



BlueMedicare Value Choice (PPO) offered by Arkansas Blue Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of BlueMedicare Value Choice (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.**
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What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Sections 1.1 and 1.4 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 1.5 for information about changes to our drug coverage.
 - Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit [go.medicare.gov/drugprices](https://www.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 1.2 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 BlueMedicare Value Choice (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in BlueMedicare Value Choice (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

- This document is available for free in Spanish.
- Please contact our Customer Service number at 1-844-201-4934 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m. CT, Monday through Friday (April 1 through September 30). From October 1 through March 31, our hours are 8 a.m. to 8 p.m. CT, seven days a week.
- This information is available in large print.
- **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 BlueMedicare Value Choice (PPO)

- Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers HMO, PFFS, PPO and PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Arkansas Blue Medicare. When it says “plan” or “our plan,” it means BlueMedicare Value Choice (PPO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for BlueMedicare Value Choice (PPO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.arkbluemedicare.com. 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.	\$29	\$29
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered services. (See Section 1.1 for details.)	From network providers: \$6,700 From network and out-of-network providers combined: \$11,300	From network providers: \$6,000 From network and out-of-network providers combined: \$11,300
Doctor office visits	<u>In-Network</u> Primary care visits: \$10 co-pay for each Medicare-covered visit. Specialist visits: \$45 co-pay for each Medicare-covered visit.	<u>In-Network</u> Primary care visits: \$0 co-pay for each Medicare-covered visit. Specialist visits: \$40 co-pay for each Medicare-covered 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	<u>In-Network</u> For each Medicare-covered hospital stay: \$360 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90.	<u>In-Network</u> For each Medicare-covered hospital stay: \$345 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90.

Cost	2021 (this year)	2022 (next year)
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$250</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$3 co-pay • Drug Tier 2: \$13 co-pay • Drug Tier 3: \$47 co-pay • Drug Tier 4: 50% of the total cost • Drug Tier 5: 28% of the total cost • Drug Tier 6: \$0 co-pay 	<p>Deductible: \$150</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$3 co-pay • Drug Tier 2: \$13 co-pay • Drug Tier 3: \$47 co-pay • Drug Tier 4: \$100 co-pay • Drug Tier 5: 30% of the total cost • Drug Tier 6: \$0 co-pay
<p>Part D Senior Savings Model</p>	<p>Part D Senior Savings Model not available.</p>	<p>To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed on the back cover of this booklet).</p>

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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)
<p>In-network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as co-pays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	\$6,700	<p>\$6,000</p> <p>Once you have paid \$6,000 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as co-pays) 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.</p>	\$11,300	<p>\$11,300</p> <p>Once you have paid \$11,300 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.</p>

Section 1.2 – 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.arkbluemedicare.com. 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 1.3 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.arkbluemedicare.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 1.4 – 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*.

Cost	2021 (this year)	2022 (next year)
Acupuncture (Non-Medicare-covered)	<u>In- and Out-of-Network</u> Prior authorization is required.	<u>In- and Out-of-Network</u> Prior authorization is <u>not</u> required.
Ambulatory Surgical Center Services	<u>In-Network</u> You pay a \$300 co-pay for each Medicare-covered surgical service in an ambulatory surgical center.	<u>In-Network</u> You pay a \$225 co-pay for each Medicare-covered surgical service in an ambulatory surgical center.
Cardiac Rehabilitation Services (Medicare-covered)	<u>In-Network</u> You pay a \$35 co-pay for each Medicare-covered cardiac rehabilitation service. You pay a \$70 co-pay for each Medicare-covered intensive-cardiac rehabilitation service.	<u>In-Network</u> You pay a \$10 co-pay for each Medicare-covered cardiac rehabilitation service. You pay a \$10 co-pay for each Medicare-covered intensive-cardiac rehabilitation service.
Chiropractic Services (Medicare-covered)	<u>In-Network</u> You pay a \$15 co-pay for each Medicare-covered visit.	<u>In-Network</u> You pay a \$20 co-pay for each Medicare-covered visit.
Dental Services (Medicare-covered)	<u>In-Network</u> You pay a \$45 co-pay for Medicare-covered services.	<u>In-Network</u> You pay a \$40 co-pay for Medicare-covered services.

Cost	2021 (this year)	2022 (next year)
Routine Dental (limitations and exclusions apply)	<p><u>In-Network</u> You pay 30% of the total cost for Restorative Services, limit one per year.</p>	<p><u>In-Network</u> You pay 50% of the total cost for Restorative Services, limit one per year.</p>
	<p>You pay 30% of the total cost for Debridement (Periodontics), limit one per 36 months.</p>	<p>You pay 50% of the total cost for Debridement (Periodontics), limit one per 36 months.</p>
	<p>You pay 50% of the total cost for Extractions, limit one per year.</p>	<p>You pay a \$20 co-pay for Extractions, limit two per year.</p>
	<p>You pay 50% of the total cost for Dentures (Prosthodontics), limit one per five years.</p>	<p>Dentures (Prosthodontics) is <u>not</u> covered.</p>
	<p>You pay 30% of the total cost for Denture adjustments (Prosthodontics), limit two per year.</p>	<p>You pay a \$20 co-pay for denture adjustments (Prosthodontics), limit two per year.</p>
	<p>You pay 30% of the total cost for Denture repairs (Prosthodontics), as needed.</p>	<p>You pay 50% of the total cost for denture repairs (Prosthodontics), limit two per year.</p>
	<p>You pay 30% of the total cost for tooth desensitizing agent (Other Services), limit one per year.</p>	<p>Tooth desensitizing agent (Other Services) is <u>not</u> covered.</p>
	<p><u>Out-of-Network</u> You pay 50% of the total cost for Dentures (Prosthodontics), limit one per five years.</p>	<p><u>Out-of-Network</u> Dentures (Prosthodontics) is <u>not</u> covered.</p>
	<p>You pay 50% of the total cost for tooth desensitizing agent (Other Services), limit one per year.</p>	<p>Tooth desensitizing agent (Other Services) is <u>not</u> covered.</p>

Cost	2021 (this year)	2022 (next year)
Diabetic Services and Supplies	<p><u>In-Network</u></p> <p><u>Diabetic Testing Supplies</u> No preferred manufacturers for diabetic supplies.</p> <p><u>Continuous Glucose Monitors (CGMs)</u> No preferred manufacturers for CGMs.</p> <p>Prior authorization is <u>not</u> required.</p> <p><u>Diabetic Therapeutic Shoes or Inserts</u> You pay a \$0 co-pay for diabetic therapeutic shoes or inserts.</p>	<p><u>In-Network</u></p> <p><u>Diabetic Testing Supplies</u> Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are the preferred manufacturers for diabetic supplies.</p> <p><u>Continuous Glucose Monitors (CGMs)</u> Dexcom and Freestyle Libre CGMs are preferred manufacturers.</p> <p>Prior authorization is required.</p> <p><u>Diabetic Therapeutic Shoes or Inserts</u> You pay 20% of the total cost for diabetic therapeutic shoes or inserts.</p>
Emergency Services	<p><u>In- and Out-of-Network</u> The emergency services co-pay will be waived if you are admitted to the hospital within three days.</p>	<p><u>In- and Out-of-Network</u> The emergency services co-pay will be waived if you are admitted to the hospital within 24 hours.</p>
Flexible Spending	<p><u>In- and Out-of-Network</u> Flexible Spending is <u>not</u> covered.</p>	<p><u>In- and Out-of-Network</u> Flexible Spending is covered.</p> <p>You pay a \$0 co-pay for a \$500 Visa/MasterCard debit card that can be used to reduce out-of-pocket dental, vision, and hearing expenses.</p>

Cost	2021 (this year)	2022 (next year)
Hearing Aids Including Fitting/Evaluation	<u>In- and Out-of-Network</u> Hearing aid purchase includes: <ul style="list-style-type: none"> •Three provider visits within first year of hearing aid purchase •45-day trial period •48 batteries per aid for non-rechargeable models 	<u>In- and Out-of-Network</u> Hearing aid purchase includes: <ul style="list-style-type: none"> •First year of follow-up provider visits •60-day trial period •80 batteries per aid for non-rechargeable models
Home Health	<u>In- and Out-of-Network</u> Prior authorization is <u>not</u> required.	<u>In- and Out-of-Network</u> Prior authorization is required.
Inpatient Hospital Stays	<u>In-Network</u> For each Medicare-covered hospital stay: You pay a \$360 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90. A new benefit period will start after three days of discharge.	<u>In-Network</u> For each Medicare-covered hospital stay: You pay a \$345 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90. Benefit period is per admission or per stay.
Inpatient Mental Health Stays	<u>In-Network</u> For each Medicare-covered hospital stay: You pay a \$350 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90. Benefit period is Original Medicare.	<u>In-Network</u> For each Medicare-covered hospital stay: You pay a \$325 co-pay per day for days 1-5 and \$0 co-pay per day for days 6-90. Benefit period is per admission or per stay.
Massage Therapy	<u>In- and Out-of-Network</u> Referral is <u>not</u> required.	<u>In- and Out-of-Network</u> Referral is required.
Medical Supplies	<u>In- and Out-of-Network</u> Prior authorization is <u>not</u> required.	<u>In- and Out-of-Network</u> Prior authorization is required.

Cost	2021 (this year)	2022 (next year)
Medicare Part B Prescription Drugs	<p><u>In- and Out-of-Network</u> Step therapy is <u>not</u> required.</p> <p>Prior authorization is <u>not</u> required.</p>	<p><u>In- and Out-of-Network</u> Step therapy is required. (In some cases, the plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.)</p> <p>Prior authorization is required.</p>
Occupational Therapy Services	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered visit.</p>	<p><u>In-Network</u> You pay a \$35 co-pay for each Medicare-covered visit.</p>
Opioid Treatment Program Services	<p><u>In-Network</u> You pay a \$45 co-pay for each Medicare-covered service.</p>	<p><u>In-Network</u> You pay a \$50 co-pay for each Medicare-covered service.</p>
Other Health Care Professionals (e.g., nurse practitioner; physician assistant)	<p><u>In-Network</u> For services provided in a Primary Care Physician office, you pay a \$10 co-pay for each Medicare-covered visit.</p> <p>For services provided in a Specialist office, you pay a \$45 co-pay for each Medicare-covered visit.</p>	<p><u>In-Network</u> For services provided in a Primary Care Physician office, Rural Health Clinic, and Federally Qualified Health Center, you pay a \$0 co-pay for each Medicare-covered visit.</p> <p>For services provided in a Specialist office, you pay a \$40 co-pay for each Medicare-covered visit.</p>

Cost	2021 (this year)	2022 (next year)
<p>Outpatient Diagnostic Procedures and Tests</p>	<p><u>In-Network</u> You pay a \$10 co-pay for services performed in a Primary Care Physician office, a \$45 co-pay for services performed in a Physician Specialist office, a \$30 co-pay for services performed in an Urgent Care facility, and a \$325 co-pay for services performed in an Outpatient Hospital.</p>	<p><u>In-Network</u> You pay a \$0 co-pay for spirometry test and home-based sleep study.</p> <p>You pay a \$20 co-pay for all other Medicare-covered Outpatient Diagnostic Procedures and Tests.</p>
<p>Outpatient Diagnostic and Therapeutic Radiology Services</p>	<p><u>In-Network</u> You pay a \$45 co-pay for services performed in a Physician Specialist office or a freestanding radiology clinic, a \$30 co-pay for services performed in an Urgent Care facility, and a \$325 co-pay for services performed in an Outpatient Hospital.</p> <p>You pay a \$0 co-pay for outpatient X-ray services performed in a Primary Care Physician office, Physician Specialist office, Urgent Care facility, and Emergency Room.</p> <p>Prior authorization is <u>not</u> required for X-ray services.</p>	<p><u>In-Network</u> You pay a \$40 co-pay for services performed in a Physician Specialist office or a freestanding radiology clinic and a \$275 co-pay for services performed in an Outpatient Hospital.</p> <p>You pay a \$25 co-pay for outpatient X-ray services performed in a Primary Care Physician office, Physician Specialist office, Urgent Care facility, and Emergency Room.</p> <p>Prior authorization is required for X-ray services.</p>

Cost	2021 (this year)	2022 (next year)
Outpatient Hospital Services	<p><u>In-Network</u> You pay a \$325 co-pay for each Medicare-covered non-surgical or surgical service in an outpatient location.</p> <p>Prior authorization is required.</p>	<p><u>In-Network</u> You pay a \$275 co-pay for each Medicare-covered non-surgical or surgical service in an outpatient location.</p> <p>Prior authorization is <u>not</u> required.</p>
Outpatient Mental Health Specialty Services	<p><u>In-Network</u> You pay a \$30 co-pay for each Medicare-covered group therapy visit.</p>	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered group therapy visit.</p>
Outpatient Psychiatric Services	<p><u>In-Network</u> You pay a \$30 co-pay for each Medicare-covered group therapy visit.</p>	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered group therapy visit.</p>
Outpatient Substance Abuse Services	<p><u>In-Network</u> You pay a \$45 co-pay for each Medicare-covered individual therapy visit.</p> <p>You pay a \$35 co-pay for each Medicare-covered group therapy visit.</p>	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered individual therapy visit.</p> <p>You pay a \$40 co-pay for each Medicare-covered group therapy visit.</p>
Physical & Speech Therapy Services	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered visit.</p>	<p><u>In-Network</u> You pay a \$35 co-pay for each Medicare-covered visit.</p>
Podiatry Services (Medicare-covered)	<p><u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered visit.</p>	<p><u>In-Network</u> You pay a \$35 co-pay for each Medicare-covered visit.</p>
Podiatry Services (Routine)	<p><u>In-Network</u> You pay a \$40 co-pay for each routine visit.</p>	<p><u>In-Network</u> You pay a \$35 co-pay for each routine visit.</p>

Cost	2021 (this year)	2022 (next year)
Primary Care Physician Visits	<u>In-Network</u> You pay a \$10 co-pay for each Medicare-covered visit.	<u>In-Network</u> You pay a \$0 co-pay for each Medicare-covered visit.
Pulmonary Rehabilitation Services (Medicare-covered)	<u>In-Network</u> You pay a \$25 co-pay for each Medicare-covered service.	<u>In-Network</u> You pay a \$30 co-pay for each Medicare-covered service.
Skilled Nursing Facility (SNF) Care	<u>In-Network</u> For each Medicare-covered SNF stay: You pay a \$0 co-pay per day for days 1-20 and \$184 co-pay per day for days 21-100.	<u>In-Network</u> For each Medicare-covered SNF stay: You pay a \$0 co-pay per day for days 1-20 and \$188 co-pay per day for days 21-100.
Special Supplemental Benefits for the Chronically Ill (Help with Certain Chronic Conditions)	<u>In-Network</u> Special Supplemental Benefits for the Chronically Ill is <u>not</u> covered.	<u>In-Network</u> You pay a \$0 co-pay for Dental Xtra SM . Dental Xtra is a program for members who have diabetes, coronary artery disease (CAD), have suffered a stroke or have been diagnosed with oral cancer, head and neck cancers or Sjögren's syndrome. The program provides qualifying members with enhanced dental benefits when using a participating dentist. To learn more, visit www.arkansasdentalblue.com
Specialist Visits	<u>In-Network</u> You pay a \$45 co-pay for each Medicare-covered visit.	<u>In-Network</u> You pay a \$40 co-pay for each Medicare-covered visit.

Cost	2021 (this year)	2022 (next year)
Supervised Exercise Therapy (SET) (Medicare-covered)	<u>In-Network</u> You pay a \$25 co-pay for each Medicare-covered service.	<u>In-Network</u> You pay a \$10 co-pay for each Medicare-covered service.
Telehealth Services	<u>In-Network</u> You pay a \$45 co-pay for telehealth services provided by a specialist.	<u>In-Network</u> You pay a \$20 co-pay for telehealth services provided by a specialist.
Urgently Needed Services	<u>In- and Out-of-Network</u> You pay a \$10 co-pay for services performed in a Primary Care Physician office. You pay a \$45 co-pay for services performed in a Physician Specialist office. You pay a \$30 co-pay for services performed in an Urgent Care facility.	<u>In- and Out-of-Network</u> You pay a \$30 co-pay for each Medicare-covered visit regardless of place of service.
Vision Care (Routine Eye Exams)	<u>Out-of-Network</u> You pay 50% of the total cost.	<u>Out-of-Network</u> You pay 40% of the total cost.

Cost	2021 (this year)	2022 (next year)
<p>Vision Care (Routine Eyewear)</p>	<p><u>In-Network</u> You pay a \$0 co-pay for elective contact lenses. You pay a \$15 co-pay for medically necessary contact lenses.</p> <p>Plan covers up to \$100 every two years for one pair of contact lenses.</p> <p>You pay a \$15 co-pay for eyeglasses (lenses and frames) and all base lenses (single vision, lined bifocal, lined trifocal, and lenticular).</p> <p>Plan covers up to a \$150 every two years for eyeglasses (lenses and frames) and all base lenses (single vision, lined bifocal, lined trifocal, and lenticular).</p> <p>All Contact lenses are in lieu of eyeglasses (lenses and frames).</p> <p><u>Out-of-Network</u> You pay 50% of the total cost for eyeglass lenses.</p> <p>Plan covers up to \$100 every two years for contact lenses in lieu of glasses.</p> <p>Plan covers up to \$150 every two years for eyeglasses (lenses and frames).</p> <p>You pay 50% of the total cost for medically necessary contact lenses.</p>	<p><u>In-Network</u> You pay a \$0 co-pay for contact lenses, eyeglasses (lenses and frames), and upgrades.</p> <p>Plan covers up to \$150 combined for contact lenses, eyeglasses (lenses and frames), and upgrades per year.</p> <p><u>Out-of-Network</u> Plan covers up to \$150 combined for contact lenses, eyeglasses (lenses and frames), and upgrades per year.</p>

Cost	2021 (this year)	2022 (next year)
Worldwide Emergency/Urgent Services	<u>In- and Out-of-Network</u> You pay 20% of the total cost for Worldwide Emergency /Urgent services.	<u>In- and Out-of-Network</u> You pay a \$90 co-pay for Worldwide Emergency /Urgent services.

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.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

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.

In some cases, current approved formulary exceptions will be covered next year. To find out whether your exception will be covered, call Customer Service.

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

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. Because you receive “Extra Help”, if you haven’t received this insert by September 30, 2021, please call 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 www.arkbluemedicare.com. 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)
<p>Stage 1: Yearly Deductible Stage</p> <p>During this stage, you pay the full cost of your tiers 4 and 5 drugs until you have reached the yearly deductible.</p>	<p>The deductible is \$250.</p> <p>During this stage, you pay a \$3 co-pay for drugs on tier 1, a \$13 co-pay for drugs on tier 2, a \$0 co-pay for drugs on tier 6 and the full cost of drugs on tiers 3, 4, and 5 until you have reached the yearly deductible.</p>	<p>The deductible is \$150.</p> <p>During this stage, you pay a \$3 co-pay for drugs on tier 1, a \$13 co-pay for drugs on tier 2, a \$47 co-pay for drugs on tier 3, a \$0 co-pay for drugs on tier 6 and the full cost of drugs on tiers 4 and 5 until you have reached the yearly deductible.</p>
<p>Part D Senior Savings Model</p>	<p>Part D Senior Savings Model not available.</p>	<p>There is no deductible for BlueMedicare Value Choice (PPO) for Select Insulins. You pay \$0 for Select Insulins.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on tier 5, your cost sharing in the initial coverage stage is changing from copayment to coinsurance. Please see the following chart for the changes from 2021 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)
<p>Stage 2: Initial Coverage Stage</p> <p>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.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p>

Stage	2021 (this year)	2022 (next year)
<p>For 2021 you paid 50% coinsurance for drugs on tier 4. For 2022 you will pay a \$100 copayment for drugs on this tier.</p>	<p>Tier 1 = Preferred Generic drugs: You pay a \$3 co-pay per prescription.</p>	<p>Tier 1 = Preferred Generic drugs: You pay a \$3 co-pay per prescription.</p>
<p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.</p>	<p>Tier 2 = Generic drugs: You pay a \$13 co-pay per prescription.</p>	<p>Tier 2 = Generic drugs: You pay a \$13 co-pay per prescription.</p>
<p>For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p>	<p>Tier 3 = Preferred Brand drugs: You pay a \$47 co-pay per prescription.</p>	<p>Tier 3 = Preferred Brand drugs: You pay a \$47 co-pay per prescription.</p>
<p>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.</p>	<p>Tier 4 = Non-Preferred Brand drugs: You pay 50% of the total cost per prescription.</p>	<p>Tier 4 = Non-Preferred Brand drugs: You pay a \$100 co-pay per prescription.</p>
	<p>Tier 5 = Specialty drugs: You pay 28% of the total cost per prescription.</p>	<p>Tier 5 = Specialty drugs: You pay 30% of the total cost per prescription.</p>
	<p>Tier 6 = Select Care drugs: You pay a \$0 co-pay per prescription.</p>	<p>Tier 6 = Select Care drugs: You pay a \$0 co-pay per prescription.</p>
<p>Part D Senior Savings Model</p>	<p>Part D Senior Savings Model not available.</p>	<p>You pay \$0 for Select Insulins.</p>
	<p>Once your total drug costs have reached \$4,130, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once your total drug costs have reached \$4,430, you will move to the next stage (the Coverage Gap Stage).</p>

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*.

BlueMedicare Value Choice (PPO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be \$0.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BlueMedicare Value 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 BlueMedicare Value 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 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.

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, Arkansas Blue Medicare 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 BlueMedicare Value Choice (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from BlueMedicare Value Choice (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 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, 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 4 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 Arkansas, the SHIP is called Senior Health Insurance Information Program.

Senior Health Insurance Information Program 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. Senior Health Insurance Information Program 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 Senior Health Insurance Information Program at 1-800-224-6330.

You can learn more about Senior Health Insurance Information Program by visiting their website (<https://insurance.arkansas.gov/pages/consumer-services/senior-health>).

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. 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 Arkansas AIDS Drug Assistance Program (Ryan White Program). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-501-661-2408 or toll free 1-888-499-6544 or visit <https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program>.

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueMedicare Value Choice (PPO)

Questions? We’re here to help. Please call Customer Service at 1-844-201-4934. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m. CT, Monday through Friday (April 1 through September 30). From October 1 through March 31, our hours are 8 a.m. to 8 p.m. CT, seven days a week. 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 BlueMedicare Value 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 www.arkbluemedicare.com. 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 www.arkbluemedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 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

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.