Wellmark. Advantage Health Plan

***Blue Medicare Advantage PPO offered by Wellmark Advantage Health Plan***

# Annual Notice of Changes for 2023

You are currently enrolled as a member of Blue Medicare Advantage PPO. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **www.Wellmark.com/Medicare/Advantage/Resources**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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

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### What to do now

1. **ASK:** Which changes apply to you

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

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

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**2. COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Blue Medicare Advantage PPO.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Blue Medicare Advantage PPO.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## Additional Resources

- Please contact our Customer Service number at 1-855-716-2544 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., local time, Monday through Friday, with weekend hours October 1 through March 31.
- This information is available in large print and 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 PPO

- Wellmark Advantage Health Plan is a PPO plan with a Medicare contract. Enrollment in Wellmark Advantage Health Plan depends on contract renewal.
- When this document says "we," "us," or "our," it means Wellmark Advantage Health Plan. When it says "plan" or "our plan," it means Blue Medicare Advantage PPO.
- Out-of-network/non-contracted providers are under no obligation to treat Blue Medicare Advantage PPO members, except in emergency situations. Please call our Customer Service number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

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## Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Blue Medicare Advantage PPO in several important areas. **Please note this is only a summary of costs.**

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium may be higher than this amount. See Section 1.1 for details. | $0 | $0 |
| **Maximum out-of-pocket amounts** <br> This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.) | From network providers: $3,900 <br> From network and out-of-network providers combined: $6,700 | From network providers: $3,750 <br> From network and out-of-network providers combined: $6,700 |
| **Doctor office visits** | Primary care visits: In-Network: $10 copay per visit. Out-of-Network: $20 copay per visit. <br> Specialist visits: In-Network: $40 copay per visit. Out-of-Network: $50 copay per visit. | Primary care visits: In-Network: $0 copay per visit. Out-of-Network: $20 copay per visit. <br> Specialist visits: In-Network: $40 copay per visit. Out-of-Network: $50 copay per visit. |
| **Inpatient hospital stays** | In-Network: For Medicare-covered hospital stays you pay: <br> $375 copay per day for days 1-4. <br> $0 copay per day for days 5-90. <br> $0 copay per day for days over 90. | In-Network: For Medicare-covered hospital stays you pay: <br> $370 copay per day for days 1-4. <br> $0 copay per day for days 5-90. <br> $0 copay per day for days over 90. |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Inpatient hospital stays (continued)** | Out-of-Network:<br>For Medicare-covered hospital stays you pay:<br>$400 copay per day for days 1-4.<br>$0 copay per day for days 5-90.<br>$0 copay per day for days over 90. | Out-of-Network:<br>For Medicare-covered hospital stays you pay:<br>$400 copay per day for days 1-4.<br>$0 copay per day for days 5-90.<br>$0 copay per day for days over 90. |
| **Part D prescription drug coverage**<br>(See Section 1.5 for details.) | Deductible: $0<br>Copay/Coinsurance for a one-month supply during the Initial Coverage Stage:<br>**Standard** retail pharmacy:<br>Drug Tier 1: $8<br>Drug Tier 2: $20<br>Drug Tier 3: $47<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance<br>**Preferred** retail pharmacy:<br>Drug Tier 1: $0<br>Drug Tier 2: $10<br>Drug Tier 3: $47<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance<br>**Mail-order** pharmacy:<br>Drug Tier 1: $0<br>Drug Tier 2: $8<br>Drug Tier 3: $49<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance | Deductible: $0<br>Copay/Coinsurance for a one-month supply during the Initial Coverage Stage:<br>**Standard** retail pharmacy:<br>Drug Tier 1: $8<br>Drug Tier 2: $20<br>Drug Tier 3: $47<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance<br>**Preferred** retail pharmacy:<br>Drug Tier 1: $0<br>Drug Tier 2: $10<br>Drug Tier 3: $47<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance<br>**Mail-order** pharmacy:<br>Drug Tier 1: $0<br>Drug Tier 2: $8<br>Drug Tier 3: $49<br>Drug Tier 4: $100<br>Drug Tier 5: 33% coinsurance |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Senior Savings Program**<br>To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the abbreviation "SI" under *Requirements/Limits*. If you have questions about the Drug List, you can also call Customer Service (phone numbers for Customer Service are printed in Section 6 of this booklet). | Not available | You pay a $35 copay for a one-month supply of Tier 3 Select Insulins. |

# SECTION 1 Changes to Benefits and Costs for Next Year

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $0 | $0 |

- 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.

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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 | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **In-network maximum out-of-pocket amount**<br><br>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $3,900 | $3,750<br><br>Once you have paid $3,750 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. |
| **Combined maximum out-of-pocket amount**<br><br>Your costs for covered medical services (such as copays) from | $6,700 | $6,700<br><br>Once you have paid $6,700 out-of-pocket for covered Part A and Part B |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Combined maximum out-of-pocket amount (continued)** in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services. | | 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 and Pharmacy Networks

Updated directories are located on our website at **www.Wellmark.com/Finder-Medicare**. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

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

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Acupuncture** | **Out-of-Network**<br>You pay a $20 copay for each Medicare-covered acupuncture service. | **Out-of-Network**<br>You pay a $55 copay for each Medicare-covered acupuncture service. |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Ambulance services** | You pay a $325 copay for each Medicare-covered, one-way air ambulance trip. | You pay a $275 copay for each Medicare-covered, one-way air ambulance trip. |
| **Diabetic supplies**<br>Blood glucose test strips, lancet devices and lancets. | You pay 20% of the total cost for Medicare-covered diabetic lancets and test strips. | You pay a $0 copay for Medicare-covered diabetic lancets and test strips. |
| **Hearing services** | **In-Network**<br>You pay a $10 copay for Medicare-covered services from a primary care provider.<br>You pay a $40 copay for Medicare-covered services from a specialist.<br>**Out-of-Network**<br>You pay a $15 copay for Medicare-covered services from a primary care provider.<br>You pay a $40 copay for Medicare-covered services from a specialist. | **In-Network**<br>You pay a $0 copay for Medicare-covered services from a primary care provider.<br>You pay a $40 copay for Medicare-covered services from a specialist.<br>**Out-of-Network**<br>You pay a $20 copay for Medicare-covered services from a primary care provider.<br>You pay a $50 copay for Medicare-covered services from a specialist. |
| **Inpatient hospital care** | You pay a $375 copay per days for days 1-4<br>You pay a $0 copay per days for days 5-90<br>You pay a $0 copay per days for days over 90 | You pay a $370 copay per days for days 1-4<br>You pay a $0 copay per days for days 5-90<br>You pay a $0 copay per days for days over 90 |
| **Inpatient services in a psychiatric hospital** | You pay a $375 copay per days for days 1-4<br>You pay a $0 copay per days for days 6-90<br>You pay a $0 copay per | You pay a $370 copay per days for days 1-4<br>You pay a $0 copay per days for days 6-90<br>You pay a $0 copay per |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Inpatient services in a psychiatric hospital (continued)** | days for days 91-190 until lifetime limitation is exhausted. | days for days 91-190 until lifetime limitation is exhausted. |
| **Meal benefit**<br>This program offers:<br>• Health-specific menus designed to support your nutritional needs<br>• High quality, refrigerated meals arrive at your home when you need them most<br>• Easy to prepare meals last for 14 days in the fridge—just heat, eat and enjoy within minutes | Meal benefit is not covered. | You pay a $0 copay for this meal benefit.<br>Members who have been discharged from an inpatient hospital or skilled nursing facility may be eligible for a 14-day, 28-meal benefit through Mom's Meals. If you qualify, your care manager will make a referral.<br>Members are eligible for this benefit for a 30-day period after they return home from the hospital.<br>Benefit is limited to twice annually. |
| **Outpatient diagnostic test and therapeutic services and supplies** | **In-Network**<br>You pay a $10 copay for Medicare-covered X-rays and low-tech radiological services in a professional office setting.<br>You pay a $285 copay for Medicare-covered X-rays and low-tech radiological services in a hospital setting.<br>You pay a $10 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET when performed by a primary care physician in | **In-Network**<br>You pay a $20 copay for Medicare-covered X-rays and low-tech radiological services in a professional office setting.<br>You pay a $20 copay for Medicare-covered X-rays and low-tech radiological services in a hospital setting.<br>You pay a $0 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET when performed by a primary care physician in |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Outpatient diagnostic test and therapeutic services and supplies (continued)** | a professional office setting.<br>You pay a $10 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET when performed by a specialist in a professional office setting.<br>You pay a $285 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET in a hospital setting.<br>You pay a $20 copay for outpatient diagnostic procedures and tests when performed by a primary care physician in a professional office setting.<br>You pay a $20 copay for outpatient diagnostic procedures and tests when performed by a specialist in a professional office setting.<br>You pay a $300 copay for outpatient diagnostic procedures and tests in a hospital setting.<br>**Out-of-Network**<br>You pay a $10 copay for Medicare-covered X-rays and low-tech radiological services in a professional office setting.<br>You pay a $300 copay for Medicare-covered X-rays and low-tech radiological | a professional office setting.<br>You pay a $40 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET when performed by a specialist in a professional office setting.<br>You pay a $100 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA and PET in a hospital setting.<br>You pay a $0 copay for outpatient diagnostic procedures and tests when performed by a primary care physician in a professional office setting.<br>You pay a $40 copay for outpatient diagnostic procedures and tests when performed by a specialist in a professional office setting.<br>You pay a $100 copay for outpatient diagnostic procedures and tests in a hospital setting.<br>**Out-of-Network**<br>You pay a $30 copay for Medicare-covered X-rays and low-tech radiological services in a professional office setting.<br>You pay a $30 copay for Medicare-covered X-rays and low-tech radiological |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Outpatient diagnostic test and therapeutic services and supplies (continued)** | services in a hospital setting.<br>You pay a $10 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA, and PET when performed by a primary care physician in a professional office setting.<br>You pay a $10 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA, and PET when performed by a specialist in a professional office setting.<br>You $20 copay for outpatient diagnostic procedures and tests when performed by a specialist in a professional office setting. | services in a hospital setting.<br>You pay a $20 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA, and PET when performed by a primary care physician in a professional office setting.<br>You pay a $50 copay for high-tech Medicare-covered diagnostic radiological services such as CT, MRI, MRA, and PET when performed by a specialist in a professional office setting.<br>You pay a $50 copay for outpatient diagnostic procedures and tests when performed by a specialist in a professional office setting. |
| **Outpatient hospital services** | **In-Network**<br>You pay a $100 copay for Medicare-covered outpatient hospital non-surgical services. | **In-Network**<br>You pay a $40 copay for Medicare-covered outpatient hospital non-surgical services. |
| **Outpatient rehabilitation services** | **In-Network**<br>You pay a $35 copay for each Medicare-covered occupational therapy visit. | **In-Network**<br>You pay a $40 copay for Medicare-covered occupational therapy visit. |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Outpatient substance abuse services** | **In-Network**<br>You pay a $35 copay for each Medicare-covered outpatient individual or group therapy visit. | **In-Network**<br>You pay a $40 copay for each Medicare-covered outpatient individual or group therapy visit. |
| **Over-the-counter items (from authorized vendor only)**<br>Over-the-counter (OTC) items are drugs and health related products that do not need a prescription. More than 300 OTC items are available under this benefit.<br>Visit **www.NationsBenefits.com/WellmarkMA**<br>Call **1-877-271-1467**, 24 hours a day, 7 days a week. TTY users call **711**. or complete the order form included in the NationsOTC catalog that you'll receive in the mail. | You have a $50 allowance every quarter to use toward OTC items.<br>Benefits are available each quarter (January, April, July, October). Unused OTC amounts do not roll over to the next quarter or to the next calendar year. All orders must be placed through the plan's approved vendor. Direct member reimbursement is not available. This benefit allowance does not count toward your annual maximum out-of-pocket amount. | You have a $55 allowance every quarter to use toward OTC items.<br>Benefits are available each quarter (January, April, July, October). Unused OTC amounts do not roll over to the next quarter or to the next calendar year. All orders must be placed through the plan's approved vendor. Direct member reimbursement is not available. This benefit allowance does not count toward your annual maximum out-of-pocket amount. |
| **Physician/Practitioner services, including doctor's office visits** | **In-Network**<br>You pay a $10 copay for each Medicare-covered primary care provider visit. | **In-Network**<br>You pay a $0 copay for each Medicare-covered primary care provider visit. |
| **Pulmonary rehabilitation services** | **In-Network**<br>You pay a $30 copay for each Medicare-covered service. | **In-Network**<br>You pay a $20 copay for each Medicare-covered service. |
| **Vision care** | **Out-of-Network**<br>You pay a $40 copay for an annual diabetic retinopathy exam through a non-VSP provider. | **Out-of-Network**<br>You pay a $20 copay for an annual diabetic retinopathy exam through a non-VSP provider. |

| Cost | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Vision care (continued)** | You pay a $40 copay for an annual eye exam to diagnose and treat diseases and conditions of the eye through a non-VSP specialist.<br>**Vision benefits beyond Original Medicare**<br>**Out-of-Network**<br>You pay a $40 copay for one supplemental routine eye exam per year.<br>**In-Network**<br>You pay a $0 copay for elective contacts OR one complete pair of glasses (lenses and frames) up to a $150 benefit allowance.<br>**Out-of-Network**<br>You pay 50% of the allowed amount for elective contacts OR one complete pair of glasses (lenses and frames) up to a $150 benefit allowance. | You pay a $50 copay for an annual eye exam to diagnose and treat diseases and conditions of the eye through a non-VSP specialist.<br>**Vision benefits beyond Original Medicare**<br>**Out-of-Network**<br>You pay 50% of the allowed amount for one supplemental routine eye exam per year.<br>**In-Network**<br>You pay a $0 copay for elective contacts OR one complete pair of glasses (lenses and frames) up to a $175 benefit allowance.<br>**Out-of-Network**<br>You pay 50% of the allowed amount for elective contacts OR one complete pair of glasses (lenses and frames) up to a $175 benefit allowance. |

## Section 1.5 – Changes to Part D Prescription Drug Coverage

### Changes to Our Drug List

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

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**.

To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the abbreviation "SI" under *Requirements/Limits*. If you have questions about the Drug List, you can also call Customer Service (phone numbers for Customer Service are printed in Section 6 of this booklet).

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

## 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. If you receive "Extra Help" and you haven't received this insert by October 31, 2022, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes 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.)

### Changes to the Deductible Stage

| Stage | 2022 (this year) | 2023 (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 | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br><br>During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**<br><br>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. 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.*<br><br>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 at a network pharmacy:<br><br>**Tier 1 - Preferred Generic:**<br><br>*Standard cost sharing:* You pay $8 per prescription.<br><br>*Preferred cost sharing:* You pay $0 per prescription.<br><br>**Tier 2 - Generic:**<br><br>*Standard cost sharing:* You pay $20 per prescription.<br><br>*Preferred cost sharing:* You pay $10 per prescription.<br><br>**Tier 3 - Preferred Brand:**<br><br>*Standard cost sharing:* You pay $47 per prescription.<br><br>*Preferred cost sharing:* You pay $47 per prescription.<br><br>*Senior Savings Program:* Not available | Your cost for a one-month supply at a network pharmacy:<br><br>**Tier 1 - Preferred Generic:**<br><br>*Standard cost sharing:* You pay $8 per prescription.<br><br>*Preferred cost sharing:* You pay $0 per prescription.<br><br>**Tier 2 - Generic:**<br><br>*Standard cost sharing:* You pay $20 per prescription.<br><br>*Preferred cost sharing:* You pay $10 per prescription.<br><br>**Tier 3 - Preferred Brand:**<br><br>*Standard cost sharing:* You pay $47 per prescription.<br><br>*Preferred cost sharing:* You pay $47 per prescription.<br><br>*Senior Savings Program:* You pay $35 for Select Insulins |

| Stage | 2022 (this year) | 2023 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage (continued)** | **Tier 4 - Non-Preferred Drug:**<br><br>*Standard cost sharing:* You pay $100 per prescription.<br><br>*Preferred cost sharing:* You pay $100 per prescription.<br><br>**Tier 5 - Specialty Tier:**<br><br>*Standard cost sharing:* You pay 33% of the total cost.<br><br>*Preferred cost sharing:* You pay 33% of the total cost.<br><br>_______________<br><br>Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage). | **Tier 4 - Non-Preferred Drug:**<br><br>*Standard cost sharing:* You pay $100 per prescription.<br><br>*Preferred cost sharing:* You pay $100 per prescription.<br><br>**Tier 5 - Specialty Tier:**<br><br>*Standard cost sharing:* You pay 33% of the total cost.<br><br>*Preferred cost sharing:* You pay 33% of the total cost.<br><br>_______________<br><br>Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).<br><br>Blue Medicare Advantage PPO offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply. |

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

**Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.**

**Additional Resources to Help** - Please contact our Customer Service number at 1-855-716-2544 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. local time, Monday through Friday, with weekend hours October 1 through March 31.

# SECTION 2 Deciding Which Plan to Choose

## Section 2.1 – If you want to stay in Blue Medicare Advantage PPO

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

## Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *– OR –* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (**www.medicare.gov/plan-compare**), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Wellmark Advantage Health Plan offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Blue Medicare Advantage PPO.

- 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 PPO.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
  - – *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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Iowa, the SHIP is called Senior Health Insurance Information Program (SHIIP).

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 (SHIIP) 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 (SHIIP) at 1-800-351-4664. You can learn more about Senior Health Insurance Information Program (SHIIP) by visiting their website (**shiip.iowa.gov**).

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# 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. 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; 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 Iowa Department of Public Health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-515-281-7689 from 8 a.m. to 4:30 p.m., local time, Monday through Friday.

# SECTION 6 Questions?

## Section 6.1 – Getting Help from Blue Medicare Advantage PPO

Questions? We're here to help. Please call Customer Service at 1-855-716-2544. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., local time, Monday through Friday, with weekend hours October 1 through March 31. Calls to these numbers are free.

### Read your 2023 *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 2023. For details, look in the 2023 *Evidence of Coverage* for Blue Medicare Advantage PPO. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **www.Wellmark.com/Medicare/**

**Advantage/Resources**. 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.Wellmark.com/Medicare/Advantage/Resources**. 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

Visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.

### Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) 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.

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