HIGHMARK® SENIOR SOLUTIONS COMPANY

Complete Blue PPO Distinct (PPO) offered by Highmark Senior Solutions Company

Annual Notice of Change for 2026

You're enrolled as a member of **Freedom Blue PPO Distinct (PPO)**.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Complete Blue PPO Distinct (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at medicare.highmark.com or call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) to get a copy by mail.

More Resources

- Call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) for more information. 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.

About Complete Blue PPO Distinct (PPO)

- 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 material says "we," "us," or "our," it means Highmark Senior Solutions Company. When it says "plan" or "our plan," it means Complete Blue PPO Distinct (PPO).

- On January 1, 2026, our plan name will change from Freedom Blue PPO Distinct (PPO) to Complete Blue PPO Distinct (PPO). We'll send you a new member ID card with our new name. From here on, our new name, Complete Blue PPO Distinct (PPO), will be on all materials.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Complete Blue PPO Distinct (PPO)**. Starting January 1, 2026, you'll get your medical and drug coverage through *Complete Blue PPO Distinct (PPO)*. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$14	**$24**
Deductible	You do not have a Deductible.	**You do not have a Deductible.**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $5,700 From network and out-of-network providers combined: $9,550	**From network providers: $6,750** **From network and out-of-network providers combined: $9,550**
Primary care office visits	**Network:** $0 copay per visit. **Out-of-Network:** $0 copay per visit.	**Network:** **$0 copay per visit.** **Out-of-Network:** **40% coinsurance per visit.**
Specialist office visits	**Network:** $20 copay per visit. **Out-of-Network:** $25 copay per visit.	**Network:** **$25 copay per visit.** **Out-of-Network:** **40% coinsurance per visit.**
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**Network:** $375 copay per admit. **Out-of-Network:** $500 copay per admit.	**Network:** **Days 1 - 3: $195 copay per day per admit & Days 4 - 90: $0 copay per day per admit.** **Out-of-Network:** **Days 1 - 4: $500 copay per day per admit & Days 5 - 90: $0 copay per day per admit.**

	2025 (this year)	2026 (next year)
Part D drug coverage deductible (Go to Section 1.7 for details.)	You do not have a Part D Drug Deductible.	**$615, except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: *Standard* $7 copay *Preferred* $0 copay • Drug Tier 2: *Standard* $15 copay *Preferred* $0 copay • Drug Tier 3: Standard 25% coinsurance Preferred 25% coinsurance You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: Standard 50% coinsurance Preferred 50% coinsurance You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: *Standard* 33% coinsurance *Preferred* 33% coinsurance Catastrophic Coverage:	**Copayment/Coinsurance during the Initial Coverage Stage:** • **Drug Tier 1:** ***Standard* $7 copay** ***Preferred* $0 copay** • **Drug Tier 2:** ***Standard* $15 copay** ***Preferred* $0 copay** • **Drug Tier 3:** ***Standard* 20% coinsurance** ***Preferred* 20% coinsurance** **You pay $35 per month supply of each covered insulin product on this tier.** • **Drug Tier 4:** ***Standard* 25% coinsurance** ***Preferred* 25% coinsurance** **You pay $35 per month supply of each covered insulin product on this tier.** • **Drug Tier 5:** ***Standard* 25% coinsurance**

	2025 (this year)	2026 (next year)
	• During this payment stage, you pay nothing for your covered Part D drugs.	***Preferred*** **25% coinsurance** **Catastrophic Coverage Stage:** • **During this payment stage, you pay nothing for your covered Part D drugs.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$14	**$24**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

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. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount	$5,700	**$6,750**

	2025 (this year)	2026 (next year)
Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.		**Once you've paid $6,750 out of pocket for covered Part A and Part B services, you'll 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 copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$9,550	**$9,550** **Once you've paid $9,550 out of pocket for covered Part A and Part B services, you'll 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 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the *2026 Provider Directory* medicare.highmark.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at medicare.highmark.com.
- Call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) for help.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the *2026 Pharmacy Directory* medicare.highmark.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at medicare.highmark.com.
- Call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture	**In-Network:** You pay a $25 copay per Medicare-covered visit. **Out-of-Network:** You pay a $30 copay per Medicare-covered visit.	**In-Network:** You pay a $20 copay per Medicare-covered visit. **Out-of-Network:** You pay 40% coinsurance per Medicare-covered visit.
Advanced Imaging	**In-Network:** You pay a $200 copay. **Out-of-Network:** You pay a $350 copay.	**In-Network:** You pay a $200 copay. **Out-of-Network:** You pay 40% coinsurance per visit.

	2025 (this year)	2026 (next year)
Cardiac Rehabilitation Services and Supervised Exercise Therapy (SET)	**In-Network:** You pay a $0 copay per cardiac rehabilitation service and supervised exercise therapy. **Out-of-Network:** You pay 30% coinsurance per cardiac rehabilitation service and supervised exercise therapy.	**In-Network:** You pay a $0 copay per cardiac rehabilitation service and supervised exercise therapy. **Out-of-Network:** You pay 40% coinsurance per cardiac rehabilitation service and supervised exercise therapy.
Chiropractic Care	**In-Network:** You pay a $15 copay per routine and Medicare-covered visit. **Out-of-Network:** You pay a $30 copay per routine and Medicare-covered visit. **In and Out-of-Network:** Routine (up to 8 visits per year) only covers maintenance manual manipulation of the spine.	**In-Network:** You pay a $15 copay per routine and Medicare-covered visit. **Out-of-Network:** You pay 40% coinsurance per routine and Medicare-covered visit. **In and Out-of-Network:** Routine (up to 8 visits per year) only covers maintenance manual manipulation of the spine.
Dental Services - Routine	**In-Network:** You pay a $0 copay for an office visit (includes oral exam, fluoride treatment and routine cleaning), 1 every 6 months. You pay a $0 copay for a dental x-ray once a year. **Out-of-Network:** You pay 30% coinsurance of the total cost for preventive dental services.	**In-Network:** You pay a $0 copay for an office visit (includes oral exam, fluoride treatment and routine cleaning), **2 every year**. You pay a $0 copay for a dental x-ray once a year. **Out-of-Network:** You pay 30% coinsurance of the total cost for preventive dental services.

	2025 (this year)	2026 (next year)
Dental Services - Comprehensive	**In-Network:** You pay 10% coinsurance for comprehensive dental services and a $0 copay for palliative care. **Out-of-Network:** You pay 50% coinsurance of the total cost for comprehensive dental services. **In and Out-of-Network:** You have a maximum $2,500 allowance (preventive and comprehensive combined) every year. Comprehensive services: • Restorative services (fillings) - 1 every 2 years per tooth per surface • Endodontic therapy (root canal) - once per tooth per lifetime • Prosthodontics ◦ 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	**In-Network:** You pay 10% coinsurance for comprehensive dental services and a $0 copay for palliative care. **Out-of-Network:** You pay 50% coinsurance of the total cost for comprehensive dental services. **In and Out-of-Network:** You have a maximum $2,500 allowance (preventive and comprehensive combined) every year. Comprehensive services: • Restorative services (fillings) - 1 every 2 years per tooth per surface • Endodontic therapy (root canal) - once per tooth per lifetime • Prosthodontics ◦ 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

	2025 (this year)	2026 (next year)
	• Extractions (simple, exposure of unerupted, erupted tooth or exposed root) • Periodontics - non-surgical treatment of gum disease, includes 1 scaling and root planing every 36 months per area of mouth. Periodontal cleaning limited to 1 every 6 months • Included with above are general services such as sedation/drugs to perform the procedure and occlusal adjustments	• Extractions (simple, exposure of unerupted, erupted tooth or exposed root) • Periodontics - non-surgical treatment of gum disease, includes 1 scaling and root planing every 36 months per area of mouth. Periodontal cleaning limited to **2 every year** • Included with above are general services such as sedation/ drugs to perform the procedure and occlusal adjustments
Diabetic Supplies and Services (Part B)	**In-Network:** You pay 0% coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott® and Dexcom®, 20% coinsurance for all other covered diabetic supplies. **Out-of-Network:** You pay 30% coinsurance of the total cost.	**In-Network:** You pay 0% coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott® and **Trividia®**, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott® and Dexcom®, 20% coinsurance for all other covered diabetic supplies. **Out-of-Network:** You pay 40% coinsurance of the total cost.

	2025 (this year)	2026 (next year)
Durable Medical Equipment	**In-Network:** You pay 20% coinsurance of the total cost. **Out-of-Network:** You pay 30% coinsurance of the total cost.	**In-Network:** You pay 0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items. **Out-of-Network:** You pay 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items.
Emergency Care	**In and Out-of-Network:** You pay a $125 copay per visit.	**In and Out-of-Network:** You pay a $130 copay per visit.
Health & Wellness	**In-network and Out-of-network** There is no fee to access SilverSneakers - a program with network gyms and fitness classes.	**In-Network:** There is no fee to access SilverSneakers - a program with network gyms and fitness classes. **Out-of-Network:** $500 deductible then paid at 50% coinsurance for approved programs.
Inpatient Hospital Care	**In-Network:** You pay a $375 copay per admit. **Out-of-Network:** You pay a $500 copay per admit.	**In-Network:** You pay Days 1 - 3: $195 copay per day per admit & Days 4 - 90: $0 copay per day per admit. **Out-of-Network:** You pay Days 1 - 4: $500 copay per day per admit &

	2025 (this year)	2026 (next year)
		Days 5 - 90: $0 copay per day per admit.
Intensive Outpatient Program Services	This benefit is not covered.	**In-Network:** You pay a $0 copay per day. **Out-of-Network:** You pay 40% coinsurance per day.
Outpatient Lab/Diagnostic Tests	**In-Network:** You pay a $0 copay per service performed in a physician's office or freestanding lab and a $0 copay per service performed in an outpatient facility. **Out-of-Network:** You pay a $20 copay per service performed in a physician's office, freestanding lab or an outpatient facility.	**In-Network:** You pay a $0 copay per service performed in a freestanding lab and a $10 copay per service performed in a physician's office or outpatient facility. **Out-of-Network:** You pay a 40% coinsurance per service performed in a physician's office, freestanding lab or an outpatient facility.
Outpatient Mental Health/ Psychiatric (Individual and Group)	**In-Network:** You pay a $40 copay for each individual or group therapy visit. **Out-of-Network:** You pay $50 copay for each individual or group therapy visit.	**In-Network:** You pay a $40 copay for each individual or group therapy visit. **Out-of-Network:** You pay 40% coinsurance for each individual or group therapy visit.
Outpatient Occupational, Physical and Speech Therapy	**In-Network:** You pay a $25 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a $25 copay per provider,	**In-Network:** You pay a $20 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a $20 copay per provider, per day for

	2025 (this year)	2026 (next year)
	per day for occupational therapy services. **Out-of-Network:** You pay a $30 copay per therapy type, per provider, per day for physical and speech therapy services. You pay a $30 copay per provider, per day for occupational therapy services.	occupational therapy services. **Out-of-Network:** You pay 40% coinsurance per therapy type, per provider, per day for physical, speech and occupational therapy services.
Outpatient Substance Abuse (Individual and Group - includes Opioid Treatment)	**In-Network:** You pay a $40 copay for each individual or group therapy visit for substance abuse services and a $40 copay for opioid treatments. **Out-of-Network:** You pay a $50 copay for each individual or group therapy visit for substance abuse and opioid treatments.	**In-Network:** You pay a $40 copay for each individual or group therapy visit and a $40 copay for opioid treatments. **Out-of-Network:** You pay 40% coinsurance for each individual or group therapy visit substance abuse and opioid treatments.
Over-the-Counter (OTC) Allowance	$75 allowance per quarter for over-the counter drugs and other items.	$40 allowance per quarter for over-the counter drugs and other items.
Partial Hospitalization	**In-Network:** You pay a $0 copay per day. **Out-of-Network:** You pay 30% coinsurance per day.	**In-Network:** You pay a $0 copay per day. **Out-of-Network:** You pay 40% coinsurance per day.
Podiatry Care	**In-Network:** You pay a $20 copay per routine visit and a $20 copay per Medicare-covered visit. **Out-of-Network:**	**In-Network:** You pay a $25 copay per routine visit and a $25 copay per Medicare-covered visit. **Out-of-Network:**

	2025 (this year)	2026 (next year)
	You pay a $25 copay per routine and Medicare-covered visit.	You pay 40% coinsurance per routine and Medicare-covered visit.
Primary Care Physician (PCP)	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay a $0 copay per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay 40% coinsurance per visit.
Pulmonary Rehabilitation Services	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay a 30% coinsurance per visit.	**In-Network:** You pay a $0 copay per visit. **Out-of-Network:** You pay a 40% coinsurance per visit.
Radiation Therapy	**In-Network:** You pay a $60 copay per visit. **Out-of-Network:** You pay a $75 copay per visit.	**In-Network:** You pay a $60 copay per visit. **Out-of-Network:** You pay 40% coinsurance per visit.
Remote Access Technologies: Nursing Hotline	This benefit is not covered.	**In-Network:** You pay $0 copay per visit. **Out-of-Network:** You pay 40% coinsurance per visit.
Skilled Nursing Facility	**In-Network:** You pay a $0 copay for days 1 – 20. You pay a $214 copay per day for days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.	**In-Network:** You pay a $0 copay for days 1 – 20. You pay a $218 copay per day for days 21-100. **Out-of-Network:** You pay 30% coinsurance of the total cost per admission.
Specialist Visit	**In-Network:**	**In-Network:**

	2025 (this year)	2026 (next year)
(including Medicare-covered Hearing, Podiatry, Dental, and Vision Exams)	You pay a $20 copay per visit. **Out-of-Network:** You pay a $25 copay per visit.	You pay a $25 copay per visit. **Out-of-Network**: You pay 40% coinsurance per visit.
SWORD	Not available.	You pay $0 for virtual physical care (a suite of digital programs), monitored by doctors of physical therapy or other clinicians, through a vendor.
Urgently Needed Care	**In and Out-of-Network:** You pay a $35 copay per visit.	**In and Out-of-Network:** You pay a $40 copay per visit.
X-Rays	**In-Network:** You pay a $15 copay. **Out-of-Network:** You pay a $35 copay.	**In-Network:** You pay a $15 copay. **Out-of-Network:** You pay a 40% coinsurance.

Section 1.6 Changes to Part D 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 calendar 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're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or

working to find a new drug. Call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Member Services 1-888-459-4020 (TTY users call 711 National Relay Service) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 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 no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	$615 During this stage, you pay $7 Standard Pharmacy or $0 Preferred Pharmacy cost sharing for Preferred Generic drugs on Tier 1 and $15 Standard Pharmacy or $0 Preferred Pharmacy 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.

Drug Costs in Stage 2: Initial Coverage

Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (31-day) supply filled at a network pharmacy with standard and preferred cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Stage 2: Initial Coverage Stage 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 is: **Tier 1 Preferred Generic:** *Standard Pharmacy cost sharing:* You pay $7 per prescription. Your cost for a three-month mail-order prescription is $21 per prescription.	Your cost for a one-month supply is: **Tier 1 Preferred Generic:** *Standard Pharmacy cost sharing:* You pay $7 per prescription. Your cost for a three-month mail-order prescription is $21 per prescription.

	2025 (this year)	2026 (next year)
	Preferred Pharmacy cost sharing: You pay $0 per prescription. Your cost for a three-month mail-order prescription is $0 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $15 per prescription. Your cost for a three-month mail-order prescription is $45 per prescription. *Preferred Pharmacy cost sharing:* You pay $0 per prescription. Your cost for a three-month mail-order prescription is $0 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay 25% of the total cost. Your cost for a three-month mail-order prescription is 25% per prescription. *Preferred cost sharing:* You pay 25% of the total cost. Your cost for a three-month mail-order prescription is 25% per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:*	*Preferred Pharmacy cost sharing:* You pay $0 per prescription. Your cost for a three-month mail-order prescription is $0 per prescription. **Tier 2 Generic:** *Standard cost sharing:* You pay $15 per prescription. Your cost for a three-month mail-order prescription is $45 per prescription. *Preferred cost sharing:* You pay $0 per prescription. Your cost for a three-month mail-order prescription is $0 per prescription. **Tier 3 Preferred Brand:** *Standard cost sharing:* You pay 20% of the total cost. Your cost for a three-month mail-order prescription is 20% per prescription. *Preferred cost sharing:* You pay 20% of the total cost. Your cost for a three-month mail-order prescription is 20% per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** *Standard cost sharing:* You pay 25% of the total cost.

	2025 (this year)	2026 (next year)
	You pay 50% of the total cost. Your cost for a three-month mail-order prescription is 50% per prescription. *Preferred cost sharing:* You pay 50% of the total cost. Your cost for a three-month mail-order prescription is 50% per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a three-month mail-order prescription is 25% per prescription. *Preferred cost sharing:* You pay 25% of the total cost. Your cost for a three-month mail-order prescription is 25% per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. _____ Once you have paid $2,100 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

SECTION 2 Administrative Changes

Description	2025	2026
Diabetic Supplies	Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail	Diabetic glucometer, test strip, and lancet brands dispensed via retail or

Description	2025	2026
	order pharmacy are limited to Abbott® and LifeScan®. Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott® and Dexcom®. All other desired brands will need to be obtained via an exception process or from a Durable Medical Equipment (DME) supplier.	mail order pharmacy are limited to Abbott® and **Trividia®**. Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott® and Dexcom®. All other desired brands will need to be obtained via an exception process or from a Durable Medical Equipment (DME) supplier.
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-888-459-4020 (TTY users call 711 National Relay Service) or visit www.Medicare.gov.

SECTION 3 How to Change Plans

To stay in Complete Blue PPO Distinct (PPO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our Complete Blue PPO Distinct (PPO).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Complete Blue PPO Distinct (PPO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Complete Blue PPO Distinct (PPO).

- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online medicare.highmark.com. Call Member Services at 1-888-459-4020 (TTY users call 711 National Relay Service) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Highmark Senior Solutions Company offers other Medicare health plans AND/OR Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  o 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.

  o Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday -Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.

  o Your State Medicaid Office.

- **Prescription Cost Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the West Virginia ADAP. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call the West Virginia ADAP Customer Service line at 1-304-232-6822 or go to their website at https://oeps.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 payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-888-459-4020 (TTY users should call 711 National Relay Service) or visit www.Medicare.gov.

SECTION 5 Questions?

Section 5.1 Get Help from Complete Blue PPO Distinct (PPO)

Get Help from Complete Blue PPO Distinct (PPO)

- **Call Member Services at 1-888-459-4020. (TTY users call 711 National Relay Service.)**
  We're 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 *2026 Evidence of Coverage***
  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the *2026 Evidence of Coverage* for Complete Blue PPO Distinct (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at medicare.highmark.com or call Member Services 1-888-459-4020 (TTY users call 711 National Relay Service) to ask us to mail you a copy. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.
- **Visit medicare.highmark.com**
  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Section 5.2 Get 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.

Call West Virginia SHIP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call West Virginia SHIP at 1-877-987-4463. Learn more about West Virginia SHIP by visiting www.wvship.org.

Section 5.3 Get Help from Medicare

Get Help 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 can call 1-877-486-2048.
- **Chat live with www.Medicare.gov**
  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**
  You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit www.Medicare.gov**
  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.
- **Read *Medicare & You 2026***
  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can 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.

Out-of-network/non- contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. 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

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).
ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).
ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbufọ èdè wà ńí àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ̀ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati`ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט פאר הילף (TTY: 711) דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك للحصول على المساعدة (TTY: 711).

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभाषे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

पया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

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, 2025, you can visit https://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 ***2026 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 Doctor* or *Find a Pharmacy* at the top right 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 Services at the number on the back of your ID card to request a printed copy.

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