BlueCross BlueShield Kansas

2022 Annual Notice of Changes

Blue Medicare Advantage Comprehensive (PPO)

South Central Region: Butler, Cowley, Dickinson, Harvey, Kingman, Marion, McPherson, Reno, Sedgwick, and Sumner

Effective from January 1, 2022 through December 31, 2022

Blue Medicare Advantage Comprehensive (PPO) offered by Blue Cross and Blue Shield of Kansas

Annual Notice of Changes for 2022

You are currently enrolled as a member of Blue Medicare Advantage Comprehensive (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 1.1, 1.2 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.

OMB Approval 0938-1051 (Expires: February 29, 2024)

- 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 2.2 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 *Blue Medicare Advantage Comprehensive*.
- 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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Blue Medicare Advantage Comprehensive (PPO).

- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our customer service number at 1-800-222-7645 for additional information. (TTY users should call 711.) Hours of operation:
  - October 1 through March 31 – Seven days a week from 8:00 AM to 8:00 PM.
  - April 1 through September 30 – Monday through Friday 8:00 AM to 8:00 PM.
- We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call customer service.
- **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 Blue Medicare Advantage Comprehensive (PPO)

- Blue Cross and Blue Shield of Kansas is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Kansas Medicare Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Blue Cross and Blue Shield of Kansas. When it says "plan" or "our plan," it means Blue Medicare Advantage Comprehensive (PPO).

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File & Use 09/15/21

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Blue Medicare Advantage Comprehensive (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 https://www.bcbsks.com/medicare/ma-welcome. You may also call customer service 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.	$40	$40
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $5,900 From network and out-of-network providers combined: $9,000	From network providers: $5,900 From network and out-of-network providers combined: $9,000
Doctor office visits	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $40 Copay per visit **Out-Of-Network** Primary care visits: 30% Coinsurance per visit Specialist visits: 30% Coinsurance per visit	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $40 Copay per visit **Out-Of-Network** Primary care visits: 30% Coinsurance per visit Specialist visits: 30% Coinsurance per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-	**In-Network** $300 Copay per day for days 1 to 5.	**In-Network** $300 Copay per day for days 1 to 5.

Cost	2021 (this year)	2022 (next year)
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.	$0 Copay per day for days 6 and beyond. **Out-of-Network** 30% Coinsurance per stay.	$0 Copay per day for days 6 and beyond. **Out-of-Network** 30% Coinsurance per stay.
Part D insulin coverage To find out which drugs are select insulins, review the most recent Drug List provided electronically at www.myprime.com. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed on the back cover of this booklet).	Drug Tier 3: *Standard:* $45 *Preferred:* $45 Drug Tier 4: *Standard:* $100 *Preferred:* $100	$35 Copay for select insulins
Part D prescription drug coverage In 2022, your plan will no longer have a preferred network. (See Section 1.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: *Standard:* $10 *Preferred:* $3 • Drug Tier 2: *Standard:* $12 *Preferred:* $5 • Drug Tier 3: *Standard:* $45 *Preferred:* $45 • Drug Tier 4: *Standard:* $100 *Preferred:* $100 • Drug Tier 5:	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: $3 • Drug Tier 2: $5 • Drug Tier 3: $45 • Drug Tier 4: $100 • Drug Tier 5: 33%

Cost	2021 (this year)	2022 (next year)
	Standard: 30% *Preferred:* 30%	

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefits and Costs 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.)	$40	$40

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 1.2 – 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 services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and coinsurance) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,900	$5,900 Once you have paid $5,900 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and coinsurance) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$9,000	$9,000 Once you have paid $9,000 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

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.bcbsks.com/medicare/find-a-provider.shtml. You may also call customer service 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. 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.myprime.com. You may also call customer service 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)
Counseling Services Members have the opportunity to enroll in Homethrive. Once enrolled, a Care Guide (licensed social worker) will be assigned to the member and their family to provider ongoing one on one counseling and expertise. This program is to ensure positive behaviors and risk mitigation while helping the member manage and cope with chronic conditions or acute injuries.	Not Covered.	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** Not covered.
Healthy Aging Support Members enrolled in Homethrive will be assigned a licensed social worker who understands the health conditions and treatment plan for those being discharged from the hospital. See chapter 4 of your Evidence of Coverage for more details.	Not Covered.	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** Not covered.
In-Home Safety Assessment Members can enroll in Homethrive's program which empowers members to live independent lives free from fear of falling. See chapter 4 of your Evidence of Coverage for more details.	Not Covered.	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** Not covered.

Cost	2021 (this year)	2022 (next year)
OTC Items As part of your benefit plan, we offer an Over-the-Counter (OTC) and Healthy Products program. This program provides a prepaid / discount card that allows you to purchase approved OTC medications and healthy products at participating retailers or online. https://athome.medline.com/card	**In-Network:** There is $90 allowance Every Three Months. **Out-of-Network:** Not covered.	**In-Network:** There is $85 allowance Every Three Months. **Out-of-Network:** Not covered.
Skilled Nursing Facility (SNF) Medicare-covered stay	In Network: You pay a $0 copayment for days 1-20. You pay a $167.50 copayment for days 21-100. Out-of-Network: 30% per stay.	In Network: You pay a $0 copayment for days 1-20. You pay a $175 copayment for days 21-100. Out-of-Network: 30% per stay.
Support for Caregivers of Enrollees Members can enroll in Homethrive to receive extra support for their unpaid caregivers. Homethrive will assign a licensed social worker to provide valuable coping mechanisms that significantly reduce their stress so they can continue to actively support the health and well-being of our member.	Not Covered.	**In-Network:** You pay nothing for this benefit. **Out-of-Network:** Not covered.

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 at www.MyPrime.com.

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 customer service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call customer service 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.

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 2022, 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 have included 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" and didn't receive this insert with this packet, please call customer service 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 https://www.bcbsks.com/medicare/ma-welcome. You may also call customer service 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	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

Please see the following chart for the changes from 2020 to 2022.

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 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. You pay a $35 Copay for select insulins. In 2022, your plan will no longer have a preferred network.	Your cost for a one-month supply at a network pharmacy: **Tier 1:** *Standard cost sharing:* You pay $10 per prescription *Preferred cost sharing* You pay $3 per prescription **Tier 2:** *Standard cost sharing:* You pay $12 per prescription *Preferred cost sharing* You pay $5 per prescription **Tier 3:** *Standard cost sharing:* You pay $45 per prescription *Preferred cost sharing* You pay $45 per prescription **Tier 4:** *Standard cost sharing:* You pay $100 per prescription	Your cost for a one-month supply at a network pharmacy: **Tier 1:** You pay $3 per prescription **Tier 2:** You pay $5 per prescription **Tier 3:** You pay $45 per prescription **Tier 4:** You pay $100 per prescription **Tier 5** You pay 33% of the total cost Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage). *OR* you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Stage	2021 (this year)	2022 (next year)
	Preferred cost sharing You pay $100 per prescription **Tier 5:** *Standard cost sharing:* You pay 30% of the total cost *Preferred cost sharing* You pay 30% of the total cost Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage). *OR* you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage 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.*

Blue Medicare Advantage Comprehensive (PPO) offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be a $35 copay for select insulins.

SECTION 2 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Geographic/Service Area	Service area consists of Butler, Cowley, Harvey, Kingman, Reno, Sedgwick, and Sumner counties.	Service area consists of Butler, Cowley, Harvey, Kingman, Marion, McPherson, Reno, Sedgwick, and Sumner counties.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Blue Medicare Advantage Comprehensive (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 Blue Medicare Advantage Comprehensive (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 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 2.1 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 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, Blue Cross and Blue Shield of Kansas offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Medicare Advantage Comprehensive (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Medicare Advantage Comprehensive (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact customer service 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, 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.*

If you enrolled in a Medicare Advantage Plan for January 1, 2022, 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, 2022. 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 Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).

SHICK 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. SHICK 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 SHICK at 1-800-860-5260.You can learn more about SHICK by visiting their website at www.kdads.ks.gov/SHICK.

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).
- **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 Kansas Ryan White Part B Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-785-296-6174.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Medicare Advantage Comprehensive (PPO)

Questions? We're here to help. Please call customer service at 1-800-222-7645. (TTY only, call 711.) We are available for phone calls from 8:00 AM to 8:00 PM seven days a week from October 1 through March 31. We are available 8:00 AM to 8:00PM Monday through Friday 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 Blue Medicare Advantage Comprehensive (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 https://www.bcbsks.com/medicare/ma-welcome. You may also call customer service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at https://www.bcbsks.com/medicare/ma-welcome. 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.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2022 Medicare Star Ratings

Blue Cross and Blue Shield of Kansas - H7063

For 2022, Blue Cross and Blue Shield of Kansas - H7063 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Blue Cross and Blue Shield of Kansas 7 days a week from 8:00 a.m. to 8:00 p.m. Central time at 800-354-9387 (toll-free) or 800-766-3777 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. Current members please call 800-222-7645 (toll-free) or 711 (TTY).

BlueCross BlueShield Kansas

800-222-7645 (TTY: 711)

bcbsks.com/mawelcome

1133 SW Topeka Blvd.
Topeka, KS 66629-0001