



Freedom Blue PPO Merit (PPO) offered by Highmark Senior Solutions Company

Annual Notice of Changes for 2025

You are currently enrolled as a member of **Freedom Blue PPO Merit**. 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 coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

- Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
 - Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for “Extra Help” from Medicare.
 - Think about whether you are happy with our plan.
- 2. COMPARE:** Learn about other plan choices
- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
 - Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.
- 3. CHOOSE:** Decide whether you want to change your plan
- If you don't join another plan by December 7, 2024, you will stay in Freedom Blue PPO Merit.
 - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Freedom Blue PPO Merit.
 - If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Service number at 1-888-459-4020 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 and audio.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Freedom Blue PPO Merit

- Highmark Senior Solutions Company is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in Highmark Senior Solutions Company depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means Highmark Senior Solutions Company. When it says “plan” or “our plan,” it means Freedom Blue PPO Merit.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Freedom Blue PPO Merit in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	\$0.00	\$0.00
Deductible	There is no deductible.	\$150, except for insulin furnished through an item of durable medical equipment.
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: \$8,300 From network and out-of-network providers combined: \$13,000	From network providers: \$8,300 From network and out-of-network providers combined: \$13,000
Doctor office visits	Primary care visits: Network: \$0 copay per visit Out-of-Network: \$0 copay per visit Specialist visits: Network: \$45 copay per visit Out-of-Network: \$65 copay per visit	Primary care visits: Network: \$0 copay per visit Out-of-Network: \$0 copay per visit Specialist visits: Network: \$45 copay per visit Out-of-Network: \$65 copay per visit
Inpatient hospital stays	Network: Days 1 - 5: \$455 copay per day per admit & Days 6 - 90: \$0 copay per day per admit Out-of-Network:	Network: Days 1 - 5: \$455 copay per day per admit & Days 6 - 90: \$0 copay per day per admit Out-of-Network:

Cost	2024 (this year)	2025 (next year)
	Days 1 - 5: \$550 copay per day per admit & Days 6 - 90: \$0 copay per day per admit	Days 1 - 5: \$550 copay per day per admit & Days 6 - 90: \$0 copay per day per admit
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$500 on Tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: <i>Standard</i> \$7 copay <i>Preferred</i> \$0 copay • Drug Tier 2: <i>Standard</i> \$20 copay <i>Preferred</i> \$10 copay • Drug Tier 3: <i>Standard</i> \$47 copay <i>Preferred</i> \$47 copay You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: <i>Standard</i> \$100 copay <i>Preferred</i> \$100 copay You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: <i>Standard</i> 25% coinsurance 	<p>Deductible: \$590 on Tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: <i>Standard</i> \$7 copay <i>Preferred</i> \$0 copay • Drug Tier 2: <i>Standard</i> \$20 copay <i>Preferred</i> \$10 copay • Drug Tier 3: <i>Standard</i> 21% coinsurance <i>Preferred</i> 21% coinsurance You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: <i>Standard</i> 21% coinsurance <i>Preferred</i> 21% coinsurance You pay \$35 per month supply of each covered insulin product on this tier.

Cost	2024 (this year)	2025 (next year)
	<p><i>Preferred</i> 25% coinsurance</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. 	<ul style="list-style-type: none"> Drug Tier 5: <p><i>Standard</i> 25% coinsurance</p> <p><i>Preferred</i> 25% coinsurance</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
<p>Monthly premium</p> <p>(You must also continue to pay your Medicare Part B premium.)</p>	\$0.00	\$0.00
<p>Part B Premium Reduction</p> <p>(If you pay a Part B premium, this amount is deducted through your Social Security payment.)</p>	\$85.00	\$76.00

- 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.

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

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.

Cost	2024 (this year)	2025 (next year)
<p>In-network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and deductible) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	\$8,300	\$8,300
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and deductible) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.</p>	\$13,000	\$13,000

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at [medicare.highmark.com](https://www.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 2025 Provider/Pharmacy Directory ([medicare.highmark.com](https://www.medicare.highmark.com)) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 Provider/Pharmacy Directory ([medicare.highmark.com](https://www.medicare.highmark.com)) 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 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	2024 (this year)	2025 (next year)
Plan Deductible	You do not have a plan level deductible.	<p>You pay a \$150 deductible</p> <p>Until you have paid the deductible amount, you must pay the full cost for most of your covered services.</p> <p>The deductible does not apply to preventive services (including in-network diagnostic mammograms and colonoscopies), in-network ambulance, emergency and urgent services, in-network diabetic supplies, in-network pcp and specialist visits, in-network Part B drugs and non-Medicare supplemental services such as routine dental, vision, hearing and transportation.</p> <p>For a full list of deductible exclusions, please see Chapter 4 of the <i>Evidence of Coverage</i>.</p> <p>Once you have paid your deductible, we will begin to pay our share of the costs for</p>

Cost	2024 (this year)	2025 (next year)
		covered medical services and you will pay your share for the rest of the calendar year.
Ambulance	<p>In-Network: You pay a \$300 copay per one-way trip for emergency and certified medically necessary non-emergency ambulance services</p> <p>Out-of-Network: You pay a \$300 copay per one-way trip for emergency services. You pay 30% coinsurance for certified medically necessary non-emergency services.</p>	<p>In-Network: You pay a \$215 copay per one-way trip for emergency and certified medically necessary non-emergency ambulance services</p> <p>Out-of-Network: You pay a \$215 copay per one-way trip for emergency services. You pay 30% coinsurance for certified medically necessary non-emergency services.</p>
Dental Services - Routine	<p>In-Network: You pay a \$0 copay for an office visit (includes oral exam, fluoride treatment and routine cleaning) every 6 months. You pay a \$0 copay per dental x-ray every year. You pay 20% coinsurance for comprehensive dental services.</p> <p>Out-of-Network: You pay 30% coinsurance of the total cost for preventive and 50% coinsurance of the total cost for comprehensive dental services.</p> <p>In and Out-of-Network: You have a maximum \$1,000 allowance (preventive and comprehensive combined) every year.</p>	<p>In-Network: You pay a \$0 copay for an office visit (includes oral exam, fluoride treatment and routine cleaning), 1 every 6 months and a \$0 copay for palliative care. A dental x-ray is included once a year with your office visit service.</p> <p>You pay 20% coinsurance for comprehensive dental services.</p> <p>Out-of-Network: You pay 30% coinsurance of the total cost for preventive and 50% coinsurance of the total cost for comprehensive dental services.</p> <p>In and Out-of-Network:</p>

Cost	2024 (this year)	2025 (next year)
	<p>Comprehensive services:</p> <ul style="list-style-type: none"> • Restorative services (fillings) - 1 every 2 years 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 • Prosthodontics (dentures) - 1 set of dentures, partials or bridges every 5 years • Extractions (simple, exposure of unerupted, 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 	<p>You have a maximum \$1,000 allowance (preventive and comprehensive combined) every year.</p> <p>Comprehensive services:</p> <ul style="list-style-type: none"> • Restorative services (fillings) - 1 every 2 years per tooth per surface • Endodontic therapy (root canal) - once per tooth per lifetime • Prosthodontics <ul style="list-style-type: none"> ◦ single crowns, inlays and onlays - 1 per tooth in a 5 year period; repairs limited to 1 per tooth every 36 months ◦ dentures - 1 set of dentures, partials or bridges every 5 years • Extractions (simple, exposure of unerupted, erupted tooth or exposed root) • Periodontics - non-surgical treatment of gum disease, includes scaling and root cleaning. Periodontal cleaning limited to 1 every 6 months

Cost	2024 (this year)	2025 (next year)
		<ul style="list-style-type: none"> Included with above are general services such as sedation/drugs to perform the procedure and occlusal adjustments
Emergency Care	<p>In and Out-of-Network: You pay a \$100 copay per visit.</p>	<p>In and Out-of-Network: You pay a \$110 copay per visit.</p>
Health & Wellness	<p>In-Network: Access to SilverSneakers - a program with network gyms and fitness classes.</p> <p>Out-of-Network: \$500 deductible then paid at 50% coinsurance for approved programs</p>	<p>Your plan provides a subscription to a fitness and health platform that gives you extra options - including access to a nationwide network of gyms, fitness studios, and community centers. This benefit also includes unlimited access to a digital library of at-home workouts, wellness and more. You will receive <u>32 credits</u> each month to use towards memberships/classes at these gyms and fitness facilities. Members must create an account online via mobile app or website and then select the fitness facility. You may also contact Member Service for assistance in creating an account. You will be responsible for all fees that exceed the monthly credit balance. Unused credits will not roll over to the following month.</p> <p>More information on how credits are used will be provided by January 2025.</p>

Cost	2024 (this year)	2025 (next year)
<p>Outpatient Occupational, Physical and Speech Therapy</p> <p>Telehealth services are available in-network only</p>	<p>In-Network:</p> <p>You pay a \$45 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a \$40 copay per provider, per day for occupational therapy services.</p> <p>Out-of-Network:</p> <p>You pay a \$55 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a \$50 copay per provider, per day for occupational therapy services.</p>	<p>In-Network:</p> <p>You pay a \$45 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a \$35 copay per provider, per day for occupational therapy services.</p> <p>Out-of-Network:</p> <p>You pay a \$55 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a \$50 copay per provider, per day for occupational therapy services.</p>
<p>Skilled Nursing Facility</p>	<p>In-Network:</p> <p>You pay a \$0 copay for days 1 – 20. You pay a \$203 copay per day for days 21-100.</p> <p>Out-of-Network:</p> <p>You pay 30% coinsurance of the total cost per admission.</p>	<p>In-Network:</p> <p>You pay a \$0 copay for days 1 – 20. You pay a \$214 copay per day for days 21-100.</p> <p>Out-of-Network:</p> <p>You pay 30% coinsurance of the total cost per admission.</p>
<p>Urgently Needed Care</p>	<p>In and Out-of-Network:</p> <p>You pay a \$50 copay per visit.</p>	<p>In and Out-of-Network:</p> <p>You pay a \$45 copay per visit.</p>
<p>Vision Care</p> <p>See Chapter 4 of the <i>Evidence Of Coverage</i> for further details on your vision benefits.</p>	<p>In-Network:</p> <p>You pay a \$45 copay for each Medicare-covered exam.</p> <p>You pay a \$0 copay for an annual routine exam.</p> <p>Out-of-Network:</p> <p>You pay a \$65 copay for each Medicare-covered exam.</p> <p>You pay a \$50 copay for an annual routine exam.</p>	<p>In-Network:</p> <p>You pay a \$45 copay for each Medicare-covered exam.</p> <p>You pay a \$0 copay for an annual routine exam.</p> <p>Out-of-Network:</p> <p>You pay a \$65 copay for each Medicare-covered exam.</p> <p>You pay a \$50 copay for an annual routine exam.</p>

Cost	2024 (this year)	2025 (next year)
	<p>In and Out-of-Network:</p> <p>You receive a \$100 allowance for non-Davis collection frames (with lenses) or contacts. The allowance is valid for a single purchase only.</p>	<p>In and Out-of-Network:</p> <p>You receive a \$150 allowance for non-Davis collection frames (with lenses) or contacts. The allowance is valid for a single purchase only.</p>

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

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website:

<https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>.

You may also contact Member Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert by September 30, 2024, please call Member Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	The deductible is \$500 on Tiers 3, 4 and 5	The deductible is \$590 on Tiers 3, 4 and 5
During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible. The deductible doesn’t apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	During this stage, you pay \$7 Standard or \$0 Preferred cost sharing for Preferred Generic drugs on Tier 1 and \$20 Standard or \$10 Preferred cost sharing for Generic drugs on Tier 2 and the full cost of drugs on Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug and Tier 5 - Specialty Drugs until you have reached the yearly deductible.	During this stage, you pay \$7 Standard or \$0 Preferred cost sharing for Preferred Generic drugs on Tier 1 and \$20 Standard or \$10 Preferred cost sharing for Generic drugs on Tier 2 and the full cost of drugs on Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug and Tier 5 - Specialty Drugs until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 3 Preferred Brand and Tier 4 Non-Preferred Drug, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2024 to 2025.

	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage	Your cost for a one-month supply is:	Your cost for a one-month supply is:
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.	Tier 1 Preferred Generic: <i>Standard cost sharing:</i> You pay \$7 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.	Tier 1 Preferred Generic: <i>Standard cost sharing:</i> You pay \$7 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.
For 2024 you paid a \$47 copayment for drugs on Tier 3 Preferred Brand and a \$100 copayment for drugs on Tier 4 Non-Preferred Drug. For 2025 you will pay 21% coinsurance on Tier 3 Preferred Brand and a 21% coinsurance on Tier 4 Non-Preferred Drug at a network pharmacy that provides standard cost sharing.	Tier 2 Generic: <i>Standard cost sharing:</i> You pay \$20 per prescription. <i>Preferred cost sharing:</i> You pay \$10 per prescription.	Tier 2 Generic: <i>Standard cost sharing:</i> You pay \$20 per prescription. <i>Preferred cost sharing:</i> You pay \$10 per prescription.
The costs in this chart are for a one-month (31-day) supply when you fill your prescription at a network pharmacy.	Tier 3 Preferred Brand: <i>Standard cost sharing:</i> You pay \$47 per prescription. <i>Preferred cost sharing:</i> You pay \$47 per prescription.	Tier 3 Preferred Brand: <i>Standard cost sharing:</i> You pay 21% of the total cost. <i>Preferred cost sharing:</i> You pay 21% of the total cost.
For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i> .	You pay \$35 per month supply of each covered insulin product on this tier. Tier 4 Non-Preferred Drug: <i>Standard cost sharing:</i> You pay \$100 per prescription. <i>Preferred cost sharing:</i> You pay \$100 per prescription.	You pay \$35 per month supply of each covered insulin product on this tier. Tier 4 Non-Preferred Drug: <i>Standard cost sharing:</i> You pay 21% of the total cost. <i>Preferred cost sharing:</i> You pay 21% of the total cost. You pay \$35 per month supply of each covered insulin product on this tier.

	2024 (this year)	2025 (next year)
<p>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.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 5 Specialty: <i>Standard cost sharing:</i> You pay 25% of the total cost.</p> <p><i>Preferred cost sharing:</i> You pay 25% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Tier 5 Specialty: <i>Standard cost sharing:</i> You pay 25% of the total cost.</p> <p><i>Preferred cost sharing:</i> You pay 25% of the total cost.</p> <hr/> <p>Once you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024	2025
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the

Description	2024	2025
		<p>year (January – December).</p> <p>To learn more about this payment option, please contact us at 1-866-845-1803 (24 hours a day, 7 days a week) or visit Medicare.gov.</p>
Member Service - Pharmacy	Not applicable	<p>For pharmacy benefit questions or concerns, call: 1-866-675-8637</p> <p>Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.</p>
Prior Authorization (for in-network services)	<p>Authorization required for:</p> <ul style="list-style-type: none"> • Partial Hospitalization • Outpatient Mental Health/Psychiatric services • Outpatient Substance Abuse/Opioid Treatment services • Outpatient Hospital Observation 	<p>Authorization requirement for services listed in 2024 column has been removed.</p> <p>Benefit categories that require authorization are marked with an asterisk (*) in the <i>Evidence of Coverage</i> Medical Benefits Chart (Chapter 4, Section 2.1)</p>

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Freedom Blue PPO Merit

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 Merit.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 Merit.
- 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 Merit.
- 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 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with 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, 2025, 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. West Virginia SHIP 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 the West Virginia SHIP at 1-877-987-4463. You can learn more about the West Virginia SHIP by visiting their website (www.wvship.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.

- **Prescription Cost Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the West Virginia ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call the West Virginia ADAP Customer Service line at 1-304-232-6822 or go to their website at <https://oeeps.wv.gov/rwp/pages/default.aspx>. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

“Extra Help” from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-888-459-4020 or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 7 Questions?

Section 7.1 – Getting Help from Freedom Blue PPO Merit

Questions? We're here to help. Please call Member Service at 1-888-459-4020. (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 2025 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for Freedom Blue PPO Merit. 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](https://www.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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.

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.

Tivity Health Inc., is a separate company that administers the SilverSneakers program. Davis Vision is a separate company. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

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 quý vị cần thông dịch viên xin gọi (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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。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。

Form CMS-10802 (Expires 12/31/25)

Form Approved OMB# 0938-1421

Notification of Availability of Electronic Materials

If you requested that the *Evidence of Coverage* or *Formulary* be mailed annually, you will receive them by October 15.

Other plan documents you may find useful include:

- Provider/Pharmacy directory
- Summary of Benefits
- Formulary

Beginning October 1, 2024, 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 **2025 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.