Complete Blue PPO Distinct (PPO) offered by Highmark Senior Health Company

Annual Notice of Changes for 2022

You are currently enrolled as a member of Complete Blue PPO Distinct. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.2 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ 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, 2021, you will be enrolled in Complete Blue PPO Distinct.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Complete Blue PPO Distinct.
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at 1-833-227-9375 for additional information. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
- This information is available in an alternate format such as large print.
- **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 Complete Blue PPO Distinct

- Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Highmark Senior Health Company. When it says "plan" or "our plan," it means Complete Blue PPO Distinct.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Complete Blue PPO Distinct in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at medicare.highmark.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$35.00	$25.00
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From **network** providers: $6,500 From **network and out-of-network** providers combined: $10,000	From **network** providers: $6,500 From **network and out-of-network** providers combined: $10,000
Doctor office visits	**Primary care visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit **Specialist visits:** **Network:** $30 copay per visit **Out-of-Network:** $30 copay per visit	**Primary care visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit **Specialist visits:** **Network:** $25 copay per visit **Out-of-Network:** $25 copay per visit
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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**Network:** $325 copay per admit **Out-of-Network:** $395 copay per admit	**Network:** $295 copay per admit **Out-of-Network:** $395 copay per admit

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.) To find out which drugs are Tier 3 insulins, review the most recent Drug List provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed in Section 6.1).	Deductible: There is no deductible. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard* $7 copay *Preferred* $0 copay • Drug Tier 2: *Standard* $20 copay *Preferred* $9 copay • Drug Tier 3: *Standard* $47 copay *Preferred* $47 copay • Drug Tier 4: *Standard* $100 copay *Preferred* $100 copay • Drug Tier 5: *Standard* 33% coinsurance *Preferred* 33% coinsurance	Deductible: There is no deductible. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard* $7 copay *Preferred* $0 copay • Drug Tier 2: *Standard* $20 copay *Preferred* $5 copay • Drug Tier 3: *Standard* $47 copay *Preferred* $47 copay *Standard or Preferred*: $35 copay per insulin prescription • Drug Tier 4: *Standard* $100 copay *Preferred* $100 copay • Drug Tier 5: *Standard* 33% coinsurance *Preferred* 33% coinsurance

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$35.00	$25.00

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

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

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

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,500	$6,500 Once you have paid $6,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount	$10,000	$10,000

Cost	2021 (this year)	2022 (next year)
Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.		Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at medicare.highmark.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

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. 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 has changed more than usual for 2022. An updated *Pharmacy Directory* is located on our website at medicare.highmark.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your pharmacy is still in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverag*e.

Opioid treatment program services
Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Advanced Imaging	**Network:** You pay a $285 copay.	**Network:** You pay a $225 copay.

Cost	2021 (this year)	2022 (next year)
	Out-of-Network: You pay a $325 copay.	**Out-of-Network:** You pay a $325 copay.
Chiropractic Care	**Network:** You pay a $20 copay per routine and Medicare-covered visit. **Out-of-Network:** You pay a $30 copay per routine and Medicare-covered visit. Routine (up to 4 visits per calendar year) only covers manual manipulation of the spine to correct subluxation	**Network:** You pay a $20 copay per routine and Medicare-covered visit. **Out-of-Network:** You pay a $25 copay per routine and Medicare-covered visit. Routine (up to 4 visits per calendar year) covers maintenance manual manipulation of the spine.
Colorectal Cancer Screening	Eligible members are people aged 50 and above.	Eligible members are people aged 45 and above.
Dental Services - Routine and Supplemental Comprehensive	**Network:** You pay a $15 copay for an office visit every 6 months. You pay a $15 copay per dental x-ray once a year. **Out-of-Network:** You pay 30% coinsurance of the total cost for preventive dental services. **In and Out-of-Network:** You pay 50% coinsurance with a maximum $750 allowance every year for: • Restorative Services -1 every 2 years per tooth per surface	**Network:** You pay a $15 copay for an office visit every 6 months. You pay a $15 copay per dental x-ray once a year. **Out-of-Network:** You pay 30% coinsurance of the total cost for preventive dental services. **In and Out-of-Network:** You pay 50% coinsurance with a maximum $3,000 allowance every year for: • Restorative Services -1 every 2 years per tooth/ surface

Cost	2021 (this year)	2022 (next year)
	• Endodontics, Prosthodontics and other Oral/Maxillofacial Surgery - 1 set of dentures, partials or bridges every 5 years • Extractions - 1 every year	• Endodontics, Prosthodontics and other Oral/ Maxillofacial Surgery - 1 set of dentures, partials or bridges every 5 years • Extractions - 1 every year
Diabetic Supplies	**Network:** You pay a 20% coinsurance for all diabetic supplies. **Out-of-Network:** You pay 30% coinsurance of the total cost. All diabetic supplies are provided through Durable Medical Equipment (DME) providers.	**Network:** You pay a $0 copay for glucometers, test strips, lancets, control solution, replacement batteries, platforms, lens shield, a continuous glucose monitoring device and non-invasive vagus nerve stimulator. All other Medicare covered Diabetic Supplies have a 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance of the total cost. Abbott and Lifescan glucometers, diabetic test strips, lancets, control solutions and a continuous glucose monitoring device are now available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).

Cost	2021 (this year)	2022 (next year)
Enhanced Disease Management	Onduo is not covered.	You pay nothing. Onduo is a virtual care program that helps individuals manage their diabetes. The program helps guide individuals to eat healthier, be more active, and create other lifestyle changes. Onduo for Type 2 Diabetes includes a smart blood glucose meter, the Onduo app, and support from personal coaches, clinicians and care specialists, including access to physicians through telemedicine when needed. To be eligible, you must have Type 2 Diabetes, be 18 years of age or older and own a smartphone (to use the app).
Hearing Exam	**Network:** You pay a $30 copay for an annual routine exam and a $30 copay per Medicare-covered exam. **Out-of-Network:** You pay a $30 copay per routine and Medicare-covered visit.	**Network:** You pay a $25 copay for an annual routine exam and a $25 per Medicare-covered exam. **Out-of-Network:** You pay a $25 copay per routine and Medicare-covered visit.
Inpatient Acute Hospital Stay	**Network:** You pay a $325 copay per admit. **Out-of-Network:** You pay a $395 copay per admit.	**Network:** You pay a $295 copay per admit. **Out-of-Network:** You pay a $395 copay per admit.
Outpatient Occupational, Physical and Speech Therapy	**Network:** You pay a $25 copay per therapy type, per provider, per	**Network:** You pay a $25 copay per therapy type, per provider, per

Cost	2021 (this year)	2022 (next year)
	day for physical and speech therapy services. You pay a $40 copay per provider, per day for occupational therapy services. **Out-of-Network:** You pay a $35 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a $50 copay per provider, per day for occupational therapy services.	day for physical and speech therapy services. You pay a $30 copay per provider, per day for occupational therapy services. **Out-of-Network:** You pay a $35 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a $50 copay per provider, per day for occupational therapy services.
Outpatient Surgery	**Network:** You pay a $300 copay for services performed as a hospital outpatient. You pay a $250 copay for services in an ambulatory surgical center. **Out-of-Network:** You pay a $375 copay for services performed as a hospital outpatient. You pay a $325 copay for services in an ambulatory surgical center.	**Network:** You pay a $250 copay for services performed as a hospital outpatient. You pay a $200 copay for services in an ambulatory surgical center. **Out-of-Network:** You pay a $375 copay for services performed as a hospital outpatient. You pay a $325 copay for services in an ambulatory surgical center.
Over-the-Counter (OTC) Drug Allowance	$25 allowance per quarter for over-the counter drugs. Items must be ordered through Fieldtex OTC Benefit Solutions and are limited to one order per quarter.	$105 allowance per quarter for over-the counter drugs. Items must be ordered through Fieldtex OTC Benefit Solutions and are limited to one order per quarter.
Podiatry Care	**Network:** You pay a $30 copay per routine visit and a $30 copay per Medicare-covered visit.	**Network:** You pay a $25 copay per routine visit and a $25 copay per Medicare-covered visit.

Cost	2021 (this year)	2022 (next year)
	Out-of-Network: You pay $30 copay of the total cost per routine and Medicare-covered visit. You have a frequency limit of 4 visits per calendar year.	**Out-of-Network:** You pay a $25 copay per routine and Medicare-covered visit. You have a frequency limit of 4 visits per calendar year.
Skilled Nursing Facility	**Network:** You pay a $0 copay for Days 1 – 20. You pay a $184 copay per day for Days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.	**Network:** You pay a $0 copay for Days 1 – 20. You pay a $188 copay per day for Days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.
Specialist Office Visit (including Medicare-covered Eye, Podiatry, Non-routine Dental, and Hearing Exams)	**Network:** You pay a $30 copay. **Out-of-Network:** You pay a $30 copay.	**Network:** You pay a $25 copay. **Out-of-Network**: You pay a $25 copay.
Telehealth	You pay the following for each telehealth service: **Network:** • PCP: $0 copay • Specialist: $30 copay • Home Health: $0 copay • Mental Health and Psychiatric: $40 copay • Opioid Treatment and Outpatient Substance Abuse: $45 copay • Physical and Speech Therapy: $25 copay **Out-of-Network:** • PCP: $0 copay • Specialist: $30 copay	You pay the following for each telehealth service: **Network:** • PCP: $0 copay • Specialist: $25 copay • Home Health: $0 copay • Mental Health and Psychiatric: $40 copay • Opioid Treatment and Outpatient Substance Abuse: $45 copay • Physical and Speech Therapy: $25 copay • Occupational Therapy: $30 copay **Out-of-Network:**

Cost	2021 (this year)	2022 (next year)
	• Home Health: 30% coinsurance • Mental Health and Psychiatric: $50 copay • Opioid Treatment and Outpatient Substance Abuse: $50 copay • Physical and Speech Therapy: $35 copay	• PCP: $0 copay • Specialist: $25 copay • Home Health: 30% coinsurance • Mental Health and Psychiatric: $50 copay • Opioid Treatment and Outpatient Substance Abuse: $50 copay • Physical and Speech Therapy: $35 copay • Occupational Therapy: $50 copay
Urgently Needed Care	You pay a $50 copay.	You pay a $30 copay.
X-Rays	**Network:** You pay a $25 copay. **Out-of-Network:** You pay a $35 copay.	**Network:** You pay a $20 copay. **Out-of-Network:** You pay a $35 copay.

Section 1.6 – 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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.

    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are currently taking a drug that Highmark Senior Health Company approved as a formulary exception in 2021, you may need to ask for a new formulary exception for the same drug in 2022.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug 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. Because you receive "Extra Help", if you haven't received this insert by September 30, 2021, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*,

which is located on our website at medicare.highmark.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (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 row are for a one-month (31-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 or for mail-order prescriptions, 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.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $7 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $9 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:*	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 Preferred Generic:** *Standard cost sharing:* You pay $7 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $5 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:*

Stage	2021 (this year)	2022 (next year)
	You pay $47 per prescription. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. **Tier 5 Specialty:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	You pay $47 per prescription. *Standard or Preferred cost sharing*: You pay a $35 copay per insulin prescription. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. **Tier 5 Specialty:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

Complete Blue PPO Distinct offers additional gap coverage for Tier 3 insulins. During the Coverage Gap stage, your out-of-pocket costs for Tier 3 insulins will be a $35 copay for a 31-day supply and a $105 copay for a 90-day supply at a retail or mail order pharmacy. To find out which drugs are Tier 3 insulins, review the most recent Drug List provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed in Section 6.1).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Complete Blue PPO Distinct

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 Complete Blue PPO Distinct.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Highmark Senior Health Company 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 Complete Blue PPO Distinct.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Complete Blue PPO Distinct.
- 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 this (phone numbers are in Section 6.1 of this booklet).
    - – *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 3 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, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE Health Insurance Counseling Program.

APPRISE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. APPRISE 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 APPRISE at 1-800-783-7067 (TTY users call 711 National Relay Service). You can learn more about APPRISE by visiting their website (www.aging.pa.gov).

SECTION 5 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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called PACE that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **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 Pennsylvania Special Pharmaceutical Benefits Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the SPBP Customer Service line at 1-800-922-9384 or go to their website at www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx.

SECTION 6 Questions?

Section 6.1 – Getting Help from Complete Blue PPO Distinct

Questions? We're here to help. Please call Customer Service at 1-833-227-9375. (TTY only, call 711 National Relay Service.) We are available for phone calls Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Complete Blue PPO Distinct. 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 medicare.highmark.com. 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 medicare.highmark.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – 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

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (www.medicare.gov) 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.

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