Freedom Blue PPO Distinct (PPO) offered by Highmark BCBSD Inc

Annual Notice of Changes for 2024

You are currently enrolled as a member of Freedom Blue PPO Distinct. 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 medicare.highmark.com. You may also call Member 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 2024 "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 2024* 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, 2023, you will stay in Freedom Blue PPO Prestige.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with Freedom Blue PPO Prestige.
- 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

- Please contact our Member Service number at 1-844-576-1246 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 call is free.
- This information is available in alternate formats 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 Freedom Blue PPO Prestige

- Highmark BCBSD Inc is a PPO plan with a Medicare contract. Enrollment in Highmark BCBSD Inc depends on contract renewal.
- When this document says "we," "us," or "our," it means Highmark BCBSD Inc. When it says "plan" or "our plan," it means Freedom Blue PPO Prestige.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Freedom Blue PPO Prestige in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$33.00	$39.00
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 2.2 for details.)	From **network** providers: $5,500 From **network and out-of-network** providers combined: $8,950	From **network** providers: $5,500 From **network and out-of-network** providers combined: $8,950
Doctor office visits	**Primary care visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit **Specialist visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit	**Primary care visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit **Specialist visits:** **Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit
Inpatient hospital stays	**Network:** $295 copay per admit **Out-of-Network:** $395 copay per admit	**Network:** $295 copay per admit **Out-of-Network:** $395 copay per admit
Part D prescription drug coverage	Deductible: $0	Deductible: $0

Cost	2023 (this year)	2024 (next year)
(See Section 2.5 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard* $7 copay *Preferred* $0 copay • Drug Tier 2: *Standard* $15 copay *Preferred* $0 copay • Drug Tier 3: *Standard* $47 copay *Preferred* $47 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: *Standard* $100 copay *Preferred* $100 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: *Standard* 33% coinsurance *Preferred* 33% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs.	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard* $7 copay *Preferred* $0 copay • Drug Tier 2: *Standard* $15 copay *Preferred* $0 copay • Drug Tier 3: *Standard* $47 copay *Preferred* $47 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: *Standard* $100 copay *Preferred* $100 copay You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: *Standard* 33% coinsurance *Preferred* 33% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
	• For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from Freedom Blue PPO Distinct to **Freedom Blue PPO Prestige**. You will receive additional information in early October.

If you decide to stay in this plan, you will receive a new identification card in December.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$33.00	$39.00

- 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 7 regarding "Extra Help" from Medicare.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

Cost	2023 (this year)	2024 (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.	$5,500	$5,500 Once you have paid $5,500 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 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.	$8,950	$8,950 Once you have paid $8,950 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.

Medicare requires all health plans to limit how much you pay out-of-pocket for 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.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at medicare.highmark.com. You may also call Member Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider/ Pharmacy 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 2024 *Provider/ 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 Member Service so we may assist.

Section 2.4 – 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	2023 (this year)	2024 (next year)
Dental Services - Routine and Supplemental Comprehensive	**In-Network:** You pay a $15 copay for an office visit (includes oral exam and routine cleaning) 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. Out-of-Network providers may balance bill for charges above the allowed amount. **In and Out-of-Network:** You pay 50% coinsurance with a maximum $3,500 allowance every year for: • Restorative services (fillings) - 1 every 24 months per tooth per surface • Endodontic therapy (root canal) - once per tooth per lifetime	**In-Network:** You pay a $0 copay for an office visit (includes oral exam, routine cleaning **and fluoride treatment**) every 6 months. You pay a $0 copay per dental x-ray once a year. You pay 40% coinsurance for comprehensive dental services. **Out-of-Network:** You pay 30% coinsurance of the total cost for preventive and 40% coinsurance of the total cost for comprehensive dental services. Out-of-Network providers may balance bill for charges above the allowed amount. **In and Out-of-Network:** You have a maximum $3,500 allowance (preventive and comprehensive combined) every year.

Cost	2023 (this year)	2024 (next year)
	• Single crowns, inlays and onlays - 1 per tooth in a 5 year period; repairs limited to 1 per tooth every 36 months • Prosthodonics (dentures) - 1 set of dentures, partials or bridges every 5 years • Extractions (erupted tooth or exposed root)	Comprehensive services: • Restorative services (fillings) - 1 every 24 months per tooth per surface • Endodontic therapy (root canal) - once per tooth per lifetime • Single crowns, inlays and onlays - 1 per tooth in a 5 year period; repairs limited to 1 per tooth every 36 months • Prosthodonics (dentures) - 1 set of dentures, partials or bridges every 5 years • Extractions (erupted tooth or exposed root) • Periodontics - non-surgical treatment of gum disease, includes scaling and root cleaning. Periodontal cleaning limited to 2 per calendar year
Diabetic Supplies	**In-Network:** Abbott and Lifescan glucometers, diabetic test strips, lancets, and an Abbott continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment	**In-Network:** Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott **and Dexcom** continuous glucose monitoring devices 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

Cost	2023 (this year)	2024 (next year)
	(DME) supplier (or via an exception process).	(DME) supplier (or via an exception process).
Emergency Care	**In and Out-of-Network:** You pay a $95 copay per visit.	**In and Out-of-Network:** You pay a $100 copay per visit.
Enhanced Disease Management	Spring Health and VIDA are not covered.	You pay nothing. Spring Health offers a mental and behavioral health care program with digital tools/ programs, coaching, and in-person and virtual clinical support to help members address a broad spectrum of behavioral health needs. VIDA offers a solution to treat and manage members with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). This program is only available using digital or smartphone technology. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. More information about these programs will be available January 2024.
In-Home Support Service	You pay nothing. Papa Pals matches young adults with seniors to provide assistance and companionship. Services include but are not	This benefit is not covered.

Cost	2023 (this year)	2024 (next year)
	limited to transportation (grocery shopping, medication pick up, and doctor's appointments), technical guidance, care gap reminders, light house help, light exercise and activity. Members are eligible for 36 hours per calendar year.	
Inpatient Hospital Care	The cost sharing for Inpatient Acute Hospital stays due to COVID-19 is waived for both in and out-of-network.	Inpatient Acute Hospital cost sharing (provided in the Summary Costs on page 4) will apply to stays due to COVID-19 for both in and out-of-network.
Meal benefit	**In and Out-of-Network:** You pay nothing for 2 meals/ day up to 14 days. Members will be eligible for the benefit upon discharge from an inpatient hospital stay to the home. The benefit must be activated within 30 days of discharge.	**In and Out-of-Network:** You pay nothing for 2 meals/ day up to 14 days. Members will be eligible for the benefit upon discharge from an inpatient hospital, **psychiatric hospital or skilled nursing facility** stay to the home. The benefit must be activated within 30 days of discharge.
Outpatient Lab/Diagnostic Tests	**In-Network:** You pay a $0 copay per service performed in a physician's office or freestanding lab and a $10 copay per service performed in an outpatient facility. **Out-of-Network:** You pay a $40 copay per service performed in a	**In-Network:** You pay a $0 copay per service performed in a physician's office or freestanding lab and a $0 copay per service performed in an outpatient facility. **Out-of-Network:** You pay a $40 copay per service performed in a physician's office,

Cost	2023 (this year)	2024 (next year)
	physician's office, freestanding lab or an outpatient facility.	freestanding lab or an outpatient facility.
Skilled Nursing Facility	**In-Network:** You pay a $0 copay for days 1 – 20. You pay a $196 copay per day for days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.	**In-Network:** You pay a $0 copay for days 1 – 20. You pay a $203 copay per day for days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.

Section 2.5 – 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," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, 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 Member Service for more information.

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. If you receive “Extra Help” and you haven’t received this insert by September 30, 2023, please call Member 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	2023 (this year)	2024 (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

	2023 (this year)	2024 (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. 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*. Most adult Part D vaccines are covered at no cost to you. 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 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 $15 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:*	Your cost for a one-month supply 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 $15 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:*

	2023 (this year)	2024 (next year)
	You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **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 $4,660, you will move to the next stage (the Coverage Gap Stage).	You pay $100 per prescription. *Preferred cost sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **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 $5,030, 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.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2023	2024
Part D mail order and retail long term supply	Tiers 1 to 4: you may get up to a 90-day supply	Tiers 1 and 2: You may get up to a 100-day supply

Description	2023	2024
		Tiers 3 and 4: You may get up to a 90-day supply
Part D **mail order** transition allowance	If a drug changes tiers or is eliminated from the "Drug List", a 90-day transition fill is available.	If a drug changes tiers or is eliminated from the "Drug List", a 31-day transition fill is available.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Freedom Blue PPO Prestige

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 Freedom Blue PPO Prestige.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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 2.1 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 2024* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

As a reminder, Highmark Blue Cross Blue Shield 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 Freedom Blue PPO Prestige.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Freedom Blue PPO Prestige.

- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member 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 5 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, 2024.

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, 2024, 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, 2024.

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 6 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 Delaware, the SHIP is called Delaware Medicare Assistance Bureau or DMAB.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. DMAB 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 DMAB at 1-800-701-0501. You can learn more about DMAB by visiting their website (insurance.delaware.gov/divisions/dmab/).

SECTION 7 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. 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 a.m. and 7 p.m., 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).
- **Help from your state's pharmaceutical assistance program.**Delaware has a program called Delaware Prescription Assistance Program (DPAP) 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.
- **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 Delaware Ryan White Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Delaware Division of Public Health at 1-302-744-1050.

SECTION 8 Questions?

Section 8.1 – Getting Help from Freedom Blue PPO Prestige

Questions? We're here to help. Please call Member Service at 1-844-576-1246. (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 *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for Freedom Blue PPO Prestige. 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 Member 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 8.2 – 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 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Benefits and/or benefit administration may be provided by or through the following entities which are independent licensees of the Blue Cross Blue Shield Association: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Qualified sign language interpreters
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711)。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 (TTY: 711)。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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711) 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 (TTY: 711). 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 (TTY: 711)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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711) 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 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 (TTY: 711). 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 (TTY: 711). 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 (TTY: 711). 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、(TTY: 711)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。

Notification of Availability of Electronic Materials

If you requested that the *Evidence of Coverage* or *Formulary* be mailed annually, you will receive them by the end of October.

Other plan documents you may find useful include:

- Provider/Pharmacy directory
- Summary of Benefits

Beginning October 1, 2023, you can visit medicare.highmark.com to view and download these documents.

Login to your Highmark account to download or request a printed copy. If you have not signed up yet, you can register at myhighmark.com. Click ***register*** to set up your profile.

Evidence of Coverage: Click **2024** ***Evidence of Coverage*** on your member home page or click Request printed copy of your Evidence of Coverage at the bottom of the website.

Formulary: Click ***Find a Prescription Drug*** at the bottom of the website.

Provider/Pharmacy Directory: Click ***Find a Provider*** or ***Find a Pharmacy*** at the bottom of the website.

Summary of Benefits: Click ***Resources*** on the top bar then ***View your plan benefits*** for your zip code. Select the ***Summary of Benefits*** under the specific plan (medicare.highmark.com/resources/medicare-library/plan-documents).

If you would prefer, you can call Member Service at the number on the back of your ID card to request a printed copy.

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