Arkansas Blue MEDICARE
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueMedicare Value (PFFS) offered by Arkansas Blue Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of BlueMedicare Value (PFFS). 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 1.2 and 1.4 for information about benefit and cost changes for our plan.

☐ 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 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.

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☐ 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 (PFFS).
   - 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 (PFFS).
   - 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 1-877-233-7022 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 (PFFS)

- Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers PFFS 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 (PFFS).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for BlueMedicare Value (PFFS) 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 See Section 1.1 for details.	$29	$29
Out-of-Network Deductible	$1,000	$1,000
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$7,500	$7,500
Doctor office visits	**In-Network** Primary care visits: $20 co-pay for each Medicare-covered visit. Specialist visits: $50 co-pay for each Medicare-covered visit.	**In-Network** Primary care visits: $20 co-pay for each Medicare-covered visit. Specialist visits: $50 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.	**In-Network** For each Medicare-covered hospital stay: $372 co-pay per day for days 1-5 and $0 co-pay per day for days 6-90.	**In-Network** For each Medicare-covered hospital stay: $372 co-pay per day for days 1-5 and $0 co-pay per day for days 6-90.

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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.)	$29	$29

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

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

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as co-pays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$7,500	$7,500 Once you have paid $7,500 out-of-pocket for covered services, you will pay nothing for your covered services 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.arkbluemedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to 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)
Dental Services (Medicare-covered)	**In-Network** You pay a $45 co-pay for Medicare-covered services. **Out-of-Network** In Arkansas: You pay 40% of the total cost, after deductible, for Medicare-covered services. Outside Arkansas: You pay a $45 co-pay for Medicare-covered services.	**In-Network** You pay a $50 co-pay for Medicare-covered services. **Out-of-Network** In Arkansas: You pay 40% of the total cost, after deductible, for Medicare-covered services. Outside Arkansas: You pay a $50 co-pay for Medicare-covered services.

Routine Dental (limitations and exclusions apply)	Plan has an unlimited maximum per year for preventive dental.	Plan covers a $2,000 annual maximum for routine dental services.
	In-Network You pay a $10 co-pay for Prophylaxis (Cleaning), limit two times per year.	**In-Network** You pay a $0 co-pay for Prophylaxis (Cleaning), limit two times per year.
	Restorative Services is not covered.	You pay 50% of the total cost for Restorative Services, limit one per year.
	Extractions is not covered.	You pay a $20 co-pay for Extractions, limit two per year.
	Periodontics is not covered.	You pay 50% of the total cost for Periodontics, limit up to two every 12 to 36 months.
	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services is not covered.	You pay a $20 co-pay for denture adjustments (Prosthodontics), limit two per year.
		You pay 50% of the total cost for denture repairs and reline (Prosthodontics), limit two every 12 to 36 months.
	Out-of-Network Restorative Services is not covered.	**Out-of-Network** You pay 50% of the total cost for Restorative Services, limit one per year.
	Extractions is not covered.	You pay 50% of the total cost for Extractions, limit two per year.
	Periodontics is not covered.	You pay 50% of the total cost for Periodontics, limit up to two every 12 to 36 months.

Cost	2021 (this year)	2022 (next year)
	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services is not covered.	You pay 50% of the total cost for denture adjustments (Prosthodontics), limit two per year, and denture repairs and reline (Prosthodontics), limit two every 12 to 36 months.
Diabetic Services and Supplies	**In-Network** **Diabetic Testing Supplies** You pay 20% of the total cost for diabetic services and supplies. No preferred manufacturers for diabetic supplies. **Continuous Glucose Monitors (CGMs)** You pay 20% of the total cost for CGMs. No preferred manufacturers for CGMs.	**In-Network** **Diabetic Testing Supplies** You pay a $0 co-pay for diabetic services and supplies. Lifescan (i.e. OneTouch) and Ascensia (i.e. Contour) are the preferred manufacturers for diabetic supplies. **Continuous Glucose Monitors (CGMs)** You pay a $0 co-pay for CGMs. Dexcom and Freestyle Libre CGMs are the preferred manufacturers.
Hearing Aids Including Fitting/Evaluation (performed by a TruHearing provider)	**In-Network** Hearing aid purchase includes: •Three provider visits within first year of hearing aid purchase •45-day trial period •48 batteries per aid for non-rechargeable models.	**In-Network** Hearing aid purchase includes: •First year of follow-up provider visits •60-day trial period •80 batteries per aid for non-rechargeable models

Cost	2021 (this year)	2022 (next year)
Inpatient Hospital Stays	**In-Network** A new benefit period will start after three days of discharge.	**In-Network** Benefit period is per admission or per stay.
Inpatient Mental Health Stays	**In-Network** Benefit period is Original Medicare.	**In-Network** Benefit period is per admission or per stay.
Medicare Part B Prescription Drugs	**In- and Out-of-Network** Step therapy is not required.	**In- and Out-of-Network** 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.)
Special Supplemental Benefits for the Chronically Ill (Help with Certain Chronic Conditions)	**In-Network** Special Supplemental Benefits for the Chronically Ill is not covered.	**In-Network** You pay a $0 co-pay for Dental Xtra℠. **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

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BlueMedicare Value (PFFS)

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 (PFFS).

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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 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 (PFFS).
- To **change to Original Medicare and add a Medicare prescription drug plan or change to a different drug plan,** you must:
    - Send us a written request to disenroll from BlueMedicare Value (PFFS) 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. Contact Member Services if you need more information on how to disenroll (phone numbers are in Section 6.1 of this booklet);

- – *and* – Contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled.

- 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 8, 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 8, 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 Questions?

Section 5.1 – Getting Help from BlueMedicare Value (PFFS)

Questions? We're here to help. Please call Customer Service at 1-877-233-7022. (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 (PFFS). 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*).

Section 5.2 – 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.