2023 Summit Health Standard + Rx (HMO-POS)

Annual Notice of Changes

January 1 – December 31, 2023

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

This document gives you the details about the changes to your Medicare health care and prescription drug coverage from January 1 to December 31, 2023. 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 document.)

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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SUMMIT
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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 help you meet your health goals. Your benefits and premiums may change slightly from year to year to make this possible. These yearly changes are listed in this enclosed Annual Notice of Change (ANOC) document. We send this packet to our members shortly before the annual enrollment period (AEP), which is Oct. 15 - Dec. 7 each 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 us, toll-free, 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 exception of Thanksgiving Day and Christmas 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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 844-827-2355. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 844-827-2355. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 844-827-2355。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 844-827-2355。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 844-827-2355. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 844-827-2355. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 844-827-2355 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 844-827-2355. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 844-827-2355 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 844-827-2355. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 844-827-2355. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 844-827-2355 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 844-827-2355. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 844-827-2355. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 844-827-2355. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 844-827-2355. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、844-827-2355 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

SUMMIT HEALTH

Your Medicare Advantage resources for 2023

Thank you for being a Summit Health member. Below are the resources you need to understand your 2023 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, 2022.

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 Thanksgiving Day and Christmas 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 Standard + Rx (HMO-POS) offered by Summit Health Plan, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Summit Health Standard + Rx (HMO-POS). 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 www.yoursummithealth.com. (You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you:

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Summit Health Standard + Rx (HMO-POS).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Summit Health Standard + Rx (HMO-POS).
- If you recently moved into, currently live in, or just moved out of 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.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 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 exception of Thanksgiving Day and Christmas 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 Standard + Rx (HMO-POS)

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

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Summit Health Standard + Rx (HMO-POS) in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$99	$89
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.)	$5,100 when using your in-network benefit. $8,000 when using a combination of in-network and your Point-of-Service (POS) benefit.	$5,880 when using your in-network benefit. $8,990 when using a combination of in-network and your Point-of-Service (POS) benefit.
Doctor office visits	Primary care visits in-network: $10 copay per visit Primary care visits when using your POS benefit: 50% of the total allowed amount per visit Specialist visits in-network: $35 copay per visit Specialist visits when using your POS benefit: 50% of the total allowed amount per visit	Primary care visits in-network: $0 copay per visit Primary care visits when using your POS benefit: 50% of the total allowed amount per visit Specialist visits in-network: $35 copay per visit Specialist visits when using your POS benefit: 50% of the total allowed amount per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	Hospital stays in-network: $350 copay per day for days 1-5; $0 copay per day for days 6 & beyond Hospital stays when using your POS benefit: 50% of the total allowed amount	Hospital stays in-network: $350 copay per day for days 1-5; $0 copay per day for days 6 & beyond Hospital stays when using your POS benefit: 50% of the total allowed amount
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $200 (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: 24% of the total cost per prescription	Deductible: $185 (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: 25% of the total cost per prescription

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 6: 29% of the total cost per prescription • Drug Tier 7: $0 copay per prescription	• Drug Tier 6: 30% of the total cost per prescription • Drug Tier 7: $0 copay per prescription

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$99	$89
Summit Health Extra Care Monthly premium	$5 (Summit Health Extra Care is an optional supplemental benefit.)	$0 Covered as part of a combined supplemental benefit including routine chiropractic services, acupuncture, and naturopathic services with a 50% coinsurance up to a combined $500 benefit maximum for all covered services. Coinsurance applied to allowed amount/billed charges as applicable.

- 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

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	2022 (this year)	2023 (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.	$5,100 when using your in-network benefit $8,000 when using your Point-of-Service (POS) benefit	$5,880 when using your in-network benefit $8,990 when using your Point-of-Service (POS) benefit Once you have paid $5,880 out-of-pocket for covered services from in-network providers, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. Both in-network and out-of-network services count toward your out-of-pocket costs. If you see both in-network and out-of-network providers, or only out-of-network providers, your maximum out-of-pocket costs will be $8,990 for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.yoursummithealth.com. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory 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 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Acupuncture (supplemental)	Covered under the Extra Care optional supplemental benefit.	Covered as part of a combined supplemental benefit including routine chiropractic services, acupuncture, and naturopathic services with a 50% coinsurance up to a combined $500 benefit maximum for all covered services. Coinsurance applied to allowed amount/billed charges as applicable.
Chiropractic Services (supplemental)	Covered under the optional Extra Care supplemental benefit.	Covered as part of a combined supplemental benefit including routine chiropractic services, acupuncture, and naturopathic services with a 50% coinsurance up to a combined $500 benefit maximum for all covered services. Coinsurance applied to allowed amount/billed charges as applicable.

Cost	2022 (this year)	2023 (next year)
Dental Services (supplemental)	**In-Network** You pay $0 copay for comprehensive dental services. You have up to $500 combined annual allowance for other routine & comprehensive dental services. Preventive services do not apply to the combined benefit maximum. Referral is required for Medicare-covered comprehensive dental services. Services must be received from dental providers that have not opted out of or are precluded from Medicare.	**In-Network** You pay 20% of the total allowed amount for comprehensive dental services. You have up to $1,000 combined annual allowance for all routine (preventive & comprehensive) dental services. All services apply to the combined benefit maximum. No referral required for Medicare-covered comprehensive dental services. Services received from opted out dental providers are covered under supplemental dental. Precluded providers are still prohibited from plan payment.
	Out-of-Network You pay $0 copay of the total allowed amount for all routine (preventive & comprehensive) dental services. You have a combined benefit maximum of up to $500 per calendar year for preventive, diagnostic, and comprehensive dental services.	**Out-of-Network** You pay 50% of the total allowed amount for all routine (preventive & comprehensive) dental services. You have up to $1,000 combined annual allowance for all routine (preventive & comprehensive) dental services.
Emergency Services	**In- and Out-of-Network** You pay a $90 copay for each visit for Medicare-covered emergency services.	**In- and Out-of-Network** You pay a $95 copay for each visit for Medicare-covered emergency services.

Cost	2022 (this year)	2023 (next year)
Hearing Aids (supplemental)	**In-Network** You pay a $699 copay per aid for Flyte Advanced Hearing Aid Products offered by TruHearing $999 copay per aid for Flyte Premium Hearing Aid Products offered by TruHearing.	**In-Network** You pay a $599 copay per aid for Advanced Hearing Aid Products offered by TruHearing $899 copay per aid for Premium Hearing Aid Products offered by TruHearing.
Naturopathic Services (supplemental)	Covered under the optional Extra Care supplemental benefit.	Covered as part of a combined supplemental benefit including routine chiropractic services, acupuncture, and naturopathic services with a 50% coinsurance up to a combined $500 benefit maximum for all covered services. Coinsurance applied to allowed amount/billed charges as applicable.
Occupational Therapy Services	Prior authorization is required.	Prior authorization is not required.
Other Health Care Professionals (e.g., nurse practitioner; physician assistant)	**In-Network** You pay a $10 copay for services received in a PCP setting; $35 copay for services received in a Specialist setting for each Medicare-covered visit. Referral is only required for services received in a non-mental health Specialist setting.	**In-Network** You pay a $0 copay for services received in a PCP setting; $35 copay for services received in a Specialist setting for each Medicare-covered visit. No referral required.

Cost	2022 (this year)	2023 (next year)
Outpatient Blood Services	Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood, including storage and administration, are covered beginning with the first pint used. The 3 pint deductible only applies to the blood itself, not the storage and administration.	Three (3) pint deductible is waived. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need.
Physical & Speech Therapy Services	Prior authorization is required.	Prior authorization is not required.
Podiatry Services	Referral is required.	No referral required.
Primary Care Physician Visits	**In-Network** You pay a $10 copay for each Medicare-covered primary care doctor visit.	**In-Network** You pay a $0 copay for each Medicare-covered primary care doctor visit.
Pulmonary Rehabilitation Services (Medicare-covered)	**In-Network** You pay a $30 copay for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** You pay a $20 copay for each Medicare-covered pulmonary rehabilitation services visit.

Cost	2022 (this year)	2023 (next year)
Skilled Nursing Facility (SNF) Care	**In-Network** You pay a $0 copay per day for days 1-20 $165 copay per day for days 21-100 For days 101 and beyond: all costs beyond day 100 do not count toward your plan maximum out-of-pocket amount.	**In-Network** You pay a $0 copay per day for days 1-20 $175 copay per day for days 21-100 For days 101 and beyond: all costs beyond day 100 do not count toward your plan maximum out-of-pocket amount.
Specialist Visits	Referral is required.	No referral required.
Worldwide Emergency/Urgent Services	You pay a $90 copay for each emergency care visit worldwide.	You pay a $95 copay for each emergency care visit worldwide.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

We made changes to our Drug List, 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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.

Changes to Prescription Drug Costs

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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. If 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."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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 $200. During this stage, you pay: Tier 1 Preferred Generic - $4 copay per prescription Tier 2 Generic - $10 copay per prescription Tier 7 Vaccines - $0 copay per prescription You pay the full cost for drugs on these tiers: Tier 3 Preferred Brand Tier 4 Non-Preferred Brand Tier 5 Preferred Specialty Tier Tier 6 Specialty Tier until you have reached the yearly deductible.	The deductible is $185. During this stage, you pay: Tier 1 Preferred Generic - $4 copay per prescription Tier 2 Generic - $10 copay per prescription Tier 7 Vaccines - $0 copay per prescription You pay the full cost for drugs on these tiers: Tier 3 Preferred Brand Tier 4 Non-Preferred Brand Tier 5 Preferred Specialty Tier Tier 6 Specialty Tier until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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.** 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.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **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 24% of the total cost per prescription. **Tier 6 – Specialty Tier:** You pay a 29% of the total cost per prescription. **Tier 7 – Vaccines:** You pay a $0 copay per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **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 25% of the total cost per prescription. **Tier 6 – Specialty Tier:** You pay 30% of the total cost per prescription. **Tier 7 – Vaccines:** You pay a $0 copay per prescription.

Stage 2: Initial Coverage Stage (continued)	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Dental Services (supplemental)	Dental providers who have opted-out of Medicare are not eligible for payment under this plan.	Dental providers who have opted-out of Medicare are eligible for payment for supplemental dental benefits under this plan.

SECTION 3 Deciding Which Plan to Choose

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

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 Standard + Rx (HMO-POS).

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 2023 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 Standard + Rx (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Summit Health Standard + Rx (HMO-POS).
- 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.

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, 2023.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In 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).

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. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (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 800-805-2313.

SECTION 7 Questions?

Section 7.1 – Getting Help from Summit Health Standard + Rx (HMO-POS)

Questions? We're here to help. Please call Customer Service at 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 exception of Thanksgiving Day and Christmas Day. (After March 31, your call will be handled by our automated phone system, Saturdays, Sundays and holidays.) Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Summit Health Standard + Rx (HMO-POS). 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

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 2023*

Read the *Medicare & You 2023* handbook. Every 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 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.

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 Thanksgiving Day and Christmas 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	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.

SUMMIT HEALTH

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

Important Summit Health Plan, Inc. information