BlueCross BlueShield of North Carolina

Blue Medicare PPO Enhanced℠ (H3404-003-002) 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 PPO Enhanced. 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 the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?

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- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

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

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- 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 PPO Enhanced.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
    - If you don't join another plan by **December 7, 2021**, you will be enrolled in Blue Medicare PPO Enhanced.
    - 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 1-877-494-7647 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Medicare PPO Enhanced

- Blue Cross and Blue Shield of North Carolina is a PPO 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 PPO Enhanced.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Blue Medicare PPO Enhanced 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* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$69	$49
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**From network providers:** $5,900 **From network and out-of-network providers combined:** $11,300	**From network providers:** $5,900 **From network and out-of-network providers combined:** $5,900
Doctor office visits	**In-Network:** Primary care visits: $10 per visit Specialist visits: $50 per visit **Out-of-Network:** Primary care visits: 40% of the total cost per visit Specialist visits: 40% of the total cost per visit	**In-Network:** Primary care visits: $0 per visit Specialist visits: $35 per visit **Out-of-Network:** Primary care visits: 40% of the total cost per visit Specialist visits: 40% of the total cost per visit

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	**In-Network:** You pay a $335 copayment per day for the first 6 days for each Medicare-covered admission to a hospital. You pay $0 for additional days at a hospital. **Out-of-Network:** You pay 40% of the total cost for each Medicare-covered admission to an out-of-network hospital.	**In-Network:** You pay a $335 copayment per day for the first 6 days for each Medicare-covered admission to a hospital. You pay $0 for additional days at a hospital. **Out-of-Network:** You pay 40% of the total cost for each Medicare-covered admission to an out-of-network hospital.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 1: $15 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 2: $6 for a 30-day supply at preferred retail pharmacy • Drug Tier 2: $0 for a 30-day supply at a preferred mail-order pharmacy • Drug Tier 2: $20 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 3: $37 for a 30-day supply at preferred retail pharmacy or	Deductible: $0 Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 1: $15 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 2: $6 for a 30-day supply at preferred retail pharmacy • Drug Tier 2: $0 for a 30-day supply at a preferred mail-order pharmacy • Drug Tier 2: $20 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 3: $37 for a 30-day supply at preferred retail pharmacy or

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (continued)	preferred mail-order pharmacy • Drug Tier 3: $47 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 4: 45% of the total cost for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 4: 50% of the total cost for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 5: 33% of the total cost for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 5: 33% of the total cost for a 30-day supply at standard retail pharmacy, standard mail-order	preferred mail-order pharmacy • Drug Tier 3: $47 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 4: $90 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 4: $100 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 5: 33% of the total cost for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 5: 33% of the total cost for a 30-day supply at standard retail pharmacy, standard mail-order

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (continued)	pharmacy, or out-of-network pharmacy • Drug Tier 6: $0 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 6: $1 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Insulins: $35 copayment for a 30-day supply at standard and preferred retail or mail order pharmacies. To find out which drugs are insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed on the back cover of this booklet).	pharmacy, or out-of-network pharmacy • Drug Tier 6: $0 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 6: $1 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Insulins: $35 copayment for a 30-day supply at standard and preferred retail or mail order pharmacies. To find out which drugs are insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Service are printed on the back cover of this booklet).

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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.)	$69	$49

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

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

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

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) 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.	$5,900	$5,900 Once you have paid $5,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$11,300	$5,900 Once you have paid $5,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of doctors and other 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 specialist (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.bluecrossnc.com/find-a-drug-or-pharmacy. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2022 Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

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

Opioid treatment program services

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

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

Cost	2021 (this year)	2022 (next year)
Acupuncture for chronic low back pain	**In-Network and Out-of-Network:** 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.	**In-Network:** You pay a $35 copayment for acupuncture for chronic low back pain in a PCP or specialist setting. **Out-of-Network:** You pay 40% of the total cost for acupuncture for chronic low back pain in a PCP or specialist setting. **In-Network and Out-of-Network:** No more than 20 acupuncture treatments may be administered every calendar year.

Cost	2021 (this year)	2022 (next year)
Chiropractic services	**In-Network and Out-of-Network:** Prior approval is NOT required from plan.	**In-Network and Out-of-Network:** 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. **In-Network:** You pay a $50 copayment for each Medicare-covered dental service. **In-Network and Out-of-Network:** You receive a $325 allowance per year for preventive dental services.	Some preventive dental services are covered. Some comprehensive dental services are covered. **In-Network:** You pay a $35 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 Cleanings: $0 copayment

Cost	2021 (this year)	2022 (next year)
Dental services (continued)		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 and Out-of-Network Out-of-Pocket Maximum.***

Cost	2021 (this year)	2022 (next year)
Fitness benefit	**In-Network and Out-of-Network:** Home fitness kits: you are eligible to receive two home fitness kits per benefit year from a variety of fitness categories	**In-Network and Out-of-Network:** Home fitness kits: you are eligible to receive one home fitness kit per benefit year from a variety of fitness categories
Hearing services	**In-Network:** You pay a $50 copayment for each Medicare-covered diagnostic hearing exam. **In-Network and Out-of-Network:** 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.	**In-Network:** You pay a $35 copayment for each Medicare-covered diagnostic hearing exam. **In-Network and Out-of-Network:** 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.

Cost	2021 (this year)	2022 (next year)
Opioid treatment program services	**In-Network and Out-of-Network:** 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	**In-Network and Out-of-Network:** 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) • 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	**In-Network and Out-of-Network:** Prior approval is NOT required from plan. COVID diagnostic procedures and tests services - $0 copayment COVID lab services - $0 copayment, excludes antibody test	**In-Network and Out-of-Network:** 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	**In-Network and Out-of-Network:** Prior approval is required for psychological and neuropsychological testing for mental health and medical reasons.	**In-Network and Out-of-Network:** Prior approval is NOT required for psychological and neuropsychological testing for mental health and medical reasons.
Outpatient rehabilitation services	**In-Network and Out-of-Network:** Prior approval is NOT required from plan for physical therapy and occupational therapy.	**In-Network and Out-of-Network:** Prior approval is required from plan for physical therapy and occupational therapy.

Cost	2021 (this year)	2022 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network:** You pay a $300 copayment for each Medicare-covered outpatient hospital facility visit. You may be charged a separate copayment for physician services.	**In-Network:** You pay a $295 copayment for each Medicare-covered outpatient hospital facility visit. You may be charged a separate copayment for physician services.
Over-the-Counter (OTC) Allowance card	**In-Network and Out-of-Network:** $25 per quarter.	**In-Network and Out-of-Network:** $70 per quarter.
Physician/Practitioner services, including doctor's office visits	**In-Network and Out-of-Network:** Prior approval is NOT required from plan for visits to specialists, any other physicians, or other health care professionals in a specialist setting. **In-Network:** You pay a $10 copayment for each Primary Care Provider or other health care professional visit for Medicare-covered benefits in a PCP setting. You pay a $50 copayment for each specialist or any other physician or other health care professional	**In-Network and Out-of-Network:** Prior approval is required from plan for visits to specialists, any other physicians, or other health care professionals in a specialist setting. **In-Network:** 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 $35 copayment for each specialist or any other physician or other health care professional visit

Cost	2021 (this year)	2022 (next year)
Physician/Practitioner services, including doctor's office visits (continued)	visit for Medicare-covered benefits in a specialist setting. You pay a $50 copayment for each visit to a participating walk-in convenience care clinic.	for Medicare-covered benefits in a specialist setting. You pay a $35 copayment for each visit to a participating walk-in convenience care clinic.
Podiatry services	**In-Network:** You pay a $50 copayment for each Medicare-covered visit for medically necessary foot care.	**In-Network:** You pay a $35 copayment for each Medicare-covered visit for medically necessary foot care.
Services to treat kidney disease	**In-Network:** You pay 20% of the total cost for Medicare-covered renal dialysis. **Out-of-Network:** You pay 40% of the total cost for Medicare-covered renal dialysis.	**In-Network and Out-of-Network:** You pay 20% of the total cost for Medicare-covered renal dialysis.
Screening for lung cancer with low dose computed tomography (LDCT)	**In-Network and Out-of-Network:** Prior approval NOT required.	**In-Network and Out-of-Network:** Prior approval required.

Cost	2021 (this year)	2022 (next year)
Skilled nursing facility (SNF) care	**In- Network:** 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.	**In-Network:** 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.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Current members who have requested and been approved for an exception for the current plan year will continue to receive the drug subject to the conditions and date noted in the approval letter sent to the member at the time the drug exception was approved.

Once an authorization is granted, the member is not required to request a new approval for the approved drug during the remainder of the current plan year or *until* the date specified in the letter as long as the following apply: The member remains enrolled in the **same** plan, the prescribing provider continues to prescribe the drug, the drug remains on the formulary, the drug remains on the same formulary tier, there is no change in prior review requirements for the drug, and the drug continues to be safe for treating the member's condition. However, the member will be required to request a new approval once the original approval end date has been reached or as specified in the conditions stated in the approval letter.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We 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. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*,

which is located on our website at www.bluecrossnc.com/medicare-members. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

For drugs on Tier 4 Non-Preferred Drugs, your cost sharing in the initial coverage stage is changing from coinsurance to copayment. Please see the following chart for the changes from 2021 to 2022.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** For 2021 you paid 50% coinsurance for standard cost sharing and 45% coinsurance for preferred cost sharing for drugs on Tier 4 Non-Preferred Drugs. For 2022 you will pay a $100 copayment standard cost sharing and $90 copayment for preferred cost sharing copayment for drugs on this tier.	Your cost for a one-month supply at a network pharmacy: ***Tier 1 Preferred Generic Drugs*:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $0 per prescription. ***Tier 2 Generic Drugs*:** *Standard cost sharing:* You pay $20 per prescription.	Your cost for a one-month supply at a network pharmacy: ***Tier 1 Preferred Generic Drugs:*** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $0 per prescription. ***Tier 2 Generic Drugs:*** *Standard cost sharing:* You pay $20 per prescription.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued) 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*. 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.	*Preferred cost sharing:* You pay $6 per prescription. ***Tier 3 Preferred Brand Drugs*:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $37 per prescription. ***Tier 4 Non-Preferred Drugs*:** *Standard cost sharing:* You pay 50% of the total cost. *Preferred cost sharing:* You pay 45% of the total cost. ***Tier 5 Specialty Drugs*:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. Tier 5 is limited to a 30-day supply per fill. ***Tier 6 Select Care Drugs*:** *Standard cost sharing:* You pay $1 per prescription. *Preferred cost sharing:* You pay $0 per prescription.	*Preferred cost sharing:* You pay $6 per prescription. ***Tier 3 Preferred Brand Drugs*:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $37 per prescription. ***Tier 4 Non-Preferred Drugs*:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $90 per prescription. ***Tier 5 Specialty Drugs*:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost. Tier 5 is limited to a 30-day supply per fill. ***Tier 6 Select Care Drugs*:** *Standard cost sharing:* You pay $1 per prescription. *Preferred cost sharing:* You pay $0 per prescription.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)	***Insulins*:** You pay $35 per 30-day supply at standard and preferred retail or mail order pharmacies for insulins.	***Insulins*:** You pay $35 per 30-day supply at standard and preferred retail or mail order pharmacies for insulins.
	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

Blue Medicare PPO Enhanced offers additional gap coverage for insulins. During the Coverage Gap stage, your out-of-pocket costs for insulins will be a $35 copayment for a 30-day supply at standard and preferred retail or mail order pharmacies and a $70 copayment for a 90-day supply at a preferred mail order pharmacy.

SECTION 2 Other 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	Iredell county is in the service area for this segment.	Iredell county is NOT in the service area for this segment.
Vaccination for COVID-19	Covered by Original Medicare.	Covered by our plan.

Description	2021 (this year)	2022 (next year)
Visitor Traveler Benefit	The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 42 states and one territory. For some of the states, Medicare Advantage PPO networks are only available in portions of the state.	Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 46 states, the District of Columbia, and one territory. Added to this program are Delaware, District of Columbia, Iowa, Maryland, and South Dakota. For some of the states, Medicare Advantage PPO networks are only available in portions of the state.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If You Want to Stay in Blue Medicare PPO Enhanced

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 PPO Enhanced plan for 2022.

Section 3.2 – If You Want to Change Plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, 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, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

As a reminder, Blue Cross 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 PPO Enhanced.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Medicare PPO Enhanced.
- 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the North Carolina AIDS Drug Assistance Program. 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 PPO Enhanced

Questions? We're here to help. Please call Customer Service at 1-877-494-7647. (TTY only, call 711.) We are available for phone calls 8 am to 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 PPO Enhanced. 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.bluecrossnc.com/medicare-members. 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.bluecrossnc.com/medicare-members. 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

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.
1-877-494-7647 (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** and select **Evidence of Coverage** for your plan. You can also complete the enclosed prepaid postage postcard and return it in the mail to request a printed copy.

Formulary

Your Formulary is a list of drugs covered by your plan.

To view your formulary, visit **Medicare.BlueCrossNC.com**, click on **For Members**, then click **Member Resources,** then click **Prescription Drug Resources** and select your plan under **Formulary Guides**. You can also complete the enclosed prepaid postage postcard and return it in the mail to request a printed copy.

Provider Directory or Pharmacy 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.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.