Alphonsus Health Plan Choice (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at www.thpmedicare.org/saint-alphonsus/for-members/plan-documents or call Member Services at 1-800-240-3851 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-800-240-3851 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This information is available in large print or audio.

About Saint Alphonsus Health Plan Choice (PPO)

- Saint Alphonsus Health Plan (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Saint Alphonsus Health Plan depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Mount Carmel Health Plan Of Idaho, Inc. (Saint Alphonsus Health Plan). When it says “plan” or “our plan,” it means Saint Alphonsus Health Plan Choice (PPO).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Saint Alphonsus Health Plan Choice (PPO).** Starting January 1, 2026, you'll get your medical and drug coverage through Saint Alphonsus Health Plan Choice (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	\$0	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$6,100 From network and out-of-network providers combined: \$6,100	From network providers: \$6,100 From network and out-of-network providers combined: \$6,100
Primary care office visits	From network providers: \$0 copay per visit From out-of-network providers: \$30 copay per visit	From network providers: \$0 copay per visit From out-of-network providers: \$30 copay per visit
Specialist office visits	From network providers: \$35 copay per visit From out-of-network providers: \$60 copay per visit	From network providers: \$35 copay per visit From out-of-network providers: \$60 copay per visit

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	From network providers: \$300 copay per day for days 1-5; \$0 copay per day for days 6-90 From out-of-network providers: 30% of the total cost per stay	From network providers: \$350 copay per day for days 1-5; \$0 copay per day for days 6-90 From out-of-network providers: 30% of the total cost per stay
Part D drug coverage deductible (Tiers 3-5) (Go to Section 1.7 for details.)	\$150 except for covered insulin products and most adult Part D vaccines.	\$250 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Sections 1.6 and 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage:	Copayment/Coinsurance during the Initial Coverage Stage:
	Drug Tier 1: \$0 at a preferred network pharmacy or \$10 at a network pharmacy You pay \$0 at a preferred network pharmacy or \$10 at a network pharmacy per month supply of each covered insulin product on this tier.	Drug Tier 1: \$0 at a preferred network pharmacy or \$10 at a network pharmacy You pay \$0 at a preferred network pharmacy or no more than \$10 at a network pharmacy per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
	Drug Tier 2: \$10 at a preferred network pharmacy or \$20 at a network pharmacy You pay \$10 at a preferred network pharmacy or \$20 at a network pharmacy per month supply of each covered insulin product on this tier.	Drug Tier 2: \$6 at a preferred network pharmacy or \$20 at a network pharmacy You pay no more than \$6 at a preferred network pharmacy or no more than \$20 at a network pharmacy per month supply of each covered insulin product on this tier.
	Drug Tier 3: 25% of the total cost at a preferred network pharmacy or 25% of the total cost at a network pharmacy You pay \$35 at a preferred network pharmacy or \$35 at a network pharmacy per month supply of each covered insulin product on this tier.	Drug Tier 3: 25% of the total cost at a preferred network pharmacy or 25% of the total cost at a network pharmacy You pay no more than \$35 at a preferred network pharmacy or no more than \$35 at a network pharmacy per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
	Drug Tier 4: 50% of the total cost at a preferred network pharmacy or 50% of the total cost at a network pharmacy You pay \$35 at a preferred network pharmacy or \$35 at a network pharmacy per month supply of each covered insulin product on this tier.	Drug Tier 4: 30% of the total cost at a preferred network pharmacy or 30% of the total cost at a network pharmacy You pay no more than \$35 at a preferred network pharmacy or no more than \$35 at a network pharmacy per month supply of each covered insulin product on this tier.
	Drug Tier 5: 31% of the total cost at a preferred network pharmacy or 31% of the total cost at a network pharmacy You pay \$35 at a preferred network pharmacy or \$35 at a network pharmacy per month supply of each covered insulin product on this tier.	Drug Tier 5: 30% of the total cost at a preferred network pharmacy or 30% of the total cost at a network pharmacy You pay no more than \$35 at a preferred network pharmacy or no more than \$35 at a network pharmacy per month supply of each covered insulin product on this tier.
	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0 There is no change for the upcoming benefit year.
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	\$14.80	\$7
Monthly premium for optional supplemental benefits: Dental Silver	\$20	\$20 There is no change for the upcoming benefit year.
Monthly premium for optional supplemental benefits: Dental Gold	\$49	\$49 There is no change for the upcoming benefit year.

Factors that could change your Part D Premium Amount

- **Late Enrollment Penalty** - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- **Higher Income Surcharge** - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare 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've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers count toward your in-network maximum out-of-pocket amount. Our costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$6,100	\$6,100 There is no change for the upcoming benefit year. Once you've paid \$6,100 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$6,100	\$6,100 There is no change for the upcoming benefit year. Once you've paid \$6,100 out of pocket for covered Part A and Part B services, you'll 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.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.thpmedicare.org/saint-alphonsus/find-a-provider to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.thpmedicare.org/saint-alphonsus/find-a-provider.
- Call Member Services at 1-800-240-3851 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-800-240-3851 (TTY users call 711) for help.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.thpmedicare.org/saint-alphonsus/find-a-provider to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.thpmedicare.org/saint-alphonsus/find-a-provider.
- Call Member Services at 1-800-240-3851 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-240-3851 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Chiropractic Services	<u>In-Network</u> \$20 copay for each Medicare-covered chiropractic services visit.	<u>In-Network</u> \$15 copay for each Medicare-covered chiropractic services visit.
Colorectal Cancer Screening (Barium Enemas)	<u>In-and Out-of-Network</u> \$0 copay for each Medicare-covered barium enema.	<u>In-and Out-of-Network</u> Medicare-covered barium enema benefit is <u>not</u> covered.
Emergency Care	\$110 copay for each visit for Medicare-covered emergency care services.	\$130 copay for each visit for Medicare-covered emergency care services.
Inpatient Hospital Care	<u>In-Network</u> For Medicare-covered inpatient hospital stays, \$300 copay per day for days 1-5; \$0 copay per day for days 6-90.	<u>In-Network</u> For Medicare-covered inpatient hospital stays, \$350 copay per day for days 1-5; \$0 copay per day for days 6-90.

	2025 (this year)	2026 (next year)
Inpatient Services in a Psychiatric Hospital	<u>In-Network</u> For Medicare-covered inpatient mental health stays, \$300 copay per day for days 1-5; \$0 copay per day for days 6-90.	<u>In-Network</u> For Medicare-covered inpatient mental health stays, \$350 copay per day for days 1-5; \$0 copay per day for days 6-90.
Medicare Part B Prescription Drugs	Plan does not use step therapy for Medicare Part B drugs.	Plan uses step therapy for select Medicare Part B drugs.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	<u>In-Network</u> For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), \$150 copay.	<u>In-Network</u> For Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans), \$200 to \$225 copay. For a complete description of Outpatient Diagnostic Radiology Services please refer to Chapter 4 of your Evidence of Coverage.

	2025 (this year)	2026 (next year)
Outpatient Hospital Observation	<u>In-Network</u> \$0 copay; There is no copayment for outpatient observation stays. Copayment applies for outpatient services rendered during observation stay. The outpatient service with the highest copayment applies each day for Medicare-covered outpatient hospital observation services.	<u>In-Network</u> \$340 copay per stay for Medicare-covered outpatient hospital observation services.
Outpatient Surgery	Includes services provided at hospital outpatient facilities and ambulatory surgical centers. <u>In-Network</u> For Medicare-covered services at an outpatient hospital facility, \$275 copay. For Medicare-covered services at an ambulatory surgical center, \$275 copay.	<u>In-Network</u> For Medicare-covered services at an outpatient hospital facility, \$350 copay. For Medicare-covered services at an ambulatory surgical center, \$350 copay.
Over-the-Counter Items	\$100 maximum plan coverage amount every 3 months for OTC items.	\$50 maximum plan coverage amount every 3 months for OTC items.

	2025 (this year)	2026 (next year)
Skilled Nursing Facility (SNF) Care	<u>In-Network</u> For Medicare-covered SNF stays, \$0 copay per day for days 1-20; \$214 copay per day for days 21-55; \$0 copay per day for days 56-100.	<u>In-Network</u> For Medicare-covered SNF stays, \$0 copay per day for days 1-20; \$218 copay per day for days 21-60; \$0 copay per day for days 61-100.
Supplemental Vision/Hearing Allowance (Flexible Benefit Card)	<u>In-and Out-of- Network:</u> You received \$500 /year on your Flexible Benefit Card to apply towards out-of-pocket costs for covered Vision/Hearing services.	<u>In-and Out-of-Network:</u> You will receive \$250 /year on your Flexible Benefit Card to apply towards certain out-of-pocket costs for plan-covered Vision/Hearing services. For a complete description of Vision/Hearing services, please refer to Chapter 4 of your <i>Evidence of Coverage</i>.
Urgently Needed Care Services	\$35 copay for each visit for Medicare-covered urgently needed care services.	\$50 copay for each visit for Medicare-covered urgently needed care services.

	2025 (this year)	2026 (next year)
Worldwide Emergency / Urgently Needed Care Services	\$110 copay for each emergency care visit outside of the United States and its territories. \$110 copay for each urgently needed care visit outside of the United States and its territories.	\$130 copay for each emergency care visit outside of the United States and its territories. \$130 copay for each urgently needed care visit outside of the United States and its territories.

Section 1.6 Changes to Part D 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 calendar 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’re taking, we’ll send you a notice about the change.

If you’re affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-240-3851 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30th, call Member Services at 1-800-240-3851 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are 3 **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 no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your total year-to-date Out-of-Pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You can have cost sharing for excluded drugs that are covered under our enhanced benefit. You stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	\$150 deductible During this stage, you pay \$0-\$20 cost sharing for drugs on Tier 1 Preferred Generic, Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier until you've reached the yearly deductible.	\$250 deductible During this stage, you pay \$0-\$20 cost sharing for drugs on Tier 1 Preferred Generic, Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. For more information about the costs of vaccines, or information about the costs for a long-term supply ; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your Evidence of Coverage.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1 (Preferred Generic): 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.	<i>Standard cost sharing:</i> You pay \$10 You pay \$10 per month supply of each covered insulin product on this tier. <i>Preferred cost sharing:</i> You pay \$0	<i>Standard cost sharing:</i> You pay \$10 You pay no more than \$10 per month supply of each covered insulin product on this tier. <i>Preferred cost sharing:</i> You pay \$0
Tier 2 (Generic): 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.	<i>Standard cost sharing:</i> You pay \$20 You pay \$20 per month supply of each covered insulin product on this tier. <i>Preferred cost sharing:</i> You pay \$10 You pay \$10 per month supply of each covered insulin product on this tier	<i>Standard cost sharing:</i> You pay \$20 You pay no more than \$20 per month supply of each covered insulin product on this tier. <i>Preferred cost sharing:</i> You pay \$6 You pay no more than \$6 per month supply of each covered insulin product on this tier
Tier 3 (Preferred Brand): 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.	<i>Standard cost sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier <i>Preferred cost sharing:</i> You pay 25% of the total cost You pay \$35 per month supply of each covered insulin product on this tier	<i>Standard cost sharing:</i> You pay 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier <i>Preferred cost sharing:</i> You pay 25% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier

	2025 (this year)	2026 (next year)
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.	<i>Standard cost sharing:</i> You pay 50% of the total cost You pay \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 50% of the total cost. <i>Preferred cost sharing:</i> You pay 50% of the total cost You pay \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 50% of the total cost.	<i>Standard cost sharing:</i> You pay 30% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 30% of the total cost. <i>Preferred cost sharing:</i> You pay 30% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 30% of the total cost.

	2025 (this year)	2026 (next year)
Tier 5 (Specialty Tier): 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.	<i>Standard cost sharing:</i> You pay 31% of the total cost You pay \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 31% of the total cost <i>Preferred cost sharing:</i> You pay 31% of the total cost You pay \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 31% of the total cost	<i>Standard cost sharing:</i> You pay 30% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 30% of the total cost. <i>Preferred cost sharing:</i> You pay 30% of the total cost You pay no more than \$35 per month supply of each covered insulin product on this tier Your cost for a one-month mail-order prescription is 30% of the total cost

Changes to the Catastrophic Coverage Stage

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

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

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Diabetic Testing Supplies	Available through all network pharmacies. Members must utilize Accu-check or LifeScan meters and test strips.	Available through all network pharmacies. Members must utilize Accu-check or True Metrix meters and test strips.
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-866-785-5714, option 2 (TTY: 711) or visit www.Medicare.gov .
Over-the-Counter (OTC) Benefit	Members are responsible for the difference if the total exceeds the quarterly allowance. The quarterly allowance may only be exceeded at the retail locations and online. Orders placed over the phone must total the quarterly allowance or less.	Members are responsible for the difference if the total exceeds the quarterly allowance. The quarterly allowance may only be exceeded at the retail locations. Orders placed over the phone and online must total the quarterly allowance or less.

SECTION 3 How to Change Plans

To stay in Saint Alphonsus Health Plan Choice (PPO), you don't need to do anything.

Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our Saint Alphonsus Health Plan Choice (PPO).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Saint Alphonsus Health Plan Choice (PPO).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Saint Alphonsus Health Plan Choice (PPO).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-240-3851 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Saint Alphonsus Health Plan offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users call, 1-800-325-0778.
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Idaho Ryan White Part B Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call Idaho Ryan White Part B Program at 1-800-926-2588. 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 payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-866-785-5714 option 2 (TTY: 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Saint Alphonsus Health Plan Choice (PPO)

- **Call Member Services at 1-800-240-3851. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the *2026 Evidence of Coverage* for Saint Alphonsus Health Plan Choice (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/for-members/plan-documents or call Member Services at 1-800-240-3851 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.thpmedicare.org/saint-alphonsus/for-members/plan-documents**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Idaho, the SHIP is called Idaho Senior Health Insurance Benefits Advisors.

Call Idaho Senior Health Insurance Benefits Advisors to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Idaho Senior Health Insurance Benefits Advisors at 1-800-247-4422. Learn more about Idaho Senior Health Insurance Benefits Advisors by visiting (<https://doi.idaho.gov/SHIBA/>).

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit www.Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION, AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS, AND ACCESSIBILITY SERVICES

Trinity Health understands that we all have different lived experiences, needs, identities, customs, and abilities. We are committed to providing quality, accessible, equitable care and services that are responsive to the needs of the diverse communities served.

Saint Alphonse Health Plan Choice (PPO) welcomes all individuals who come to us for care, treatment, and services. We comply with all Federal civil right laws and do not exclude anyone or treat them differently because of their age, race, color, ethnicity (including limited English proficiency and primary language), national origin, religion, culture, language, physical or mental disability, socioeconomic status (including ability to pay or participation in Medicaid, Medicare or Children's Health Insurance Program), sex (including sex at birth or legal sex), sex characteristics (including intersex traits), pregnancy or related conditions, sex stereotypes, sexual orientation, gender identity or expression, veteran status, or any other category protected by law.

As a sponsored ministry of the Catholic Church, we provide healthcare services guided by the moral principles described in the Ethical and Religious Directives for Catholic Healthcare Services published by the U.S. Conference of Catholic Bishops.

Saint Alphonse Health Plan Choice (PPO) provides free auxiliary aids and communication services, so that people can communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact

Language Assistance Services at 1-800-240-3851
Telecommunications Relay Service (TRS): 7-1-1

Saint Alphonse Health Plan Choice (PPO) allows service animals that are trained to do work or perform tasks for the benefit of individuals with a disability.

If you need another type of reasonable modification or accessibility services, please discuss it with your provider or the Section 1557/Americans with Disabilities Act Coordinator:

ATTN: Member Services Manager

3100 Easton Square Place, Suite 300
Columbus, OH 43219

Phone:

1-800-240-3851 (TTY 711)

Fax:

1-833-802-2495

Email:

medigoldappeals@mchs.com

If you believe that Saint Alphonus Health Plan Choice (PPO) has failed to provide these services or discriminated in another way, you can file a grievance with:

Member Services

3100 Easton Square Place Suite 300
Columbus, OH 43219

1-800-240-3851

medigoldappeals@mchs.com

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

This notice is available at the Saint Alphonus Health Plan Choice (PPO) website:
www.thpmedicare.org/saint-alphonus/

Notice of Accessibility

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-240-3851 (TTY: 711) or speak to your provider.

Spanish: Español

ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-800-240-3851 (TTY: 711) o hable con su proveedor.

Simplified Chinese: 中文

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-240-3851（文本电话：711）或咨询您的服务提供商。”

Vietnamese: Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-240-3851 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.”

Albanian: SHQIP

VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndhima të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-240-3851 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.”

Korean: 한국어

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-240-3851 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.”

Bengali: বাংলা

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-240-3851 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”

Polish: POLSKI

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-240-3851 (TTY: 711) lub porozmawiaj ze swoim dostawcą”.

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-240-3851 (TTY: 711) an oder wenden Sie sich an Ihren Anbieter.

Italian: Italiano

ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-240-3851 (TTY: 711) o parla con il tuo fornitore.

Japanese: 日本語

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-240-3851 (TTY: 711)までお電話ください。または、ご利用の事業者にご相談ください。

Russian: РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-240-3851 (TTY: 711) или обратитесь к своему поставщику услуг.

Croatian: hrvatski

PAŽNJA: Ako govorite hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima također su dostupne besplatno. Nazovite 1-800-240-3851 (TTY: 711) ili razgovarajte sa svojim davateljem usluga.

Serbian: Српски

ПАЖЊА: Ако говорите Српски, доступне су вам бесплатне услуге језичке помоћи. Одговарајућа помоћна средства и услуге за пружање информација у приступачним форматима такође су доступни бесплатно. Позовите 1-800-240-3851 (TTY: 711) или разговарајте са својим оператером.

Tagalog: Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-240-3851 (TTY: 711) o makipag-usap sa iyong provider.

Haitian: Kreyòl Ayisyen

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan 1-800-240-3851 (TTY: 711) oswa pale avèk founisè w la.

Yiddish:

אכטונג: אויב איר רעדט אריינשטעלן שפראך, זענען פרייע שפראך הילף סערוויסעס פאראן פאר אייך. פאסיגע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך פאראן פריי פון אפצאל. רופט אדער רעדט מיט אייער פראוויידער (TTY: 711) 1-800-240-3851

Arabic: العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-240-3851 (TTY: 711) أو تحدث إلى مقدم الخدمة.

French: Français

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-240-3851 (ATS : 711) ou contactez votre fournisseur.

Urdu: اردو

دھیان دیں: اگر آپ بولتے ہیں انسرٹ لینگویج، آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں پر کال (TTY: 711) معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-240-3851 کریں یا اپنے فراہم کنندہ سے بات کریں۔

Greek: Ελληνικά

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-240-3851 (TTY: 711) ή απευθυνθείτε στον πάροχό σας».

Swahili/Bantu: Kiswahili

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-240-3851 (TTY: 711) au zungumza na mtoa huduma wako.”

Farsi/Persian:

فارسی

توجه: اگر وارد کردن زبان صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-240-3851 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

Dutch: Nederlands

LET OP: Als u Nederlands spreekt, kunt u gratis gebruikmaken van taalondersteuning. Ook zijn er gratis hulpmiddelen en diensten beschikbaar om informatie in toegankelijke formaten te verstrekken. Bel 1-800-240-3851 (TTY: 711) of neem contact op met uw provider.

Ukrainian: українська мова

УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-240-3851 (TTY: 711) або зверніться до свого постачальника».

Romanian: România

ATENȚIE: Dacă vorbiți România, aveți la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit materiale auxiliare și servicii adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-240-3851 (TTY: 711) sau discutați cu furnizorul dumneavoastră.

Laotian: ລາວ

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-240-3851 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."

Hindi: हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-240-3851 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

Thai: ไทย

หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-240-3851 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

Karen: ထာရှင်လီၤဖဲအံၤ

ဆူ- နမ့ၢ်ကတိၢ် ထာရှင်လီၤဖဲအံၤ အသိ, တၢ်အိၣ်ဒီး ကျိၣ်တၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢ် ဘျုးလၢ်စ့ၤလၢနီၢ်လီၤ. တၢ်အိၣ်ဒီး တၢ်မၤစၢၤတၢ်နီၢ်ဟ့ၣ်ပီးလီၤဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြးအဘျုး လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနီၢ်အိၣ်သ့တဖျုး လၢတလၢ်ဘျုးလၢ်စ့ၤ လၢနီၢ်လီၤ. ကိး 1-800-240-3851 (TTY: 711) မ့တမ့ၢ် ကတိၢ်တၢ်ဒီး နပုၤလၢဟ့ၣ် နတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်."

Somali: Soomaali

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luqadda bilaashka ah ayaa diyaar kuu ah. Kaalmooyinka iyo adeegyada ku habboon ee lagu bixiyo macluumaadka qaabab la heli karo ayaa sidoo kale lagu heli karaa lacag la'aan. Wac 1-800-240-3851 (TTY: 711) ama la hadal adeeg bixiyahaaga.