2022 Summit Health Value + Rx (HMO)

Annual Notice of Changes

January 1 – December 31, 2022

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Summit Health Value + Rx (HMO)

This booklet gives you the details about the changes to your Medicare health care and prescription drug coverage from January 1 to December 31, 2022. This is an important legal document. Please keep it in a safe place.

Summit Health Plan, Inc. is an HMO with a Medicare contract. Enrollment in Summit Health Plan, Inc. depends on contract renewal.

This information may be available in a different format, including large print. Please call Customer Service if you need plan information in another format or language. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Esta información está disponible en otros idiomas e otros formatos alternativos, sin costo. Por favor comuníquese al departamento de servicios a los miembros al 844-827-2355. Usuarios de TTY (teléfono de texto), llamen al 711. El servicio al cliente está disponible de 7 a.m. a 8p.m. hora oficial del Pacífico, los siete días de la semana. El servicio al cliente también tiene servicios de intérpretes de idiomas gratis disponibles para las personas que no hablan ingles.

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Dear [First Name/Last Name],

Thank you for being a valued Summit Health Medicare Advantage member. Every year, we work to offer the best benefits and services to you to help you meet your health goals. Your benefits and premiums may change slightly from year to year to make this possible. These annual changes are listed in this Annual Notice of Change (ANOC). We send this packet to our members shortly before the annual enrollment period (AEP), which is Oct. 15 - Dec. 7 every year. Please take a moment to review this packet of important changes.

If you are satisfied with your plan and do not wish to make any changes, no further action is needed from you. You will automatically renew this coming new year.

If you have questions about your benefits or plan changes, our Customer Service team is here to help you. You can reach, toll-free, us at 844-827-2355. (TTY call 711.) We are available for phone calls from 7 a.m. to 8 p.m., Pacific Time, seven days a week from Oct. 1- March 31, with the exceptions of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone system on Saturdays, Sundays and holidays.)

We look forward to continuing to serve you as our member.

Sean Jessup
President of Summit Health

SUMMIT HEALTH

Now you can get plan documents delivered to you online

Online documents give you easy access to all your Medicare information.

The Centers for Medicare and Medicaid Services (CMS) requires that your important plan documents are made available to you electronically. You can find your important plan documents on yoursummithealth.com and in Member Dashboard.

To receive an email from Summit Health when new materials are available, simply log in to your Member Dashboard by visiting yoursummithealth.com. The sign in button is on the top right side of your screen. If you don't have an account, you can create one. Once logged in, select the "Account" tab. Next, click on "Manage notification settings." From here, you can update your email and make your electronic delivery preference.

Once you request electronic delivery, you will no longer receive this hard copy document in the mail, unless you request it.

Questions? Call us at 844-827-2355.

YourSummitHealth.com

Cut down on more paper — sign up for eBill today!

Now you can pay your premium online with eBill. Using eBill, you can view invoices online and set up your preferred payment methods (debit card, checking or savings) and set a recurring payment using our AutoPay feature. To access eBill, log in to your Member Dashboard and click on the eBill tab.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

844-827-2355 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Summit Health Plan
Attention: Appeal Unit
P.O. Box 820070
Portland, OR 97282
Fax: 855-466-7208

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

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

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@yoursummithealth.com

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ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION: si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

YourSummitHealth.com

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અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການ ຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍ ຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទ ទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณ สามารถใช้บริการช่วยเหลือด้านภาษา ได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

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Your Medicare Advantage resources for 2022

Thank you for being a Summit Health member. Below are the resources you need to understand your 2022 coverage.

Evidence of Coverage (EOC)

The EOC shows all of your benefit details. Use it to find out what is covered and how your plan works. Your EOC will be available online at yoursummithealth.com by Oct. 15, 2021.

If you would like an EOC mailed to you, you may call Customer Service at (844) 827-2355 or email MedicalMedicare@yoursummithealth.com.

Provider and Pharmacy Directories

If you need help finding a network provider and/or pharmacy, please call Customer Service at (844) 827-2355 or visit yoursummithealth.com to access our online searchable directory. This can be accessed by clicking on the “Find Care” link on our website.

If you would like a Provider Directory or Pharmacy Directory mailed to you, you may call the number above, request one at the website link provided above, or email MedicalMedicare@yoursummithealth.com.

List of Covered Drugs (Formulary)

Your plan has a List of Covered Drugs (Formulary) which represents the prescription therapies believed to be a necessary part of a quality treatment program.

If you have a question about covered drugs, please call Pharmacy Customer Service at (844) 827-2355 or visit yoursummithealth.com to access the online formulary.

If you would like a formulary mailed to you, you may call the number above, or email PharmacyMedicare@yoursummithealth.com.

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You can also log into your Member Dashboard account to view your plan documents.

This information is available for free in other languages. Customer Service (844) 827-2355 (TTY users call 711) is available from 7 a.m. to 8 p.m. Pacific Time, seven days a week from October 1 through March 31 with the exception of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone systems Saturdays, Sundays, and holidays.)

Summit Health Plan, Inc. is an HMO with a Medicare contract. Enrollment in Summit Health Plan, Inc. depends on contract renewal.

Thank you again for being a Summit Health member.
Please let us know if you have any questions.

Your Summit Health Customer Service Team

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Summit Health Value + Rx (HMO) offered by Summit Health Plan, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Summit Health Value + Rx (HMO). 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 1.1 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 3.2 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 Summit Health Value + Rx (HMO).
- 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 Summit Health Value + Rx (HMO).
- 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

- This document is available for free in Spanish.

- Please contact our Customer Service number at 1-844-827-2355 for additional information. (TTY users should call 711). Hours are 7 a.m. to 8 p.m., Pacific Time, seven days a week from October 1 through March 31, with the exceptions of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone system, Saturdays, Sundays and holidays.)
- This information may be available in a different format, including large print. Please call Customer Service if you need plan information in another format or language.
- **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 Summit Health Value + Rx (HMO)

- Summit Health Plan, Inc. is an HMO with a Medicare contract. Enrollment in Summit Health Plan, Inc. depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Summit Health Plan, Inc. When it says "plan" or "our plan," it means Summit Health Value + Rx (HMO).

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Summit Health Value + Rx (HMO) 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 www.yoursummithealth.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.	$69	$69
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,850	$6,650
Doctor office visits	Primary care visits: $15 copay per visit Specialist visits: $40 copay per visit	Primary care visits: $10 copay per visit Specialist visits: $40 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.	$370 copay per day for days 1-5; $0 copay per day for days 6 & beyond	$370 copay per day for days 1-5; $0 copay per day for days 6 & beyond

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $285 (for Tier 3, Tier 4, and Tier 5) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copay per prescription • Drug Tier 2: $15 copay per prescription • Drug Tier 3: $47 copay per prescription • Drug Tier 4: $100 copay per prescription • Drug Tier 5: 28% of the total cost per prescription • Drug Tier 6: $0 copay per prescription • Drug Tier 7 is not available	Deductible: $250 (for Tier 3, Tier 4, Tier 5, and Tier 6) Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copay per prescription • Drug Tier 2: $10 copay per prescription • Drug Tier 3: $45 copay per prescription • Drug Tier 4: $100 copay per prescription • Drug Tier 5: 23% of the total cost per prescription • Drug Tier 6: 28% of the total cost per prescription • Drug Tier 7: $0 copay per prescription

Annual Notice of Changes for 2022
Table of Contents

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.)	$69	$69
Summit Health Extra Care Monthly premium (Summit Health Extra Care is an optional supplemental benefit.) (You must also continue to pay your Medicare Part B premium and your Summit Health Value + Rx (HMO) premium.)	$5	$5

- 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 6 regarding "Extra Help" from Medicare.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,850	$6,650 Once you have paid $6,650 out-of-pocket for in-network covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.yoursummithealth.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider 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.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.yoursummithealth.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are 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 Coverage.*

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)
Acupuncture for lower back pain (Medicare covered)	**In-Network** You pay $15 copay for services received in a PCP setting; $40 copay for services received in a Specialist setting for each Medicare covered visit.	**In-Network** You pay $10 copay for services received in a PCP setting; $40 copay for services received in a Specialist setting for each Medicare covered visit.

Cost	2021 (this year)	2022 (next year)
Cardiac Rehabilitation Services (Medicare covered)	**In-Network** You pay $30 copay for each Medicare covered cardiac rehabilitation services visit. You pay $30 copay for each Medicare covered intensive-cardiac rehabilitation services visit.	**In-Network** You pay $40 copay for each Medicare covered cardiac rehabilitation services visit. You pay $50 copay for each Medicare covered intensive-cardiac rehabilitation services visit.
Emergency Services	**In-Network & Out-of-Network** You pay $90 copay for each visit for Medicare covered emergency services.	**In-Network & Out-of-Network** You pay $90 copay for each visit for Medicare covered emergency services. If Observation Services are rendered due to a related ER transfer, only Observation cost-sharing applies.
Hearing Aids	**In-Network** Your hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid You must see a TruHearing provider to use this benefit.	**In-Network** Your hearing aid purchase includes: • Follow-up provider visits within first year of hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid You must see a TruHearing provider to use this benefit.
Hearing Exams (Non-Medicare covered)	**In-Network** You pay $0 copay for one routine hearing exam per calendar year. Visits for hearing aid fitting and evaluation are not covered.	**In-Network** You pay $0 copay for one routine hearing exam per calendar year. You pay $0 copay for an unlimited number of visits for hearing aid fitting and evaluation.

Cost	2021 (this year)	2022 (next year)
Medicare Part B Prescription Drugs	**In-Network** Step therapy benefit steps from Part B to Part B.	**In-Network** Step therapy benefit steps from Part B to Part B and from Part B to Part D.
Other Health Care Professionals (e.g., nurse practitioner; physician assistant)	**In-Network** You pay $15 copay for services received in a PCP setting; $40 copay for services received in a Specialist setting for each Medicare covered visit.	**In-Network** You pay $10 copay for services received in a PCP setting; $40 copay for services received in a Specialist setting for each Medicare covered visit.
Outpatient Diagnostic Procedures and Tests	**In-Network** You pay $0 copay for Medicare covered diagnostic procedures and tests.	**In-Network** You pay 20% of the total allowed amount for Medicare covered diagnostic procedures and tests.
Primary Care Physician Visits	**In-Network** You pay $15 copay for each Medicare covered primary care doctor visit.	**In-Network** You pay $10 copay for each Medicare covered primary care doctor visit.
Urgently Needed Services	**In-Network & Out-of-Network** You pay $65 copay for each Medicare covered urgent care visit.	**In-Network & Out-of-Network** You pay $50 copay for each Medicare covered urgent care visit.
Vision Care (Non-Medicare covered Eye Exams)	**Out-of-Network** Routine eye exam services are not available out-of-network. Any services received from a provider outside of the VSP Advantage network would be your responsibility.	**Out-of-Network** You pay 50% of the total allowed amount for one routine exam per calendar year.

Cost	2021 (this year)	2022 (next year)
Vision Care (Non-Medicare covered Eyewear)	**Out-of-Network** Routine vision hardware services are not available out-of-network. Any services received from a provider outside of the VSP Advantage network would be your responsibility.	**Out-of-Network** You pay: 50% of the total allowed amount for one pair of covered lenses every two calendar years. $0 copay for one pair of frames with up to a $50 maximum frame allowance every two calendar years You pay: 50% of the total allowed amount for visually necessary contact lenses (certain medical conditions in lieu of lens/frames), no maximum allowance $0 copay for elective (in lieu of glasses) contact lens and fitting exam with up to a $100 maximum allowance every two calendar years.
Worldwide Urgent Care Services	You pay $65 copay for each urgent care visit worldwide.	You pay $50 copay for each urgent care visit worldwide.

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.
    - 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.

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 have included 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" and didn't receive this insert with this packet, 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 www.yoursummithealth.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 During this stage, **you pay the full cost** of your Tier 3 Preferred Brand, Tier 4 Non-Preferred Brand, Tier 5 Preferred Specialty Tier, and Tier 6 Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $285. During this stage, you pay $4 copay per prescription for drugs on Tier 1 Preferred Generic Drugs, $15 copay per prescription for drugs on Tier 2 Generic Drugs, $0 copay per prescription for drugs on Tier 6 Part D Vaccines; and the full cost of drugs on Tier 3 Preferred Brand Drugs, Tier 4 Non-Preferred Brand Drugs, and Tier 5 Specialty Tier until you have reached the yearly deductible.	The deductible is $250. During this stage, you pay $4 copay per prescription for drugs on Tier 1 Preferred Generic, $10 copay per prescription for drugs on Tier 2 Generic, $0 copay per prescription for drugs on Tier 7 Vaccines; and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Brand, Tier 5 Preferred Specialty Tier, and Tier 6 Specialty Tier until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 6, your cost sharing in the initial coverage stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2021 to 2022.

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 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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
For 2021, you paid a $0 copay per prescription for drugs on Tier 6. For 2022 you will pay $0 copay per prescription for the same drugs on Tier 7. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply 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.	**Tier 1 – Preferred Generic Drugs:** You pay a $4 copay per prescription. **Tier 2 – Generic Drugs:** You pay a $15 copay per prescription. **Tier 3 – Preferred Brand Drugs:** You pay a $47 copay per prescription. **Tier 4 – Non-Preferred Brand Drugs:** You pay a $100 copay per prescription. **Tier 5 – Specialty Tier Drugs:** You pay 28% of the total cost per prescription. **Tier 6 – Part D Vaccines:** You pay a $0 copay per prescription. **Tier 7 –** is not available	**Tier 1 – Preferred Generic:** You pay a $4 copay per prescription. **Tier 2 – Generic:** You pay a $10 copay per prescription. **Tier 3 – Preferred Brand:** You pay a $45 copay per prescription. **Tier 4 – Non-Preferred Brand:** You pay a $100 copay per prescription. **Tier 5 – Preferred Specialty Tier:** You pay 23% of the total cost per prescription. **Tier 6 – Specialty Tier:** You pay 28% of the total cost per prescription. **Tier 7 – Vaccines:** You pay a $0 copay per prescription.

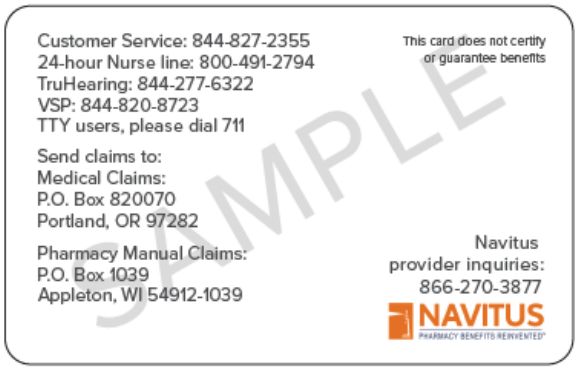
Stage	2021 (this year)	2022 (next year)
	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

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*.

SECTION 2 Administrative Changes

For 2022, our 24-hour Nurse line phone number is changing to 1-800-491-2794. Because of this change you will receive a new ID card to reflect this new 24-hour Nurse line phone number. Your new ID card will be sent to you the end of December. If you have any questions about your new ID card, please call Customer Service 1-844-827-2355. (TTY only, call 711). We are available for phone calls 7 a.m. to 8 p.m., Pacific Time, seven days a week, from October 1 through March 31, with the exceptions of Christmas Day and Thanksgiving Day, (After March 31, your calls will be handled by our automated phone system Saturdays, Sundays, and holidays.) See what the new ID card will look like:



Description	2021 (this year)	2022 (next year)
Dental Services (Non-Medicare covered)	Benefit allowance for out-of-network services based on billed charges.	Benefit allowance for out-of-network services is based on non-participating provider fee schedules, and may result in additional out of pocket costs.
New 24-hour Nurse Line	24-hour Nurse line through 12/31/2021 is 866-321-7580	Effective 1/1/2022 the new 24-hour Nurse line is 800-491-2794 You will receive a new ID card to reflect this new 24-hour Nurse line phone number

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Summit Health Value + Rx (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Summit Health Value + Rx (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change 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 5), or call Medicare (see Section 7.2).

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, Summit Health Plan, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Summit Health Value + Rx (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Summit Health Value + Rx (HMO).
- 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 7.1 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 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, 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 5 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 Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).

SHIBA 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. 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 1-800-722-4134. You can learn more about SHIBA by visiting their website (shiba.oregon.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **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 CAREAssist Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist at 1-800-805-2313.

SECTION 7 Questions?

Section 7.1 – Getting Help from Summit Health Value + Rx (HMO)

Questions? We're here to help. Please call Customer Service at 1-844-827-2355 (TTY only, call 711.) We are available for phone calls from 7 a.m. to 8 p.m., Pacific Time, seven days a week from October 1 through March 31, with the exceptions of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone systems Saturdays, Sundays and holidays.). 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 Summit Health Value + Rx (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.yoursummithealth.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 www.yoursummithealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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.

SUMMIT HEALTH

Customer Service - Contact Information		
Call	**844-827-2355** Calls to this number are free. Customer Service is available from 7 a.m. to 8 p.m., Pacific Time, seven days a week from October 1 through March 31, with the exception of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone systems Saturdays, Sundays and holidays.) Customer Service also has free language interpreter services available for non-English speakers.	
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. This number is available 24 hours a day, seven days a week.	
Fax	**855-466-7208** Attn: Summit Health Medicare Advantage	
Write	**Medical Requests** Summit Health Plan, Inc. Attn: Medicare Advantage P.O. Box 820070 Portland OR 97282 MedicalMedicare @yoursummithealth.com	**Pharmacy Requests** Summit Health Plan, Inc. Attn: Medicare Advantage PO Box 22859 Portland OR 97269 PharmacyMedicare @yoursummithealth.com
Website	**YourSummitHealth.com**	

Senior Health Insurance Benefits Assistance (SHIBA) (Oregon's SHIP) - Contact Information	
Senior Health Insurance Benefits Assistance (SHIBA) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.	
Call	1-800-722-4134
TTY	711
Write	SHIBA P.O. Box 14480 Salem OR 97309-0405
Website	shiba.oregon.gov

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

601 S.W. Second Ave.
Portland, OR 97204-3154

Important Summit Health Plan, Inc. information