



2025 Annual Notice of Changes

Blue Medicare Advantage (PPO)

Northeast Region: Chase, Coffee, Douglas, Franklin, Geary, Jackson, Jefferson, Leavenworth, Linn, Lyon, Miami, Morris, Osage, Pottawatomie, Shawnee, Riley and Wabaunsee

Effective from January 1, 2025 through December 31, 2025

Blue Medicare Advantage (PPO) offered by Blue Cross and Blue Shield of Kansas

Annual Notice of Changes for 2025

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 6 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 <https://www.bcbsks.com/medicare/forms>. 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.**

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 coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 “Drug List” to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
- Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for “Extra Help” from Medicare.
- 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 Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- 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, 2024, you will stay in Blue Medicare Advantage.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Blue Medicare Advantage.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our customer service number at 1-800-222-7645 for additional information. (TTY users should call 711.) Hours of operation:
 - October 1 through March 31 – Seven days a week from 8:00 AM to 8:00 PM.
 - April 1 through September 30 – Monday through Friday 8:00 AM to 8:00 PM. This call is free.
- We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call customer service.
- **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)

- Blue Cross and Blue Shield of Kansas is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of Kansas Medicare Advantage depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Kansas. When it says “plan” or “our plan,” it means Blue Medicare Advantage (PPO).

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Blue Medicare Advantage (PPO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$0	\$0
<p>Maximum out-of-pocket amounts</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)</p>	<p>From network providers: \$5,700</p> <p>From network and out-of-network providers combined: \$8,900</p>	<p>From network providers: \$5,200</p> <p>From network and out-of-network providers combined: \$8,900</p>
<p>Doctor office visits</p>	<p>In-Network:</p> <p>Primary care visits: \$10 copay per visit</p> <p>Specialist visits: \$40 copay per visit</p> <p>Out-Of-Network: 40% coinsurance per visit</p>	<p>In-Network:</p> <p>Primary care visits: \$5 copay per visit</p> <p>Specialist visits: \$40 copay per visit</p> <p>Out-Of-Network: 40% coinsurance per visit</p>

Cost	2024 (this year)	2025 (next year)
<p>Inpatient hospital stays</p>	<p>In-Network: \$300 copay per day for days 1 to 5. \$0 copay per day for days 6 and beyond. Out-of-Network: 40% coinsurance per stay.</p>	<p>In-Network: \$330 copay per day for days 1 to 6. \$0 copay per day for days 7 and beyond. Out-of-Network: 40% coinsurance per stay.</p>
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$0 copay during the Initial Coverage Stage: Your cost for a one-month supply filled at a network pharmacy: Tier 1: You pay \$3 per prescription. Tier 2: You pay \$5 per prescription. Tier 3: You pay \$45 per prescription.</p>	<p>Deductible: \$0 copay during the Initial Coverage Stage: Your cost for a one-month supply filled at a network pharmacy: Tier 1: <i>Preferred:</i> \$0 per prescription <i>Standard:</i> \$5 per prescription. Tier 2: <i>Preferred:</i> \$5 per prescription <i>Standard:</i> \$10 per prescription. Tier 3: <i>Preferred:</i> \$42 per prescription <i>Standard:</i> \$47 per prescription. You pay \$30 <i>Preferred</i>/ \$35 <i>Standard</i> per month supply</p>

Cost	2024 (this year)	2025 (next year)
	<p>Tier 4: You pay \$100 per prescription.</p> <p>Tier 5: You pay 33% of the total cost.</p> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage). <i>OR</i> you have paid \$8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. <p>For example: For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called</p>	<p>of each covered insulin product on this tier.</p> <p>Tier 4: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 33% of the total cost. You pay \$30 <i>Preferred</i>/ \$35 <i>Standard</i> per month supply of each covered insulin product on this tier.</p> <p>Tier 5: <i>Preferred:</i> 33% of the total cost. <i>Standard:</i> 33% of the total cost.</p> <p>Once your total drug costs have reached \$2,000, you will move to the next stage (Catastrophic Coverage Stage).</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • During this payment stage, the plan pays the

Cost	2024 (this year)	2025 (next year)
	<p>coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.</p>	<p>full cost for your covered Part D drugs.</p> <ul style="list-style-type: none"> You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0
Optional Supplemental Package 1	\$25	\$25

- 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	2024 (this year)	2025 (next year)
<p>In-network maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and coinsurance) 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.</p>	<p>\$5,700</p>	<p style="text-align: center;">\$5,200</p> <p>Once you have paid \$5,200 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.</p>
<p>Combined maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copays and coinsurance) from 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.</p>	<p>\$8,900</p>	<p style="text-align: center;">\$8,900</p> <p>Once you have paid \$8,900 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.</p>

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are also located on our website at www.bcbsks.com/medicare/find-a-provider.shtml. You may also call customer services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are no changes to our network of providers for next year.

Please review the 2025 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

There are no changes to our network of pharmacies for next year.

Please review the 2025 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	2024 (this year)	2025 (next year)
Dental Service	Up to a maximum benefit of \$1,750 every year for non-Medicare-covered preventive and comprehensive dental services.	Up to a maximum benefit of \$2,500 every year for non-Medicare -covered preventive and comprehensive dental services.
Doctor Office Visit	<p>In-Network:</p> <p>Primary Care Visits: \$10 copay per visit.</p> <p>Specialist Visits: \$40 copay per visit.</p> <p>Out-Of-Network: You pay 40% coinsurance for this benefit.</p>	<p>In-Network:</p> <p>Primary Care Visits: \$5 copay per visit.</p> <p>Specialist Visits: \$40 copay per visit.</p> <p>Out-Of-Network: You pay 40% coinsurance for this benefit.</p>

Cost	2024 (this year)	2025 (next year)
Hearing Services	<p>In-Network: \$50 copay for each Medicare-covered diagnostic hearing exam. \$0 copay for routine hearing exam (one per year).</p> <p>\$495 copay per aid for Basic Aids \$895 copay per aid for Standard Aids \$1,295 copay per aid for Advanced Aids \$1,695 copay per aid for Premium Aids</p>	<p>In-Network: \$45 copay for each Medicare-covered diagnostic hearing exam. \$0 copay for routine hearing exam (one per year).</p> <p>\$295 copay per aid for Basic Aids \$695 copay per aid for Standard Aids \$1,095 copay per aid for Advanced Aids \$1,495 copay per aid for Premium Aids</p>
Inpatient Acute Medicare-covered stay	<p>In-Network: You pay \$300 copay per day for days 1-5.</p> <p>You pay \$0 copay per day for days 6-90.</p> <p>Out-of-Network: You pay the 40% coinsurance for this benefit.</p>	<p>In-Network: You pay \$330 copay per day for days 1-6.</p> <p>You pay \$0 copay per day for days 7-90.</p> <p>Out-of-Network: You pay the 40% coinsurance for this benefit.</p>
Medicare-covered Emergency Care	<p>In-Network: You pay \$90 copay for this benefit.</p>	<p>In-Network: You pay \$125 copay for this benefit.</p>

Cost	2024 (this year)	2025 (next year)
Medicare-covered Ground/Air Ambulance	<p>In-Network: You pay \$270 copay for this benefit.</p> <p>Out-of-Network: You pay \$270 copay for this benefit.</p>	<p>In-Network: You pay \$300 copay for this benefit.</p> <p>Out-of-Network: You pay \$300 copay for this benefit.</p>
Other Health Care Professional	<p>In-Network: \$30 copay for each Medicare-covered Other Health Care Professional.</p> <p>Out-Of-Network: 40% coinsurance per visit</p>	<p>In-Network: \$40 copay for each Medicare-covered Other Health Care Professional.</p> <p>Out-Of-Network: 40% coinsurance per visit</p>
Outpatient Substance Abuse Services	<p>In-Network: \$50 copay for each Medicare-covered individual therapy visit.</p> <p>\$50 copay for each Medicare-covered group therapy visit.</p> <p>Out-of-Network: You pay 40% coinsurance for this benefit.</p>	<p>In-Network: \$40 copay for each Medicare-covered individual therapy visit.</p> <p>\$40 copay for each Medicare-covered group therapy visit.</p> <p>Out-of-Network: You pay 40% coinsurance for this benefit.</p>
Skilled Nursing Facility (SNF) Medicare-covered stay	<p>In-Network: You pay a \$0 copay per day for days 1-20.</p>	<p>In-Network: You pay a \$10 copay per day for days 1-20.</p>

Cost	2024 (this year)	2025 (next year)
	<p>You pay a \$203 copay per day for days 21-100.</p> <p>Out-of-Network: You pay 40% coinsurance for this benefit.</p>	<p>You pay a \$214 copay per day for days 21-100.</p> <p>Out-of-Network: You pay 40% coinsurance for this benefit.</p>
<p>Vision Care</p>	<p>In-Network: \$50 copay for all other Medicare-covered eye exams.</p> <p>\$50 copay for Medicare-covered eyewear.</p> <p>Out-Of-Network: 40% coinsurance for each Medicare-covered service. If member chooses to go to a non-EyeMed provider, our plan will cover up to \$85 every year for one routine eye exam and \$150 every year for non-Medicare covered eyewear. Member will be required to file a paper claim to EyeMed for reimbursement.</p>	<p>In-Network: \$45 copay for all other Medicare-covered eye exams.</p> <p>\$45 copay for Medicare-covered eyewear.</p> <p>Out-Of-Network: 40% coinsurance for each Medicare-covered service. If member chooses to go to a non-EyeMed provider, our plan will cover up to \$250 every year for one routine eye exam and \$250 every year for non-Medicare covered eyewear. The members are responsible for 80% of the overage for glasses, 100% for disposable contacts and 85% for conventional contacts. Member will be required to file a paper claim to EyeMed for reimbursement.</p>

Cost	2024 (this year)	2025 (next year)
Worldwide Emergency Coverage	In-Network: You pay \$90 copay for this benefit.	In-Network: You pay \$125 copay for this benefit.

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 at www.MyPrime.com.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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.

Starting in 2025, we may immediately remove a brand name drug on our “Drug List” if, at the same time, we replace it with a new generic version on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our “Drug List,” but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month’s supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website:

<https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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.**

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>The number of days in a one-month supply is 30:</p> <p>Tier 1: You pay \$3 per prescription.</p> <p>Tier 2: You pay \$5 per prescription.</p> <p>Tier 3: You pay \$45 per prescription.</p>	<p>The number of days in a one-month supply is 30:</p> <p>Tier 1: Your cost for a one-month supply is: <i>Preferred: \$0</i> <i>Standard: \$5</i></p> <p>Tier 2: Your cost for a one-month supply is: <i>Preferred: \$5</i> <i>Standard: \$10</i></p> <p>Tier 3: Your cost for a one-month supply is: <i>Preferred: \$42</i> <i>Standard: \$47</i> You pay \$30 <i>Preferred</i>/ \$35 <i>Standard</i> per month</p>

Stage	2024 (this year)	2025 (next year)
	<p>Tier 4: You pay \$100 per prescription.</p> <p>Tier 5: You pay 33% of the total cost.</p> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage). <i>OR</i> you have paid \$8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>supply of each covered insulin product on this tier.</p> <p>Tier 4: Your cost for a one-month supply is: <i>Preferred:</i> 31% of the total cost. <i>Standard:</i> 33% of the total cost. You pay \$30 <i>Preferred</i>/ \$35 <i>Standard</i> per month supply of each covered insulin product on this tier.</p> <p>Tier 5: Your cost for a one-month supply is: <i>Preferred:</i> 33% of the total cost. <i>Standard:</i> 33% of the total cost.</p> <p>Once your total drug costs have reached \$2,000, you will move to the next stage (Catastrophic Coverage Stage).</p> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • During this payment stage, the plan pays the

Stage	2024 (this year)	2025 (next year)
		full cost for your covered Part D drugs. You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 2 Administrative Changes

Cost	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan Not Applicable		The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January - December). To learn more about this payment option, please contact us at 1-833-696-2087 or visit Medicare.gov.

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – 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 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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 2.1 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Blue Cross and Blue Shield of Kansas 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 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 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 Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHICK 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 1-800-860-5260. You can learn more about SHICK by visiting their website at www.kdads.ks.gov/SHICK.

SECTION 6 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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 am and 7 pm, 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.
- **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. 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. 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. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-785-296-6174. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn’t save you money or lower your drug costs.**

“Extra Help” from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income

level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-800-222-7645 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Medicare Advantage (PPO)

Questions? We're here to help. Please call customer service at 1-800-222-7645. (TTY only, call 711.) We are available for phone calls from 8:00 AM to 8:00 PM seven days a week from October 1 through March 31. We are available 8:00 AM to 8:00PM Monday through Friday April 1 through September 30. Calls to these numbers are free.

Read your 2025 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 2025. For details, look in the *2025 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 <https://www.bcbsks.com/medicare/forms>. 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 <https://www.bcbsks.com/medicare/ma-welcome>. 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 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

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 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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.



866-335-7042
(TTY: 711)

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