Provider Partners Pennsylvania Community Plan (HMO I-SNP) offered by Provider Partners Health Plans

Annual Notice of Changes for 2022

You are currently enrolled as a member of Provider Partners Pennsylvania Community Plan. Next year, there will be some changes to the plan's costs and benefits. This booklet tells about the changes.

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You 2022 handbook.
- Look in Section 3.2 to learn more about your choices.

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

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

- If you don't join another plan by December 7, 2021, you will be enrolled in Provider Partners Pennsylvania Community Plan.
- To change to a **different plan** that may better meet your needs, 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 Services number at 1-800-405-9681 for additional information. (TTY users should call 711). Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.
- This material may be available in an alternate format (e.g., braille, large print, etc).
- **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 Provider Partners Pennsylvania Community Plan

- Provider Partners Pennsylvania Community Plan is a Health Maintenance Organization (HMO)Special Needs Plan (SNP) with a Medicare contract. Enrollment in Provider Partners Medicare Advantage Plan depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Provider Partners Health Plans. When it says “plan” or “our plan,” it means Provider Partners Pennsylvania Community Plan.

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Provider Partners Pennsylvania Community Plan 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.pphealthplan.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$37.50	$40.70
Deductible	$203	$233
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$7,550	$7,550
Doctor office visits	Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit	Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit

Cost	2021 (this year)	2022 (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.	$1,484 deductible for each benefit period. Days 1-60: $0 copay per day for each benefit period. Days 61-90: $371 copay per day for each benefit period. Days 91 and beyond: $742 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs.	$1,556 deductible for each benefit period. Days 1–60 $0 copay for each benefit period. Days 61–90: $389 copay per day of each benefit period. Days 91 and beyond: $778 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $445 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25%	Deductible: $480 Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25%

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SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$37.50	$40.70

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550 Only In-Network Medicare-covered benefits and associated costs apply to your Maximum Out-Of-Pocket Coverage.	$7,550 Once you have paid $7,550 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year. In Network Medicare-covered benefits, Non-Medicare-covered supplemental benefits and associated costs apply to your Maximum Out of Pocket Coverage.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.pphealthplan.com/provider-directory. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2022 Evidence of Coverage.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Additional Telehealth Services	Prior authorization is required.	No prior authorization is required.

Cost	2021 (this year)	2022 (next year)
Chiropractic Services	Prior authorization is required.	No prior authorization is required.
Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	Prior authorizations are required for billed charges in excess of $500.	No prior authorization is required.
Dialysis Services	Prior authorization is required.	No prior authorization is required.
Medicare Part B Rx Drugs and Home Infusion Drugs	Prior authorization is required for billed charges in excess of $500.	Prior authorization is required for billed charges in excess of $1,500.
Outpatient Blood Services	Prior authorization is required.	No prior authorization is required.
Outpatient Diagnostic and Therapeutic Radiological Services	Prior authorization is required for a CT scan.	Prior authorization is not required for a CT scan.
Outpatient Hospital Services	Prior authorization is required for Medicare-covered Outpatient Hospital Services. Prior authorization is required for Medicare -covered Observation Services.	No prior authorization is required for Medicare-covered Outpatient Hospital Services. No prior authorization is required for Medicare-covered Observation Services.
Podiatry Services	You pay $20 copay for up to 4 visits every year.	You pay $0 copay for up to 6 visits every year.

Cost	2021 (this year)	2022 (next year)
Special Supplemental Benefits for the Chronically Ill	The Plan did not cover this benefit.	You pay $0 for the companion support program which provides emotional support and socialization by pairing a member with a compatible companion or K9 companion. This can include one on one support or in a group setting. Companion visits are limited to 1 hour a month.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **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.

In order to prevent coverage gaps, the plan will provide up to a 30-day supply (or 31-day supply in the long-term care setting) of the requested Part D covered non-formulary prescription drug or the formulary prescription drug that is subject to new prior authorization, step therapy requirements or more restrictive quantity limits when you had a prescription for the medication filled within the past 120 days (this look-back period may vary for some classes of medications) from the date of the attempted fill. The plan will send you a notice saying that you must either switch to a drug on the Provider Partners Pennsylvania Community Plan formulary or get an exception (Coverage Determination) to continue taking the non-formulary medication.

We will apply the transition policy across years should you enroll into Provider Partners Pennsylvania Community Plan with an effective enrollment date of either October 1, November 1, or December 1 and need access to a transition supply. In addition, we will send enrollees with an October 1, November 1 or December 1 effective enrollment date an ANOC as soon as possible after the effective enrollment date to serve as advance notice of any formulary or benefit changes in the following contract year.

If you do not switch plans for calendar year 2022 and you are on a drug as a result of a granted exception in the 2021 plan year, you may possibly be able to continue to receive that exception into the 2022 plan year. Should Provider Partners Pennsylvania Community Plan choose not to honor the exception beyond the end of the 2021 plan year, the plan will notify you in writing at least 60 days before the end of the current plan year and will do either of the following:
1)Offer to process a prospective exception request for the next plan year, or
2)Provide you with a temporary supply of the requested prescription drug at the beginning of the plan year and then provide you with notice that you must either switch to a therapeutically appropriate drug on the formulary or get an exception to continue taking the requested drug.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We 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. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021, 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.pphealthplan.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your drugs until you have reached the yearly deductible.	The deductible is $445.	The deductible is $480.

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	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. The number of days in a one-month supply has changed from 2021 to 2022 as noted in the chart. 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.	Your cost for a 30-day supply filled at a network pharmacy with standard cost sharing: **Tier 1:** You pay 25% of the total cost. Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a 31-day supply filled at a network pharmacy with standard cost sharing: **Tier 1:** You pay 25% of the total cost. Once your total drug costs have reached $4,430 you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Provider Service Phone number change	The Provider Service phone number is 1-800-405-9681. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.	The Provider Service phone number is 1-855-969-5907. (TTY users should call 711.) Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.
Electronic Funds Transfer withdraw date	Payments will be deducted approximately on the 15th day of each month.	Payments will be deducted approximately on the 25th day of each month
Appeals & Grievances Submission Fax number	The fax number is 844-593-6221.	The fax number is 888-918-2989.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Provider Partners Pennsylvania Community Plan

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 Provider Partners Pennsylvania Community Plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, read the Medicare & You 2022 handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

As a reminder, Provider Partners 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 Provider Partners Pennsylvania Community Plan.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Provider Partners Pennsylvania Community Plan.
- 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 7.1 of this booklet).
    - – or – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

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

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

You can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania the SHIP is called Pennsylvania Medicare Education and Decision Insight – PA MEDI.

PA MEDI is an 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. PA MEDI 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 PA MED at 1-800-783-7067. You can learn more about PA MEDI by visiting their website www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE), PACE Needs Enhancement Tier (PACENET), and Mental Health Department of Public Welfare Special Pharmaceutical Benefits Program (SPBP) 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 5 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 Community AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

SPBP HIV/AIDS
Department of Public Welfare
Special Pharmaceutical Benefits Program
Harrisburg, PA 17105
(800)433-4459 Toll Free

SECTION 7 Questions?

Section 7.1 – Getting Help from Provider Partners Pennsylvania Community Plan

Questions? We're here to help. Please call Member Services at 1-800-405-9681. (TTY only, call 711). We are available for phone calls from 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30. Calls to these numbers are free.

Read your 2022 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 Evidence of Coverage for Provider Partners Pennsylvania Community Plan. 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.pphealthplan.com. 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.pphealthplan.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read Medicare & You 2022

You can read the Medicare & You 2022 handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.