Vibra Health Plan Essential Advocate (PPO) offered by Vibra Health Plan Inc.

Annual Notice of Changes for 2021

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

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price

information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Vibra Health Plan Essential Advocate PPO.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by December 7, 2020, you will be enrolled in Vibra Health Plan Essential Advocate PPO.
- If you join another plan by **December 7, 2020,** your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-844-388-8268 for additional information. (TTY users should call 711). Hours are Monday through Friday, 8 a.m. to 8 p.m., with extended hours October 1 through March 31. After these hours, you may leave a message on our secure voice messaging system.
- This information may be available in different formats, including CD, and large print. Please call Member Services at the numbers listed above if you need plan information in another format.
- **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 Vibra Health Plan Essential Advocate PPO

- Vibra Health Plan Essential Advocate PPO is offered by Vibra Health Plan Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in Vibra Health Plan Essential Advocate PPO depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Vibra Health Plan Inc. When it says "plan" or "our plan," it means Vibra Health Plan Essential Advocate PPO.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Vibra Health Plan Essential Advocate PPO in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.VibraHealthPlan.com. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $6,700 From network and out-of-network providers combined: $10,000	From network providers: $6,700 From network and out-of-network providers combined: $10,000
Doctor office visits	**In-or Out-of-Network** Primary care visits: $5 copay per visit Specialist visits: $40 copay per visit	**In-or Out-of-Network** Primary care visits: $5 copay per visit Specialist visits: $40 copay per visit

Cost	2020 (this year)	2021 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-or Out-of-Network** $210 copay per day for days 1-8, per admission Our plan covers an unlimited number of medically necessary days for an inpatient hospital stay.	**In-or Out-of-Network** $235 copay per day for days 1-8, per admission Our plan covers an unlimited number of medically necessary days for an inpatient hospital stay.
Part D prescription drug coverage (See Section 1.6 for details.)	**Deductible:** $0 **Copayment or Coinsurance during the <u>Initial Coverage Stage:</u>** **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* $15 copay per prescription *Preferred cost-sharing:* $0 copay per prescription	**Deductible:** $0 **Copayment or Coinsurance during the <u>Initial Coverage Stage:</u>** **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* $15 copay per prescription *Preferred cost-sharing:* $0 copay per prescription

Cost	2020 (this year)	2020 (next year)
Part D prescription drug coverage *(continued)*	**Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* $20 copay per prescription *Preferred cost-sharing:* $0 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* $47 copay per prescription *Preferred cost-sharing:* $40 copay per prescription **Drug Tier 4 – Non Preferred Brand:** *Standard cost-sharing:* $100 copay per prescription *Preferred cost-sharing:* $93 copay per prescription **Drug Tier 5 – Specialty Drugs:** *Standard cost-sharing:* 33% of the total cost *Preferred cost-sharing:* 33% of the total cost	**Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* $20 copay per prescription *Preferred cost-sharing:* $0 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* $47 copay per prescription *Preferred cost-sharing:* $40 copay per prescription **Drug Tier 4 – Non Preferred Drugs:** *Standard cost-sharing:* $100 copay per prescription *Preferred cost-sharing:* $93 copay per prescription **Drug Tier 5 – Specialty Drugs:** *Standard cost-sharing:* 33% of the total cost *Preferred cost-sharing:* 33% of the total cost

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage *(continued)*	**Drug Tier 6 – Select Care Drugs:** *Standard cost-sharing:* $7 copay per prescription *Preferred cost-sharing:* $0 copay per prescription **Select Insulins** *Standard cost-sharing* Select Insulins **not** covered *Preferred cost-sharing* Select Insulins **not** covered	**Drug Tier 6 – Select Care Drugs:** *Standard cost-sharing:* $7 copay per prescription *Preferred cost-sharing:* $0 copay per prescription **Select Insulins** *Standard cost-sharing* $5 copay for a 30-day supply of Select Insulins *Preferred cost-sharing* $5 copay for a 30-day supply of Select Insulins To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are in Section 6.1).

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Vibra Health Plan Essential Advocate in 2021

On January 1, 2021, Vibra Health Plan Inc., will be combining Vibra Health Plan Essential PPO with one of our plans, Vibra Health Plan Essential Advocate PPO.

If you do nothing to change your Medicare coverage by December 7, 2020, we will automatically enroll you in our Vibra Health Plan Essential Advocate PPO. This means starting January 1, 2021, you will be getting your medical and prescription drug coverage through Vibra Health Plan Essential Advocate PPO. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change plans, you can do so between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in Vibra Health Plan Essential PPO and the benefits you will have on January 1, 2021, as a member of Vibra Health Plan Essential Advocate PPO. You will also receive a new member ID card in December 2020 that will have your new Vibra Health Plan Essential Advocate PPO information and group number that will be effective January 1, 2021. If you have questions about this change you can contact Member Services, the phone numbers are in Section 7.1.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

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

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

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700 **In-Network**	$6,700 **In-Network** Once you have paid $6,700 In-Network 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 does not count toward your maximum out-of-pocket amount.	$10,000 combined **In-and-Out-of-Network**	$10,000 combined **In-and-Out-of-Network** Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

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

2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

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

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

Section 2.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.VibraHealthPlan.com. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see

Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Expanded Telehealth Visits	**In- or Out-of-Network** Expanded telehealth visits are **not** covered (NOTE: expanded telehealth may be covered during a public health emergency (e.g., Covid-19).	**In- or Out-of-Network** You pay the following copay/coinsurance for telehealth services when a provider is able to offer telehealth visits as an alternative to face to face office visits: $5 copay – PCP visits $40 copay – Specialist visit $0 copay – Preventive visits (includes annual wellness visit, diabetic education) $40 copay – Mental health visits (Individual or Group), including psychiatric visits $40 copay – Substance abuse visits (Individual or Group) 20% coinsurance of the total cost for dialysis services *NOTE:* You may also use our Amwell Virtual benefit to obtain remote office visits for $0 copay. Refer to the *Evidence of Coverage* for additional information.
Ambulance Services Includes ground and air ambulance services	**In-or Out-of-Network** You pay $225 copay per one way trip in an ambulance	**In-or Out-of-Network** You pay $250 copay per one way trip in an ambulance

Cost	2020 (this year)	2021 (next year)
Inpatient Hospital Stays Includes inpatient acute, inpatient rehabilitation, long -term care hospitals, and other types of inpatient hospital services.	**In-or Out-of-Network** You pay $210 copay per day for days 1-8, per admission Our plan covers an unlimited number of medically necessary days for an inpatient hospital stay.	**In-or Out-of-Network** You pay $235 copay per day for days 1-8, per admission Our plan covers an unlimited number of medically necessary days for an inpatient hospital stay.
Inpatient Hospital Mental Health Care Covered services include mental health care services requiring a hospital stay.	**In-or Out-of-Network** You pay $205 copay per day for days 1-8, per admission	**In-or Out-of-Network** You pay $225 copay per day for days 1-8, per admission
Outpatient Lab Services	**In-or Out-of-Network** You pay $15 copay for lab services, per visit	**In-or Out-of-Network** You pay $25 copay for lab services, per visit
Outpatient Hospital Surgery	**In-or Out-of-Network** You pay $325 copay, per surgery in an outpatient hospital	**In-or Out-of-Network** You pay $350 copay, per surgery in an outpatient hospital
Outpatient Substance Abuse Visits (Individual & Group)	**In-or Out-of-Network** You pay $50 copay per substance abuse visit	**In-or Out-of-Network** You pay $40 copay per substance abuse visit
Over The Counter (OTC) Items – Monthly Allowance OTC items/supplies must be purchased through Medline. You can place OTC orders by calling the toll-free number, using the website, or mailing a catalog order form.	**In- and Out-of-Network** You receive a $30 OTC allowance per month Unused OTC balance does not carry over to the next month	**In- and Out-of-Network** You receive a $25 OTC allowance per month Unused OTC balance does not carry over to the next month

Cost	2020 (this year)	2021 (next year)
Over The Counter (OTC) Items *(continued)*	The OTC allowance does not apply to the maximum out-of-pocket	The OTC allowance does not apply to the maximum out-of-pocket
Skilled Nursing Facility (SNF) Our plan uses benefit period for skilled nursing stays. A benefit period begins the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient or SNF care for 60 days in a row.	**In- and Out-of-Network** You pay: $0 copay per day for days 1-20 $172 copay per day for days 21-100 Copays are applied per admission. 100 days covered per benefit period	**In- and Out-of-Network** You pay: $0 copay per day for days 1-20 $184 copay per day for days 21-100 Copays are applied per admission. 100 days covered per benefit period
Worldwide Coverage	**In- and Out-of-Network** You pay a $90 copay for worldwide emergency room visits You pay a $65 copay for worldwide urgently needed care visits There is a $2,500 combined plan maximum for emergency and urgently need care. Once the plan maximum is met, you are responsible for all worldwide emergency or urgent care services.	**In- and Out-of-Network** You pay a $90 copay for worldwide emergency room visits You pay a $65 copay for worldwide urgently needed care visits There is a $20,000 combined plan maximum for emergency and urgently need care. Once the plan maximum is met, you are responsible for all worldwide emergency or urgent care services.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

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

If you are a current member of the plan, and one of your drugs will no longer be covered, you should work with your doctor (or other prescriber) to find an appropriate alternative therapy on our new formulary. If there is no appropriate alternative therapy available, you can request a formulary exception beginning December 1, 2020. For more information, please see Chapter 9 of your *Evidence of Coverage* or call Member Services.

If you currently have a formulary exception in place, the plan will allow you to continue to receive your drug for the length of time indicated in your formulary exception approval letter. Please be aware that you may be responsible for a different cost share than you were paying last year.

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.

Starting in 2021, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may 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.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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

Changes to Prescription Drug Costs

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

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.VibraHealthPlan.com. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2020 (this year)	2021 (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 (30-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. 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: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $15 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $20 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay $15 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $20 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription

Stage 2: Initial Coverage Stage *(continued)*	**Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $40 copay per prescription **Drug Tier 4 – Non-Preferred Brand:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $93 copay per prescription **Drug Tier 5 – Specialty Drugs:** *Standard cost-sharing:* You pay 33% coinsurance of the total cost *Preferred cost-sharing:* You pay 33% coinsurance of the total cost **Drug Tier 6 - Select Care Drugs:** *Standard cost-sharing:* You pay $7 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription	**Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $40 copay per prescription **Drug Tier 4 – Non-Preferred Drugs:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $93 copay per prescription **Drug Tier 5 – Specialty Drugs:** *Standard cost-sharing:* You pay 33% coinsurance of the total cost *Preferred cost-sharing:* You pay 33% coinsurance of the total cost **Drug Tier 6 - Select Care Drugs:** *Standard cost-sharing:* You pay $7 copay per prescription *Preferred cost-sharing:* You pay $0 copay per prescription

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage *(continued)*	**Select Insulins** *Standard cost-sharing* Select Insulins **not** covered *Preferred cost-sharing* Select Insulins **not** covered Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	**Select Insulins** *Standard cost-sharing* You pay $5 copay for a 30-day supply of Select Insulins *Preferred cost-sharing* You pay $5 copay for a 30-day supply of Select Insulins Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

NOTE: Vibra Health Plan Essential Advocate PPO offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be a $5 copay for a 30-day supply.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Vibra Health Plan Essential Advocate PPO

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 Vibra Health Plan Essential Advocate PPO.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

As a reminder, Vibra 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 Vibra Health Plan Essential Advocate PPO.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Vibra Health Plan Essential Advocate PPO.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 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, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare

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

APPRISE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. APPRISE counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (www.aging.state.pa.us).

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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called PACE that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Pennsylvania Department of ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Pennsylvania Department of Health at 1-977-PA-HEALTH (1-877-724-3258).

SECTION 7 Questions?

Section 7.1 – Getting Help from Vibra Health Plan Essential Advocate PPO

Questions? We're here to help. Please call Member Services at 1-844-388-8268. (TTY only, call 711). We are available for phone calls Monday through Friday, 8 a.m. to 8 p.m., with extended hours October 1 through March 31. After these hours, you may leave a message on our secure voice messaging system. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Vibra Health Plan Essential Advocate PPO. 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.VibraHealthPlan.com. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.VibraHealthPlan.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2021*

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2022.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This information is not a complete description of benefits. Call 1-844-388-8268 (TTY: 711) for more information.