City of Kansas City PPO Plan 1 (PPO) offered by Blue Medicare Advantage

Annual Notice of Changes for 2022

You are currently enrolled as a member of City of Kansas City PPO Plan 1. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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 1.5 and 1.6 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 1.6 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 1.3 for information about our *Provider and Pharmacy 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 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. Contact your employer for instructions on when you may change to a different plan that may better meet your needs.

4. **ENROLL:** To change plans, join a plan offered by your employer. Or, you may select other options during Medicare's Annual Enrollment Period between October 15 and December 7.

Additional Resources

- Please contact our Customer Service 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 City of Kansas City PPO Plan 1

- Blue Cross and Blue Shield of Kansas City 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 Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City's Blue Medicare Advantage is a PPO with a Medicare contract. Enrollment in Blue Medicare Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Blue Cross and Blue Shield of Kansas City. When it says "plan" or "our plan," it means City of Kansas City PPO Plan 1.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for City of Kansas City PPO Plan 1 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/cityofkcmo. 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. See Section 1.1 for details.	Please refer to your Employer's Benefit department for your premium.	Please refer to your Employer's Benefit department for your premium.
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.)	**In-Network Providers:** $2,000 In-network and out-of-network providers combined: $10,000	**In-Network providers:** $2,000 In-network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $30 Copay per visit **Out-of-Network** Primary care visits: $5 Copay per visit Specialist visits: $30 Copay per visit	**In-Network** Primary care visits: $5 Copay per visit Specialist visits: $30 Copay per visit **Out-of-Network** Primary care visits: $5 Copay per visit Specialist visits: $30 Copay per 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	**In-Network** You pay a $165 Copay per day for days 1-5. You pay a $0 Copay per day for days 6 & beyond. **Out-of-Network**	**In-Network** You pay a $165 Copay per day for days 1-5. You pay a $0 Copay per day for days 6 & beyond. **Out-of-Network**

Cost	2021 (this year)	2022 (next year)
hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $165 Copay per day for days 1-5. You pay a $0 Copay per day for days 6-90.	You pay a $165 Copay per day for days 1-5. You pay a $0 Copay per day for days 6-90.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 • Drug Tier 2: $10 • Drug Tier 3: $25 • Drug Tier 4: $50 • Drug Tier 5: 33%	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 • Drug Tier 2: $10 • Drug Tier 3: $25 • Drug Tier 4: $50 • Drug Tier 5: 33%

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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.)	Please refer to your Employer's Benefit department for your premium.	Please refer to your Employer's Benefit department for your premium.

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

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. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$2,000	$2,000 Once you have paid $2,000 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 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. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$10,000	$10,000 Once you have paid $10,000 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 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 and Pharmacy Directory* is located on our website at www.medicarebluekc.com/cityofkcmo. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy 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 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 *Provider and Pharmacy Directory* is located on our website at www.medicarebluekc.com/cityofkcmo. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – 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)
Hearing Services	**In Network:** You pay a $30 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. You pay a $0 copay for one routine hearing exam each year. You pay a $0 copay for each fitting and evaluation for Hearing Aid visit. Our plan also covers $500 benefit maximum for non-Medicare hearing aids In and Out of Network combined. **Out-Of-Network** You pay a $30 copay for each Medicare-covered hearing exam to diagnose and treat hearing and balance issues. You pay a $0 copay for one routine hearing exam each year. You pay a $0 copay for each fitting and evaluation for Hearing Aid visit. Our plan also covers $500 benefit maximum for non-Medicare hearing aids In and Out of Network combined.	**In Network:** You pay a $30 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. You pay a $0 copay for one routine hearing exam each year. You pay a $0 copay for each fitting and evaluation for Hearing Aid visit. You pay a $0 copay for Level I hearing aids per ear, per year when using the NationsBenefits network. A $500 benefit allowance per ear every year. **Out-Of-Network** You pay a $30 copay for each Medicare-covered hearing exam to diagnose and treat hearing and balance issues. You pay a $0 copay for one routine hearing exam each year. You pay a $0 copay for each fitting and evaluation for Hearing Aid visit. You pay a $0 copay for Level I hearing aids per ear, per year when using the NationsBenefits network. A $500 benefit allowance per ear every year.

Cost	2021 (this year)	2022 (next year)
Meals for Chronic Conditions	For members who qualify due to certain chronic conditions under the Special Supplemental Benefits for the Chronically Ill benefit, you pay nothing 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.	For members who qualify with certain chronic conditions you pay $0 copay for up to 2 meals per day, for up to 4 weeks or 56 pre-cooked, pre-packaged meals. Members who qualify with certain chronic conditions may also choose nutritional shakes for up to 4 weeks (24 shakes).

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.
    - 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.

Formulary exception approvals are typically valid for 12 months.

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 have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet, 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.medicarebluekc.com/cityofkcmo. 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	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy 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.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generics:** You pay $5 per prescription **Generics:** You pay $10 per prescription **Preferred Brand:** You pay $25 per prescription **Non-Preferred Drug:** You pay $50 per prescription **Specialty Tier:** You pay 33% of the total cost Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Preferred Generics:** You pay $5 per prescription **Generics:** You pay $10 per prescription **Preferred Brands:** You pay $25 per prescription **Non-Preferred Drugs:** You pay $50 per prescription **Specialty Tiers:** You pay 33% of the total cost 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 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.) 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.
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 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)
Hearing Services	Hearing network and services are provided through TruHearing.	Hearing network and services are provided by Nations Benefits. To schedule an appointment call 877-208-2596 (TTY: 711) between 8 a.m. to 8 p.m., Monday through Friday or go online NationsHearing.com/BlueKC
Optometry & 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.medicarebluekc.com/cityofkcmo. 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 *City of Kansas City PPO Plan 1*

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, you will automatically be enrolled in our City of Kansas City PPO Plan 1.

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.

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 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 Cross and Blue Shield of Kansas City 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 City of Kansas City PPO Plan 1.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from City of Kansas City PPO Plan 1.
- 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 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 for next year, you can do so by contacting your Employer. 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.*

Note: If you're in a drug management program, you may not be able to change plans.

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 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).
- **Prescription Cost Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Kansas Ryan White Part B Program in Kansas and Missouri Department of Health and Senior Services in Missouri. 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 *City of Kansas City PPO Plan 1*

Questions? We're here to help. Please call Customer Service at 1-866-508-7140. (TTY only, call 711.) We are available for phone calls 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 City of Kansas City PPO Plan 1. 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/cityofkcmo. 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.medicarebluekc.com/cityofkcmo. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

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 & 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.