Blue Medicare Advantage Flex (Local PPO) offered by Blue Medicare Advantage

Annual Notice of Changes for 2022

You are currently enrolled as a member of *Blue Medicare Advantage Flex*. 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 1.3 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 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.

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

- 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 and You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in *Blue Medicare Advantage Flex.*
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

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

- If you **don't join another plan by December 7, 2021**, you will be enrolled in *Blue Medicare Advantage Flex*.
- 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 Services number at 1-866-508-7140 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day.
- This document may be available in other formats such as braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *Blue Medicare Advantage Flex*

- Blue Medicare Advantage is an independent licensee of the Blue Cross and Blue Shield Association. All products are offered by Missouri Valley Life And Health Insurance Company, a wholly-owned subsidiary of Blue Medicare Advantage. Blue Medicare Advantage's Blue Medicare Advantage Flex is a PPO with a Medicare contract. Enrollment in Blue Medicare Advantage Flex depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Blue Medicare Advantage. When it says "plan" or "our plan," it means Blue Medicare Advantage Flex.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for *Blue Medicare Advantage Flex* 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.medicarebluekc.com. You may also call Customer Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $4,000 From network and out-of-network providers combined: $4,000	From network providers: $4,000 From network and out-of-network providers combined: $4,000
Doctor office visits	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $20 Copay per visit **Out-of-Network** Primary care visits: $5 Copay per visit Specialist visits: $20 Copay per visit	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $20 Copay per visit **Out-of-Network** Primary care visits: $0 Copay per visit Specialist visits: $20 Copay per visit

Cost	2021 (this year)	2022 (next year)
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** You pay a $285 Copay per day for days 1-6. You pay a $0 Copay per day for days 7 and beyond. **Out-of-Network** You pay a $285 Copay per day for days 1-6. You pay a $0 Copay per day for days 7-90.	**In-Network** You pay a $285 Copay per day for days 1-6. You pay a $0 Copay per day for days 7 and beyond. **Out-of-Network** $285 Copay per day for days 1-6. You pay a $0 Copay per day for days 7-90.

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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.)	$0	$0

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

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

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount.	$4,000	$4,000 Once you have paid $4,000 out-of-pocket for covered Part A and Part B services from network providers, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2021 (this year)	2022 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$4,000	$4,000 Once you have paid $4,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.medicarebluekc.com. You may also call Customer 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.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Dental Services	**In-Network:** You pay a $20 Copay for Medicare-covered Dental services. **In-Network and Out-of-Network:** You pay nothing for preventive dental services. **In-Network and Out-of-Network:** You pay 50% coinsurance for covered comprehensive dental services. • Non-routine, Diagnostic, Periodontic Services (2 visits per year)	**In-Network and Out-of-Network:** You pay a $20 Copay for Medicare-covered Dental services. There is a $1,000 per year benefit allowance every year for Dental, Hearing services, Transportation and Eyewear combined. Allowance is combined In and Out of Network.

Cost	2021 (this year)	2022 (next year)
	• Restorative Services (filings or crowns) (2 teeth per year) • Endodontic Services (root canal) (1 tooth per year) • Extractions (simple or surgical) (2 teeth per year) There is a $1,000 benefit allowance for preventive and comprehensive dental services every year.	
Diabetic Supplies (Medicare-covered)	**In-Network and Out-of-Network:** You pay a $0 copay for Bayer/Ascensia Medicare covered diabetes monitoring supplies when obtained at a pharmacy. You pay 20% coinsurance for all other brands of Medicare covered diabetes monitoring supplies when obtained at a pharmacy. You pay a $0 copay for Medicare-covered diabetes monitoring supplies when obtained from Edgepark.	**In-Network and Out-of-Network:** You pay a $0 copay for Bayer/Ascensia Medicare covered diabetes monitoring supplies when obtained at a pharmacy. You pay 20% coinsurance for all other brands of Medicare covered diabetes monitoring supplies at a Pharmacy or any brand at a DME provider. You pay a $0 copay for Continuous Glucose Monitors (CGM) at a Pharmacy.
Hearing Services	**In-Network and Out-of-Network:** You pay a $20 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. **In-Network and Out-of-Network:** You pay a $0 copay for 1 routine hearing	**In-Network and Out-of-Network:** You pay a $20 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. **In-Network and Out-of-Network:** There is a $1,000 per year benefit allowance every

Cost	2021 (this year)	2022 (next year)
	exam a year when using the TruHearing network. **In-Network and Out-of-Network:** You pay a $0 copay for up to 3 fitting evaluations for hearing aids per year when using the TruHearing network. **In-Network and Out-of-Network:** You pay a $699 copay for the TruHearing Advanced hearing aid model. Benefit includes one hearing aid per ear each year. You pay a $999 copay for the TruHearing Premium hearing aid model. Benefit includes one hearing aid per ear each year.	year for Dental, Hearing services, Transportation and Eyewear combined. Allowance is combined In and Out of Network.
Over the Counter Items (OTC)	Your benefit is $25 per month for eligible OTC items.	Your benefit is $500 every year for eligible OTC items.
Physician Services	**In-Network and Out-of-Network:** You pay a $5 copay for each primary care provider visit. **In-Network:** You pay a $0 copay for other health care professional services for primary care. You pay a $20 copay for other healthcare professionals for specialty care.	**In-Network and Out-of-Network:** You pay a $0 copay for each primary care provider visit. **In-Network:** You pay a $0 copay for other health care professional services for primary care. You pay a $20 copay for other healthcare professionals for specialty care.

Cost	2021 (this year)	2022 (next year)
	Out-of-Network: You pay a $5 copay for other health care professional services for primary care. You pay a $20 copay for other healthcare professionals for specialty care.	**Out-of-Network:** You pay a $0 copay for other health care professional services for primary care. You pay a $20 copay for other healthcare professionals for specialty care.
Podiatry Services	**In-Network and Out-of-Network:** You pay a $20 copay up to 6 routine foot care visits a year.	**In-Network and Out-of-Network:** You pay a $20 copay up to 6 routine foot care visits a year. For members who qualify due to certain chronic conditions under Flexible Uniformity, you pay $0 copay for an in-home foot evaluation, including a waterless pedicure up to 12 visits a year.
Radiological Services (Medicare-covered)	**In-Network:** You pay a $185 copay for diagnostic radiology services in a physician's office or free-standing radiology clinic. You pay $285 copay diagnostic radiology services at all other locations. **Out-of-Network:** You pay 20% coinsurance for diagnostic radiology services.	**In-Network:** You pay a $185 copay for diagnostic radiology services in a physician's office or free-standing radiology clinic. You pay $285 copay diagnostic radiology services at all other locations. **Out-of-Network:** You pay a $185 copay for diagnostic radiology services in a physician's office or free-standing radiology clinic. You pay $285 copay diagnostic radiology services at all other locations.

Cost	2021 (this year)	2022 (next year)
Special Supplemental Benefits for the Chronically Ill Meals and Meal Supplemental Nutritional Shakes	For members who qualify with certain conditions you pay a $0 copay for up to 2 meals per day, for up to 10 weeks. Members who qualify with certain conditions you pay a $0 copay for Nutritional shakes available for up to 8 weeks (60 units) per year.	Not a covered benefit.
Step Therapy	Not Applicable	Requires the previous use of one of more drugs before coverage of a different drug is provided.
Surgical Services in an Ambulatory Surgery Center (Medicare-covered)	**In-Network and Out-of-Network:** You pay a $285 copay for each surgery at an ambulatory surgical center.	**In-Network and Out-of-Network:** You pay a $285 copay for each surgery at an ambulatory surgical center. You pay 20% coinsurance for minor surgical procedures at an ambulatory surgical center.
Transportation Services	Not a covered benefit.	You may use your Blue Benefit Bucks card to schedule and pay for transportation services to any health location. There is a $1000 per year benefit allowance every year combined with Hearing Services, Transportation, Dental and Eyewear services.
Vision Services	**In-Network and Out-of-Network:** You pay a $20	**In-Network and Out-of-Network:** You pay a $20 copay

Cost	2021 (this year)	2022 (next year)
	copay for each Medicare-covered eye exam. **In-Network and Out-of-Network:** You pay a $0 copay for Medicare-covered glaucoma and diabetic eye exams. **In-Network and Out-of-Network:** You pay $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal, or lenticular lenses). There is $300 allowance Every Year for eyeglasses (lenses and frames) or contact lenses. Allowance is combined In-Network and Out-of-Network. You pay a $0 copay for routine eye exam every year. You must use an EyeMed network provider for in-network benefits.	for each Medicare-covered eye exam. **In-Network and Out-of-Network:** You pay a $0 copay for Medicare-covered glaucoma and diabetic eye exams. There is a $1000 per year benefit allowance every year combined with Hearing Services, Transportation, Dental and Eyewear services. You pay a $0 copay for routine eye exam every year.

SECTION 2 Administrative Changes

Cost	2021 (this year)	2022 (next year)
Customer Support	To contact Customer Service, you may call 1-866-508-7140 (TTY 711.)	To contact Customer Service, you may call 1-866-508-7140 (TTY 711.)

Cost	2021 (this year)	2022 (next year)
		You may skip the wait and text the word: #BKC4HELP to the number 543210. This holds your place in line and the next available Customer Service representative will call you. You may access benefits via interactive text by texting the word: #BMA22 to the number 543210. You receive brief highlights of all your benefit extras via text message.
Healthy Reward Money for healthy actions • Annual Wellness visit • Colorectal screening • Diabetic eye exam; or • Mammogram	After having a healthy action, you selected a $25 gift card (up to $50 per year) after registering online.	When you have a healthy action, $25 benefit allowance will be deposited on to your Blue Benefit Bucks card, up to $50 per year. Your Blue Benefit Bucks can be used for dental, eyewear, transportation, hearing, healthy foods, or over the counter items. Your Blue Benefit Bucks card will be mailed to you in December. Allow 8-10 weeks* from the date of service for your $25 healthy action to be credited to your Blue Benefit Bucks card. *Additional time may apply based on receipt and processing of the claim.

Cost	2021 (this year)	2022 (next year)
Optometry and Ophthalmology Providers	Routine eye care (refraction exam and glasses or contacts) is provided through EyeMed.	Routine eye care (refraction exam and glasses and/or contacts) may be accessed through your Blue Medicare Advantage provider. To find a participating Optometrist or Ophthalmologist go online at www.BlueKCMA.com. Select Find a Doctor at the top right corner of the web page.
Over the Counter Items (OTC)	Your benefit administrator is Solutran for Healthy Benefits.	Your benefit administrator is NationsBenefits. You can order online and monitor your balances at NationsOTC.com/BlueKC Your new OTC card will be mailed to you in mid-December.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Blue Medicare Advantage Flex*

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Blue Medicare Advantage Flex.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare and You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Blue Medicare 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 *Blue Medicare Advantage Flex.*
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Blue Medicare Advantage Flex.*
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

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

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

change at other times of the year. For more information, see Chapter 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 Chapter 8, Section 2.2 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK). In Missouri, the SHIP is called Community Leaders Assisting the Insured of Missouri (CLAIM).

SHICK and CLAIM are independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHICK and CLAIM counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call (SHICK) at 1-785-296-4986 or toll free 1-800-860-5260 (TTY: 711). You can call CLAIM at 1-573-817-8320 or toll free 1-800-390-3330 (TTY: 711). You can learn more about SHICK by visiting their website www.kdads.ks.gov. You can learn more about CLAIM by visiting their website www.missouriclaim.org.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance the Kansas Ryan White Part B Program in Kansas and Missouri Department of Health and Senior Services in Missouri. Note: To be eligible for the ADAP operating in your State, 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.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

In Kansas –

The Kansas Ryan White Part B Program
1000 SW Jackson, Ste. 210
Topeka, KS 66612

Phone: 1-785-296-6174 (TTY: 711)
Fax: 1-785-559-4225

In Missouri –
HIV/AIDS Case Management Program Bureau of HIV, STD, and Hepatitis
Missouri Department of Health and Senior Services
P.O. Box 570
Jefferson City, MO 65102-0570

Phone: 1-573-751-6439 (TTY: 711)
Fax: 1-573-751-6447
Email: info@health.mo.gov

SECTION 7 Questions?

Section 7.1 – Getting Help from *Blue Medicare Advantage Flex*

Questions? We're here to help. Please call Customer Services at 1-866-508-7140. (TTY only, call 711.) We are available for phone calls seven days a week from 8 a.m. to 8 p.m. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for *Blue Medicare Advantage Flex.* 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.medicarebluekc.com. You may also call Customer Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.medicarebluekc.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare and You 2022*

You can read the *Medicare and 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.