BlueCross BlueShield Kansas

2023 Annual Notice of Changes

Blue Medicare Advantage Choice (PPO)

NE and SC Region: Butler, Chase, Coffey, Cowley, Dickinson, Douglas, Franklin, Geary, Harvey, Jackson, Jefferson, Kingman, Linn, Lyon, Marion, McPherson, Miami, Morris, Osage, Pottawatomie, Reno, Riley, Sedgwick, Shawnee, Sumner, and Wabaunsee.

Effective from January 1, 2023, through December 31, 2023

37-051 07/22

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

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

Annual Notice of Changes for 2023

You are currently enrolled as a member of Blue Medicare Advantage Choice (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at https://www.bcbsks.com/medicare/ma-welcome. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

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

What to do now

1. ASK: Which changes apply to you

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

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in *Blue Medicare Advantage Choice*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Blue Medicare Advantage Choice.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

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 Choice (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 document 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 Choice (PPO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Blue Medicare Advantage Choice (PPO) in several important areas. **Please note this is only a summary of costs.**

SECTION 1 Changes to Benefits and Costs for Next Year

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $4,000 From network and out-of-network providers combined: $8,000	From network providers: $3,000 From network and out-of-network providers combined: $5,400
Doctor office visits	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $25 Copay per visit **Out-Of-Network** Primary care visits: 40% Coinsurance per visit Specialist visits:	**In-Network** Primary care visits: $0 per visit Specialist visits: $0-$25 Copay per visit **Out-Of-Network** Primary care visits: 40% Coinsurance per visit Specialist visits:

Cost	2022 (this year)	2023 (next year)
	40% Coinsurance per visit	40% Coinsurance per visit
Inpatient hospital stays	**In-Network** $250 Copay per day for days 1 to 5. $0 Copay per day for days 6 and beyond. **Out-of-Network** 40% Coinsurance per stay.	**In-Network** $250 Copay per day for days 1 to 5. $0 Copay per day for days 6 and beyond. **Out-of-Network** 40% Coinsurance per stay.
Part D prescription drug coverage	Deductible: $250 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: 28%	Deductible: $250 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: 28%

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

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

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

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

Cost	2022 (this year)	2023 (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.	$4,000	$3,000 Once you have paid $3,000 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	2022 (this year)	2023 (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 costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$8,000	$5,400 Once you have paid $5,400 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 and Pharmacy Networks

Updated directories are also located on our website at www.bcbsks.com/medicare/find-a-provider.shtml. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are no changes to our network of providers for next year.

Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

There are no changes to our network of pharmacies for next year.

Please review the 2023 Pharmacy Directory to see which pharmacies are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Primary Care Physician Services	**In-Network:** You pay $5 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Occupational Therapy Services	**In-Network:** You pay $40 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0- $40 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Physician Specialist Services	**In-Network:** You pay $25 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0- $25 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Mental Health Specialty Service	**In-Network:** You pay $25 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0- $25 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Podiatry Services	**In-Network:** You pay $25 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0- $25 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.

Cost	2022 (this year)	2023 (next year)
Other Health Care Professional Services	**In-Network:** You pay $25 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0-$25 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit. Prior Authorization may be required.
Psychiatric Services	**In-Network:** You pay $40 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0- $40 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Physical Therapy and Speech Language Pathology Services	**In-Network:** You pay $40 minimum copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.	**In-Network:** You pay $0-$40 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Additional Telehealth Services	Not covered.	**In-Network:** You pay $0-$40 copay for this benefit. **Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Opioid Treatment Program Services	**In-Network:** You pay $5 minimum copay for this benefit.	**In-Network:** You pay $0-$5 copay for this benefit.

Cost	2022 (this year)	2023 (next year)
	Out-of-Network: You pay 40% minimum coinsurance for this benefit.	**Out-of-Network:** You pay 40% minimum coinsurance for this benefit.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users).	Preferred continuous blood glucose monitoring systems are Dexcom G5 or G6 and Freestyle Libre.	Preferred continuous blood glucose monitoring systems are Dexcom G5 or G6.
Vision care	Member is responsible for any amount spent over eyewear coverage limit. Please note refractions are not covered.	Member is responsible for any amount spent over eyewear coverage limit. Please note refractions are covered.
Hearing Aids: Up to two hearing aids from the applicable TruHearing Catalog every 1 year (limit 1 hearing aid per year). Benefit is combined in- and out-of-network. You must see a TruHearing provider to use this benefit Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits	**In-Network** $25 copay for each Medicare-covered diagnostic hearing exam. $0 copay* for routine hearing exam (one per year). $699 copay* for each TruHearing Advanced Aid $999 copay* for each TruHearing Premium Aid (up to two hearing aids every year, or one per ear). **Out-Of-Network** 40% coinsurance for each Medicare-covered diagnostic hearing exam. 40% coinsurance* for one routine hearing exam per year.	**In-Network** $25 copay for each Medicare-covered diagnostic hearing exam. $0 copay* for routine hearing exam (one per year). $495 copayment per aid for Basic Aids* $895 copayment per aid for Standard Aids* $1,295 copayment per aid for Advanced Aids* $1,695 copayment per aid for Premium Aids* **Routine hearing exam and hearing aid copayments are not subject to the out-of-pocket maximum.*

Cost	2022 (this year)	2023 (next year)
• Additional batteries: batteries when a rechargeable hearing aid is purchased • Hearing aids that are not in the applicable catalog • Costs associated with loss & damage warranty claims • Costs associated with excluded items are the responsibility of the member and not covered by the plan.	(*) indicates Routine Hearing Exam and Hearing Aid cost-shares are not subject to the maximum out-of-pocket.	*TruHearing provider must be used for in- and out-of-network hearing aid benefit.*
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws	Prior Authorization Required	No Prior Authorization Required
Meal benefit After discharge from an inpatient hospital, you may be eligible for up to 14 meals over a 7-day period*. These meals are precooked and frozen, and will be delivered to your home. Our plan partners with Mom's Meals to provide your meal benefit.	Not Covered	$0 copay* for up to 14 meals over a 7-day period after discharge from an inpatient hospital. (*) indicates Meal Benefit cost-shares are not subject to the maximum out-of-pocket.
Skilled Nursing Facility (SNF) Medicare-covered stay	**In Network:**	**In Network:**

Cost	2022 (this year)	2023 (next year)
	You pay a $0 copayment for days 1-20. You pay a $175 copayment for days 21-100. **Out-of-Network:** 40% coinsurance per stay	You pay a $0 copayment for days 1-20. You pay a $196 copayment for days 21-100. **Out-of-Network:** 40% coinsurance per stay
In-Home Safety Assessment	You pay nothing for this benefit.	This service is not covered.
Dental Services	**Medicare-Covered Dental Services:** **In-network:** $25 copay **Out-of-network:** 40% coinsurance Our plan pays up to $900 for preventive and comprehensive dental services every year for services received in-network or out-of-network. **Preventive Dental Services:** • Routine cleanings (up to 2 every year) • Bitewing x-rays (up to 2 every year) • Oral exams (up to 2 every year) **In-network:** $0 copay **Out-of-network:** 40% coinsurance **Comprehensive Dental Services:**	**Medicare-Covered Dental Services:** **In-network:** $25 copay **Out-of-network:** 40% coinsurance Our plan pays up to $1,050 for preventive and comprehensive dental services every year for services received in-network or out-of-network. **Preventive Dental Services:** • Routine cleanings (up to 2 every year) • Bitewing x-rays (up to 2 every year) • Oral exams (up to 2 every year) **In-network:** $0 copay **Out-of-network:** 40% coinsurance

Cost	2022 (this year)	2023 (next year)
	Reference Evidence of Coverage for additional detail on covered comprehensive services /limitations. • Restorative • Endodontics • Periodontics • Extractions • Prosthodontics and Oral /Maxillofacial Services **In-network:** 50% coinsurance **Out-of-network:** 50% coinsurance *Non Medicare-Covered Preventive Dental Service cost-shares are not subject to the maximum out-of-pocket.*	**Comprehensive Dental Services:** Reference Evidence of Coverage for additional detail on covered comprehensive services /limitations. • Restorative • Endodontics • Periodontics • Extractions • Prosthodontics and Oral /Maxillofacial Services **In-network:** 50% coinsurance **Out-of-network:** 50% coinsurance *Non Medicare-Covered Preventive Dental Service cost-shares are not subject to the maximum out-of-pocket.*

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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

Starting in 2023, 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.

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. If you receive "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes 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.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	This plan has a $250 pharmacy deductible on Tier 3-5 drugs. Tier 1 and Tier 2 drugs are not included in the deductible.	This plan has a $250 pharmacy deductible on Tier 4-5 drugs. Tier 1, Tier 2 and Tier 3 drugs are not included in the deductible. .

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2022 to 2023.

Stage	2022 (this year)	2023 (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 (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 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	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

Stage	2022 (this year)	2023 (next year)
your drugs will be in a different tier, look them up on the Drug List.]	**Tier 5:** You pay 28% 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).	**Tier 5** You pay 28% of the total cost Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage). *OR* you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Blue Medicare Advantage Choice (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 Choice (PPO).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 Choice (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 Choice (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription

drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).

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 5 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. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (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 6 Questions?

Section 6.1 – Getting Help from Blue Medicare Advantage Choice (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 *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Blue Medicare Advantage Choice (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 Member Services 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 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

BlueCross BlueShield Kansas

800-222-7645
(TTY: 711)

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