

Samaritan Dual Advantage (HMO)(D-SNP) offered by Samaritan Health Plans

Annual Notice of Changes for 2025

You are currently enrolled as a member of Samaritan Dual Advantage. 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 samhealthplans.org/Advantage. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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 Samaritan Dual Advantage.
- 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 Samaritan Dual Advantage.
- Look in section 3.2, page 14 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Service number at 866-207-3182 for additional information. (TTY users should call 800-735-2900.) Hours are 8 a.m. to 8 p.m. daily, October 1 through March 31, and 8 a.m. to 8 p.m. Monday through Friday, from April 1 through September 30. This call is free.
- This document is available in alternate formats (e.g., braille, large print, audio.)
- **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 Samaritan Dual Advantage

- Samaritan Advantage Health Plans is an HMO with a Medicare Contract. Enrollment in Samaritan Advantage Health Plans depends on contract renewal. The plan also has a written agreement with the Oregon Health Plan Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Samaritan Health Plans. When it says "plan" or "our plan," it means Samaritan Dual Advantage.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Samaritan Dual Advantage in several important areas. **Please note this is only a summary of costs.** If you are eligible for Medicare cost-sharing assistance under the Oregon Health Plan (Medicaid), you pay \$0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	\$40.60	\$26.10
Deductible	\$240 - except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under the Oregon Health Plan (Medicaid), you pay \$0.	\$257 except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing assistance under the Oregon Health Plan (Medicaid), you pay \$0.
Doctor office visits	Primary care visits: 0% or 20% per visit Specialist visits: 0% or 20% per visit If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay \$0 per visit.	Primary care visits: 0% or 20% per visit Specialist visits: 0% or 20% per visit If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay \$0 per visit.
Inpatient hospital stays	\$0 or \$1,632 deductible for each benefit period.	\$0 or \$1,676 deductible for each benefit period.

Cost	2024 (this year)	2025 (next year)
	\$0 per day for days 1 through 60. \$408 per day for days 61 through 90. \$0 copay for days 91 and beyond. There is no limit to the number of days covered by the plan for each defined benefit period. If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay \$0.	\$0 per day for days 1 through 60. \$419 per day for days 61 through 90. \$0 copay for days 91 and beyond. There is no limit to the number of days covered by the plan for each defined benefit period. If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay \$0.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: \$545, except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance as applicable during the Initial Coverage Stage: - Generic/Preferred/Multi-Source Drugs: \$0 / \$1.55 / \$4.50 per prescription. - All Other Drugs: \$0 / \$4.60 / \$11.20 per prescription. Catastrophic Coverage: - During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: \$590, except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: - Generic/Preferred/Multi-Source Drugs: \$0 / \$1.60 / \$4.90 per prescription. - All Other Drugs: \$0 / \$4.80 / \$12.15 per prescription. Catastrophic Coverage: - During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount	\$8,300	\$9,350
This is the <u>most</u> you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	If you are eligible for Medicare cost-sharing assistance under the Oregon Health Plan (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	If you are eligible for Medicare cost-sharing assistance under the Oregon Health Plan (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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	\$40.60	\$26.10
You must also continue to pay your Medicare Part B premium unless it is paid for you by the Oregon Health Plan (Medicaid.)		

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	\$8,300	\$9,350
Because our members also get assistance from the Oregon Health Plan (Medicaid), very few members ever reach this out-of-pocket maximum.		Once you have paid \$9,350 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.
If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.		
Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		

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 samhealthplans.org/Advantage. You may also call Customer Service 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* samhealthplans.org/Advantage 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* samhealthplans.org/Advantage 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 a part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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 services	Not a covered benefit.	\$1,000 combined benefit limit for preventive and comprehensive dental services, hearing aids and supplies, and routine vision hardware. Covered services include but are not limited to cleanings, extractions, oral exams, teeth whitening and dental x-rays. Orthodontia is not a covered benefit.
Emergency services	You pay a \$0-\$90 copay for each Medicare-covered emergency room visit. You pay a \$0-\$90 copay for worldwide emergency care.	You pay a 0% or 20% coinsurance of the cost up to \$110 for each Medicare-covered emergency room visit. You pay a \$0-\$110 copay for worldwide emergency care.

Cost	2024 (this year)	2025 (next year)
Health education	You pay \$0 for health education classes through Samaritan Health Services. Health coaching: up to 3 sessions at a SamFit facility only.	Not a covered benefit.
Hearing aids	\$750 benefit limit for hearing aids, repairs and supplies.	\$1,000 combined benefit limit for hearing aids and supplies, preventive and comprehensive dental services, and routine vision hardware.
Over-the-Counter (OTC) benefit	You have a \$175 allowance every quarter for over-the-counter items. Any unused amount does not carry over to the next quarter.	You have a \$132 allowance every quarter for over-the-counter items. Any unused amount does not carry over to the next quarter.
Routine vision hardware	\$175 benefit limit every calendar year for contact lenses, or eyeglasses (frames, lenses and upgrades).	\$1,000 combined benefit limit for routine vision hardware, hearing aids and supplies, preventive and comprehensive dental services.
Telehealth services	You pay \$0 copay for telehealth visits with a primary care physician.	You pay \$0 copay for telehealth visits with a primary care physician, specialist, physical, occupational, or speech therapy visits, and outpatient mental health care
Urgent care services	You pay 0% or 20% coinsurance of the cost up to \$55 for each Medicare-covered urgent care visit.	0% or 20% coinsurance of the cost up to \$45 for each Medicare-covered urgent care visit.

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. **You can get the complete Drug List** by calling Customer Service or visiting our website (samhealthplans.org/Advantage).

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 Customer Service 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 Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert by September 30th, please call Customer Service 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 Part D 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 \$545.	The deductible is \$590.

Changes to Your Cost Sharing in the Initial Coverage Stage

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. 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.	The number of days in a one-month supply is 34. Your cost for a one-month supply: Generic/Preferred/ Multi-source Drugs: You pay \$0/\$1.55/\$4.50 per prescription. All Other Drugs: You pay \$0/\$4.60/\$11.20 per prescription. Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).	The number of days in a one-month supply is 30. Your cost for a one-month supply: Generic/Preferred/ Multi-source Drugs: You pay \$0/\$1.60/\$4.90 per prescription. All Other Drugs: You pay \$0/\$4.80/\$12.15 per prescription. 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 866-207-3182 or visit Medicare.gov.
Primary Care Providers (PCPs)	You are not required to choose a PCP.	You must choose a PCP to provide and oversee your medical care.

SECTION 3 Deciding Which Plan to Choose**Section 3.1 – If you want to stay in Samaritan Dual Advantage**

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 Samaritan Dual Advantage.

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.

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, Samaritan Health Plans offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Samaritan Dual Advantage.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Samaritan Dual Advantage.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Customer Service 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.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

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 the Oregon Health Plan (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.

Because you have Oregon Health Plan (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also 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 and Medicaid

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA 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 SHIBA at 800-722-4134. You can learn more about SHIBA by visiting their website (shiba.oregon.gov).

For questions about your Oregon Health Plan benefits, contact the Oregon Health Authority at 800-273-0557, TTY users should call 711, Monday through Friday 8 a.m. to 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Oregon Health Plan coverage.

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.** Because you have the Oregon Health Plan (Medicaid), you are already enrolled in “Extra Help,” also called the Low-Income Subsidy. “Extra Help” pays some of your prescription drug premiums, yearly deductibles, and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about “Extra Help,” 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 Oregon Health Plan (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. 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 CAREassist at 971-673-0144. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call CAREassist at 971-673-0144. 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 866-207-3182 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Samaritan Dual Advantage

Questions? We’re here to help. Please call Customer Service at 866-207-3182. (TTY only, call 800-735-2900.) We are available for phone calls 8 a.m. to 8 p.m. daily, October 1 through March 31, and 8 a.m. to 8 p.m. Monday through Friday, from April 1 through September 30. 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 Samaritan Dual Advantage. 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 samhealthplan.org/Advantage. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at samhealthplans.org/Advantage. 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.

Section 7.3 – Getting Help from Medicaid

To get information from the Oregon Health Plan (Medicaid) you can call the Oregon Health Authority (OHA) at 800-273-0557. TTY users should call 711.