BlueCross BlueShield of North Carolina

Blue Medicare Medical Only℠ (HMO) (H3449-012) *offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC)*

Annual Notice of Changes for 2022

You are currently enrolled as a member of Blue Medicare Medical Only. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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

What to do now

1. ASK: Which changes apply to you

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

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1, 1.2 and 1.5 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

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☐ 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

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

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

- If you join another plan by **December 7, 2021**, your new coverage will start on January 1, 2022. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at 1-888-310-4110 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm daily.
- This document is available in languages other than English, in braille, or in large print. Please call Customer Service for additional information.
- **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 Medical Only

- Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Blue Cross and Blue Shield of North Carolina (Blue Cross NC). When it says "plan" or "our plan," it means Blue Medicare Medical Only.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Blue Medicare Medical Only 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.bluecrossnc.com/medicare-members. 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	$0	$0
Maximum out-of-pocket amount 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.)	$4,400	$3,900
Doctor office visits	Primary care visits: $20 per visit Specialist visits: $40 per visit	Primary care visits: $0 per visit Specialist visits: $25 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 hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $335 copayment per day up for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	You pay a $295 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0 There will be no change in your premium amount

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

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

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount.	$4,400	$3,900 Once you have paid $3,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.bluecrossnc.com/find-a-doctor-or-facility/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2022 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we 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 and to manage your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

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

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

Cost	2021 (this year)	2022 (next year)
Acupuncture for chronic low back pain	You pay a $30 copayment for acupuncture for chronic low back pain in a PCP or specialist setting. No more than 20 acupuncture treatments may be administered annually.	You pay a $25 copayment for acupuncture for chronic low back pain in a PCP or specialist setting. No more than 20 acupuncture treatments may be administered every calendar year.
Annual Routine Physical Exam	Must be provided by your PCP on record to be covered. Covered annually.	Must be provided by a PCP to be covered. Covered once every calendar year.

Cost	2021 (this year)	2022 (next year)
Annual Wellness Visit	Must be provided by your PCP on record to be covered. Covered annually.	Must be provided by a PCP to be covered. Covered once every calendar year.
Chiropractic services	Prior approval is NOT required from plan.	Prior approval is required from plan.
COVID-19	During a public health emergency, the cost share for COVID-19 clinical visits, testing, and related treatment is waived for both in-network and out-of-network providers.	Cost share for all services is set forth in Chapter 4 of your EOC. Plan will follow any requirements set forth by Centers for Medicare & Medicaid Services (CMS).
Dental services See your Evidence of Coverage for more details. ***You must use a provider that is contracted with our dental vendor to provide these non-Medicare-covered services.***	Some preventive dental services are covered. Comprehensive dental services are NOT covered. You pay a $40 copayment for each Medicare-covered dental service. You receive a $300 allowance per year for preventive dental services.	Some preventive dental services are covered. Some comprehensive dental services are covered. You pay a $25 copayment for each Medicare-covered dental service. You receive a $2,000 allowance every calendar year for non-Medicare-covered preventive and comprehensive dental services. **Non-Medicare-covered preventive dental services:** Oral exams: $0 copayment

Cost	2021 (this year)	2022 (next year)
Dental services (continued)		Cleanings: $0 copayment Fluoride treatments: $0 copayment Dental x-rays: $0 copayment **Non-Medicare covered comprehensive dental services:** Restorative services: $0 copayment Endodontics: $0 copayment Periodontics: $0 copayment Extractions: $0 copayment Prosthodontics and maxillofacial services: $0 copayment **** Non-Medicare-covered dental services do not apply to your In-Network Out-of-Pocket Maximum.***
Fitness benefit	Home fitness kits: you are eligible to receive <u>two</u> home fitness kits per benefit year from a variety of fitness categories	Home fitness kits: you are eligible to receive <u>one</u> home fitness kit per benefit year from a variety of fitness categories

Cost	2021 (this year)	2022 (next year)
Hearing services	You pay a $40 copayment for each Medicare-covered diagnostic hearing exam. You pay a $75 additional cost per aid for option hearing aid rechargeability. Hearing aid purchase includes: • 3 provider visits within the first year • 45-day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models A routine hearing exam by a TruHearing provider is covered once per year.	You pay a $25 copayment for each Medicare-covered diagnostic hearing exam. You pay a $50 additional cost per aid for option hearing aid rechargeability. Hearing aid purchase includes: • First year of follow-up visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models A routine hearing exam by a TruHearing provider is covered once every calendar year.
Inpatient hospital care Prior approval is required from plan, except in an emergency. Call 1-888-296-9790 (TTY call 711).	You pay a $335 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	You pay a $295 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.

Cost	2021 (this year)	2022 (next year)
Inpatient mental health care Prior approval is required, except in an emergency. Call 1-800-266-6167 (TTY call 711).	You pay a $300 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	You pay a $295 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.
Opioid treatment program services	Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	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)
Outpatient diagnostic tests and therapeutic services and supplies	Prior approval is NOT required from plan. COVID diagnostic procedures and tests services - $0 copayment COVID lab services - $0 copayment, excludes antibody test	Prior approval is required from plan for all services except labs and x-rays. Cost share for all services is set forth in Chapter 4 of your EOC. Plan will follow any requirements set forth by Centers for Medicare & Medicaid Services (CMS).
Outpatient mental health care	Prior approval is required for psychological and neuropsychological testing for mental health and medical reasons.	Prior approval is NOT required for psychological and neuropsychological testing for mental health and medical reasons.
Outpatient rehabilitation services	Prior approval is NOT required from plan for physical therapy and occupational therapy.	Prior approval is required from plan for physical therapy and occupational therapy.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $325 copayment for each Medicare-covered outpatient hospital facility visit.	You pay a $275 copayment for each Medicare-covered outpatient hospital facility visit.
Over-the-Counter (OTC) Allowance card	Not offered.	$100 per quarter. Balances do not carry over from quarter to quarter.

Cost	2021 (this year)	2022 (next year)
Physician/Practitioner services, including doctor's office visits	Prior approval is NOT required from plan for visits to specialists, any other physicians, or other health care professionals in a specialist setting. You pay a $20 copayment for each Primary Care Provider or other health care professional visit for Medicare-covered benefits in a PCP setting. You pay a $40 copayment for each specialist or any other physician or other health care professional visit for Medicare-covered benefits in a specialist setting. You pay a $40 copayment for each visit to a participating walk-in convenience care clinic.	Prior approval is required from plan for visits to specialists, any other physicians, or other health care professionals in a specialist setting. You pay a $0 copayment for each Primary Care Provider or other health care professional visit for Medicare-covered benefits in a PCP setting. You pay a $25 copayment for each specialist or any other physician or other health care professional visit for Medicare-covered benefits in a specialist setting. You pay a $25 copayment for each visit to a participating walk-in convenience care clinic.
Podiatry services	You pay a $40 copayment for each Medicare-covered visit for medically necessary foot care.	You pay a $25 copayment for each Medicare-covered visit for medically necessary foot care.
Screening for lung cancer with low dose computed tomography (LDCT)	Prior approval NOT required.	Prior approval required.

Cost	2021 (this year)	2022 (next year)
Skilled nursing facility (SNF) care	You pay: $0 each day for days 1-20 a $184 copayment each day for days 21-60 $0 each day for days 61-100 for a Medicare-covered admission to a Skilled Nursing Facility.	You pay: $0 each day for days 1-20 a $188 copayment each day for days 21-60 $0 each day for days 61-100 for a Medicare-covered admission to a Skilled Nursing Facility.
Vision care	Routine eye exams are covered annually. **In-Network or Out-of-Network Providers:** $100 allowance per year for routine eyewear.	Routine eye exams are covered once every calendar year. **In-Network or Out-of-Network Providers:** $300 allowance per year for routine eyewear.
"Welcome to Medicare" preventive visit	Must be provided by your PCP on record to be covered.	Must be provided by a PCP to be covered.

SECTION 2 Administrative Changes

These are changes that affect your healthcare coverage, other than out-of-pocket costs, described elsewhere in this document.

Description	2021 (this year)	2022 (next year)
Coverage timeframes	Covered annually: • Acupuncture treatments for low back pain • Annual routine physical exam • Annual wellness visit • Cardiovascular disease risk reduction visit • Cervical and vaginal cancer screening • Dental allowance • Depression screening • Hearing – routine exam • Obesity screening • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for sexually transmitted infections (STIs) • Vision care – routine eye exams	Covered once every calendar year: • Acupuncture treatments for low back pain • Annual routine physical exam • Annual wellness visit • Cardiovascular disease risk reduction visit • Cervical and vaginal cancer screening • Dental allowance • Depression screening • Hearing – routine exam • Obesity screening • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for sexually transmitted infections (STIs) • Vision care – routine eye exams
Plan Service Area	Graham County is NOT in the service area.	Graham County added to the service area.
Vaccination for COVID-19	Covered by Original Medicare.	Covered by our plan.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If You Want to Stay in Blue Medicare Medical Only

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 Medical Only.

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,
- -- *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 (SHIP) (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 NC 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 Medical Only.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Medicare Medical Only.
- 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 or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In North Carolina, the SHIP is called Seniors' Health Insurance Information Program.

SHIIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. 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 SHIIP at 1-855-408-1212. You can learn more about SHIIP by visiting their website (http://www.ncdoi.com/SHIIP.)

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 8 am and 5:30 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the North Carolina AIDS Drug Assistance Program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call the North Carolina AIDS Drug Assistance Program at 1-877-466-2232 (toll free in NC) or 1-919-733-9161 (out-of-state) or visit their website at http://epi.publichealth.nc.gov/cd/hiv/adap.html.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the North Carolina AIDS Drug Assistance Program at 1-877-466-2232 (toll free in NC) or 1-919-733-9161 (out-of-state) or visit their website at epi.dph.ncdhhs.gov/cd/hiv/hmap.html.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Medicare Medical Only

Questions? We're here to help. Please call Customer Service at 1-888-310-4110 (TTY only, call 711). We are available for phone calls 8 am - 8 pm daily. Calls to these numbers are free.

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Blue Medicare Medical Only. 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* will be separately mailed to you upon request.

Visit Our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & 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.

Review other plan materials available as of October 15, 2021.

View online or request a printed copy by calling us.
1-888-310-4110 (TTY 711) 8 a.m. to 8 p.m. daily

Evidence of Coverage (EOC)

Your EOC provides you with details about your plan benefits.

To view your EOC, visit **Medicare.BlueCrossNC.com**, click on **For Members**, then click **Forms Library**. You can also complete the enclosed prepaid postage postcard and return it in the mail to request a printed copy.

Provider Directory

To search for providers online, visit **Medicare.BlueCrossNC.com**, click on **Find a Doctor/Drug/Facility** at the top.

You may also view our **Notice of Privacy Practices** online at www.bluecrossnc.com/about-us/policies-and-best-practices/notice-privacy-practices.