Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage Blue Classic (HMO) offered by HMO Partners, Inc. (d/b/a Health Advantage)

Annual Notice of Changes for 2022

You are currently enrolled as a member of Health Advantage Blue Classic (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 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, 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.

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

☐ 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 Health Advantage Blue Classic (HMO).
- 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 Health Advantage Blue Classic (HMO).
- 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 1-877-349-9335 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 Health Advantage Blue Classic (HMO)

- HMO Partners, Inc. DBA Health Advantage offers HMO plans with a Medicare contract. Enrollment in Health Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means HMO Partners, Inc (d/b/a Health Advantage). When it says "plan" or "our plan," it means Health Advantage Blue Classic (HMO).

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Health Advantage Blue Classic (HMO) 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.HAmedicare.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.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.1 for details.)	$6,000	$6,000
Doctor office visits	Primary care visits: $0 co-pay for each Medicare-covered visit. Specialist visits: $40 co-pay for each Medicare-covered visit.	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.	For each Medicare-covered hospital stay: $350 co-pay per day for days 1-5 and $0 co-pay per day for days 6-90.	For each Medicare-covered hospital stay: $375 co-pay per day for days 1-5 and $0 co-pay per day for days 6-90.

<table>
<tr><th>Cost</th><th>2021 (this year)</th><th>2022 (next year)</th></tr>
<tr><td>Part D prescription drug coverage
(See Section 1.5 for details.)</td><td>Deductible: $250

Copayment/Coinsurance during the Initial Coverage Stage:

Standard Retail
• Drug Tier 1: $10 co-pay
• Drug Tier 2: $20 co-pay
• Drug Tier 3: $47 co-pay
• Drug Tier 4: 47% of the total cost
• Drug Tier 5: 28% of the total cost
• Drug Tier 6: $0 co-pay

Preferred Retail
• Drug Tier 1: $3 co-pay
• Drug Tier 2: $13 co-pay
• Drug Tier 3: $40 co-pay
• Drug Tier 4: 45% of the total cost
• Drug Tier 5: 28% of the total cost
• Drug Tier 6: $0 co-pay</td><td>Deductible: $250

Copayment/Coinsurance during the Initial Coverage Stage:

Standard Retail
• Drug Tier 1: $3 co-pay
• Drug Tier 2: $13 co-pay
• Drug Tier 3: $40 co-pay
• Drug Tier 4: 45% of the total cost
• Drug Tier 5: 28% of the total cost
• Drug Tier 6: $0 co-pay

Preferred Retail
Preferred cost sharing does not apply for the 2022 plan year.</td></tr>
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Annual Notice of Changes for 2022
Table of Contents

Summary of Important Costs for 2022 1

SECTION 1 Changes to Benefits and Costs for Next Year 4

Section 1.1– Changes to Your Maximum Out-of-Pocket Amount 4

Section 1.2 – Changes to the Provider Network 4

Section 1.3– Changes to the Pharmacy Network 5

Section 1.4 – Changes to Benefits and Costs for Medical Services 5

Section 1.6 – Changes to Part D Prescription Drug Coverage 9

SECTION 2 Deciding Which Plan to Choose 14

Section 2.1 – If you want to stay in Health Advantage Blue Classic (HMO) 14

Section 2.2 – If you want to change plans 14

SECTION 3 Deadline for Changing Plans 15

SECTION 4 Programs That Offer Free Counseling about Medicare 15

SECTION 5 Programs That Help Pay for Prescription Drugs 15

SECTION 6 Questions? 16

Section 6.1 – Getting Help from Health Advantage Blue Classic (HMO) 16

Section 6.2 – Getting Help from Medicare 17

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1– 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) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,000	$6,000 Once you have paid $6,000 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

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.HAmedicare.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.

Our network has changed more than usual for 2022. An updated *Pharmacy Directory* is located on our website at www.HAmedicare.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **We strongly suggest that you review our current *Pharmacy Directory* to see if your pharmacy is still 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)
Routine Dental (limitations and exclusions apply)	Plan has an unlimited maximum per year for preventive dental services. **In-Network** You pay a $10 co-pay for Prophylaxis (Cleaning), limit two times per year. Restorative Services is not covered. Extractions is not covered. Periodontics is not covered. Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services is not covered.	Plan covers a $2,000 annual maximum for routine dental services. **In-Network** You pay a $0 co-pay for Prophylaxis (Cleaning), limit two times per year. You pay 50% of the total cost Restorative Services, limit one per year. You pay a $20 co-pay for Extractions, limit two per year. You pay 50% of the total cost for Periodontics, limit up to two every 12 to 36 months. 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.

Cost	2021 (this year)	2022 (next year)
Diabetic Services and Supplies	**In-Network** **Diabetic Testing Supplies** No preferred manufacturers for diabetic supplies. **Continuous Glucose Monitors (CGMs)** No preferred manufacturers for CGMs. Prior authorization is not required.	**In-Network** **Diabetic Testing Supplies** Lifescan (i.e., OneTouch) and Ascensia (i.e., Contour) are the preferred manufacturers for diabetic supplies. **Continuous Glucose Monitors (CGMs)** Dexcom and Freestyle Libre CGMs are the preferred manufacturers. Prior authorization is required.
Emergency Services	**In- and Out-of-Network** The emergency services co-pay will be waived if you are admitted to the hospital within three days.	**In- and Out-of-Network** The emergency services co-pay will be waived if you are admitted to the hospital within 24 hours.
Hearing Aids Including Fitting/Evaluation	**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
Home Health	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
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.

Cost	2021 (this year)	2022 (next year)
Inpatient Mental Health Stays	**In-Network** Benefit period is Original Medicare.	**In-Network** Benefit period is per admission or per stay.
Medical Supplies	**In-Network** Prior authorization is not required.	**In-Network** Prior authorization is required.
Medicare Part B Prescription Drugs	**In-Network** Step therapy not required. Prior authorization is not required.	**In-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.) Prior authorization is required.
Outpatient Diagnostic Therapeutic and Radiology Services	**In-Network** You pay a $25 co-pay for outpatient X-ray services performed in an outpatient or free-standing facility. Prior authorization is not required for X-ray services.	**In-Network** You pay a $0 co-pay for outpatient X-ray services performed in an outpatient or free-standing facility. Prior authorization is required for X-ray services.
Outpatient Hospital Services	**In-Network** Prior authorization is required.	**In-Network** Prior authorization is not required.
Skilled Nursing Facility (SNF) Care	**In-Network** 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.	**In-Network** 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.

Cost	2021 (this year)	2022 (next year)
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 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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.HAmedicare.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)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tiers 3, 4, and 5 drugs until you have reached the yearly deductible.	The deductible is $250. During this stage, you pay a $3 co-pay (at preferred pharmacies) and a $10 co-pay (at standard pharmacies) for drugs on Tier 1, a $13 co-pay (at preferred pharmacies) and a $20 co-pay (at standard pharmacies) for drugs on Tier 2, a $0 co-pay (at preferred and standard pharmacies) for drugs on Tier 6 and the full cost of drugs on tiers 3, 4, and 5 until you have reached the yearly deductible.	The deductible is $250. During this stage, you pay a $3 co-pay (at standard pharmacies) for drugs on Tier 1, a $13 co-pay (at standard pharmacies) 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.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage 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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:

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. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Tier 1 = Preferred Generic drugs:** *Standard cost sharing:* You pay a $10 co-pay per prescription. *Preferred cost sharing:* You pay a $3 co-pay per prescription. **Tier 2 = Generic drugs:** *Standard cost sharing:* You pay a $20 co-pay per prescription. *Preferred cost sharing:* You pay a $13 co-pay per prescription. **Tier 3 = Preferred Brand drugs:** *Standard cost sharing:* You pay a $47 co-pay per prescription. *Preferred cost sharing:* You pay a $40 co-pay per prescription. **Tier 4 = Non-Preferred drugs:** *Standard cost sharing:* You pay 47% of the total cost. *Preferred cost sharing:* You pay 45% of the total cost.	**Tier 1 = Preferred Generic drugs:** *Standard cost sharing:* You pay a $3 co-pay per prescription. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year. **Tier 2 = Generic drugs:** *Standard cost sharing:* You pay a $13 co-pay per prescription. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year. **Tier 3 = Preferred Brand drugs:** *Standard cost sharing:* You pay a $40 co-pay per prescription. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year. **Tier 4 = Non-Preferred drugs:** *Standard cost sharing:* You pay 45% of the total cost. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5 = Specialty drugs:** *Standard cost sharing:* You pay 28% of the total cost. *Preferred cost sharing:* You pay 28% of the total cost. **Tier 6 = Select Care drugs:** *Standard cost sharing:* You pay a $0 co-pay per prescription. *Preferred cost sharing:* You pay a $0 co-pay per prescription. ______________ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 = Specialty drugs:** *Standard cost sharing:* You pay 28% of the total cost. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year. **Tier 6 = Select Care drugs:** *Standard cost sharing:* You pay a $0 co-pay per prescription. *Preferred cost sharing:* Preferred cost sharing does not apply for the 2022 plan year. ______________ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Health Advantage Blue Classic (HMO)

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 Health Advantage Blue Classic (HMO).

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.

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, HMO Partners, Inc (d/b/a Health Advantage) offers other Medicare health 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 Health Advantage Blue Classic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Health Advantage Blue Classic (HMO).
- 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 visit https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program.

SECTION 6 Questions?

Section 6.1 – Getting Help from Health Advantage Blue Classic (HMO)

Questions? We're here to help. Please call Customer Service at 1-877-349-9335. (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 Health Advantage Blue Classic (HMO). 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.HAmedicare.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.HAmedicare.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.