Blue Medicare PPO Enhanced offered by Blue Cross and Blue Shield of North Carolina (BCBSNC)

Annual Notice of Changes for 2013

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.**

Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This document may be available in an alternate format such as Braille or larger print. Please call Customer Service for additional information (phone numbers are in Section 7.1 of this booklet).

About Blue Medicare PPO Enhanced

- Blue Cross and Blue Shield of North Carolina (BCBSNC) is a Medicare Advantage organization with a Medicare contract. BCBSNC is an independent licensee of the Blue Cross and Blue Shield Association.
- When this booklet says "we," "us," or "our," it means Blue Cross and Blue Shield of North Carolina (BCBSNC). When it says "plan" or "our plan," it means Blue Medicare PPO Enhanced.

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections and 1.1, 1.2, 1.5 and 1.6 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors 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 costs in the plan.** 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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to stay with Blue Medicare PPO Enhanced:	**If you decide to change plans:**
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change by December 7, you will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2013. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2013

The table below compares the 2012 costs and 2013 costs for Blue Medicare PPO Enhanced in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

	2012 (this year)	2013 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$47.20	$47.20
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.)	**From in-network providers:** $3,400 **From in-network and out-of network providers combined:** $5,100	**From in-network providers:** $3,400 **From in-network and out-of network providers combined:** $5,100
Doctor office visits	**In-Network:** Primary care visits: $15 per visit Specialist visits: $40 per visit **Out-of Network:** Primary care visits: 20% per visit Specialist visits: 20% per visit	**In-Network:** Primary care visits: $20 per visit Specialist visits: $40 per visit **Out-of Network:** Primary care visits: 20% per visit Specialist visits: 20% per visit

	2012 (this year)	2013 (next year)
In-patient hospital stays	**In-Network:** You pay a $195 copayment per day up to 6 days for each Medicare-covered admission to a hospital. You pay $0 for additional days at a hospital. **Out-of-Network:** You pay 20% of the cost for each Medicare-covered admission to an out-of-network hospital.	**In-Network:** You pay a $195 copayment per day up to 6 days for each Medicare-covered admission to a hospital. You pay $0 for additional days at a hospital. **Out-of-Network:** You pay 20% of the cost for each Medicare-covered admission to an out-of-network hospital.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copays during the Initial Coverage Stage: • Drug Tier 1: $7 • Drug Tier 2: $25 • Drug Tier 3: $40 • Drug Tier 4: $80 • Drug Tier 5: 33%	Deductible: $0 Copays during the Initial Coverage Stage: • Drug Tier 1: $8 • Drug Tier 2: $25 • Drug Tier 3: $40 • Drug Tier 4: $80 • Drug Tier 5: 33%

Annual Notice of Changes for 2013
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

	2012 (this year)	2013 (next year)
Monthly premium (You must continue to pay your Medicare Part B premium.)	$47.20	$47.20

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- 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.

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 the maximum out-of-pocket amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

	2012 (this year)	2013 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services from in-network providers, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$5,100	$5,100 Once you have paid $5,100 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 in-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.

We included a copy of our Provider Directory in the envelope with this booklet. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2013 Provider Directory to see if your providers are in our network**.

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 has both preferred and non-preferred pharmacies. Preferred pharmacies will offer you lower cost-sharing than non-preferred pharmacies.

There are changes to our network of pharmacies for next year.

We included a copy of our Pharmacy Directory in the envelope with this booklet. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2013 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 *2013 Evidence of Coverage.*

	2012 (this year)	2013 (next year)
Abdominal aortic aneurysm screening	**In-Network:** You pay $0 for this one-time Medicare-covered screening ultrasound. **Out-of-Network:** You pay 20% of the cost for this one-time Medicare-covered screening ultrasound.	**In-Network and Out-of-Network:** You pay $0 for this one-time Medicare-covered screening ultrasound.

	2012 (this year)	2013 (next year)
Bone mass measurement	**In-Network:** You pay $0 for each Medicare-covered bone mass measurement. **Out-of-Network:** You pay 20% of the cost for each Medicare-covered bone mass measurement.	**In-Network and Out-of-Network:** You pay $0 for each Medicare-covered bone mass measurement.
Breast cancer screening (mammograms)	**In-Network:** You pay $0 for Medicare-covered screening mammograms. **Out-of-Network:** You pay 20% of the cost for Medicare-covered screening mammograms.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered screening mammograms.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	**In-Network:** You pay $0 for a Medicare-covered cardiovascular disease risk reduction visit. **Out-of-Network:** You pay 20% of the cost for a Medicare-covered cardiovascular disease risk reduction visit.	**In-Network and Out-of-Network:** You pay $0 for a Medicare-covered cardiovascular disease risk reduction visit.

	2012 (this year)	2013 (next year)
Cardiovascular disease testing	**In-Network:** You pay $0 for Medicare-covered cardiovascular disease testing. **Out-of-Network:** You pay 20% of the cost for Medicare-covered cardiovascular disease testing.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered cardiovascular disease testing.
Cervical and vaginal cancer screening	**In-Network:** You pay $0 for covered pap smears and pelvic exams. **Out-of-Network:** You pay 20% of the cost for covered pap smears and pelvic exams.	**In-Network and Out-of-Network:** You pay $0 for covered pap smears and pelvic exams.
Colorectal cancer screening	**In-Network:** You pay $0 for Medicare-covered colorectal screening exams. **Out-of-Network:** You pay 20% of the cost for Medicare-covered colorectal screening exams.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered colorectal screening exams.

	2012 (this year)	2013 (next year)
Depression screening	**In-Network:** You pay $0 for a Medicare-covered depression screening. **Out-of-Network:** You pay 20% of the cost for a Medicare-covered depression screening.	**In-Network and Out-of-Network:** You pay $0 for a Medicare-covered depression screening.
Diabetes screening	**In-Network:** You pay $0 for a Medicare-covered diabetes screening. **Out-of-Network:** You pay 20% of the cost for Medicare-covered diabetes screening.	**In-Network and Out-of-Network:** You pay $0 for a Medicare-covered diabetes screening.
Diabetes self-management training, diabetic services and supplies	**In-Network:** You pay $0 for Medicare-covered diabetes self-management training. You pay 20% of the cost for each Medicare-covered diabetic supply item. **Out-of-Network:** You pay 20% of the cost for Medicare-covered diabetes self-management training. You pay 20% of the cost for each Medicare-covered diabetic supply item.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered diabetes self-management training. You pay 20% of the cost for Medicare-covered therapeutic shoes or inserts. **In-Network:** You pay $0 for each Medicare-covered diabetic supply item.

	2012 (this year)	2013 (next year)
	In-Network and Out-of-Network: You pay 20% of the cost for Medicare-covered therapeutic shoes or inserts.	**Out-of-Network:** You pay 20% of the cost for each Medicare-covered diabetic supply item.
HIV screening	**In-Network:** You pay $0 for Medicare-covered HIV screening tests. **Out-of-Network:** You pay 20% of the cost for Medicare-covered HIV screening tests.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered HIV screening tests.
Immunizations	**In-Network:** You pay $0 for Medicare-covered flu, pneumonia and Hepatitis B vaccines. **Out-of-Network:** You pay 20% of the cost for Medicare-covered flu, pneumonia and Hepatitis B vaccines.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered flu, pneumonia and Hepatitis B vaccines.
Medical nutrition therapy	**In-Network:** You pay $0 for Medicare-covered medical nutrition therapy. **Out-of-Network:** You pay 20% of the cost for Medicare-covered	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered medical nutrition therapy.

	2012 (this year)	2013 (next year)
	medical nutrition therapy.	
Obesity screening and therapy to promote sustained weight loss	**In-Network:** You pay $0 for Medicare-covered obesity screenings and therapy. **Out-of-Network:** You pay 20% of the cost for Medicare-covered obesity screenings and therapy.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered obesity screenings and therapy.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network:** You pay a $100 copayment for each Medicare-covered ambulatory surgical center visit. You pay a $100 copayment for each Medicare-covered outpatient hospital facility visit. You may be charged a separate copayment for physician services. **Out-of-Network:** You pay 20% of the cost for each Medicare-covered ambulatory surgical center visit or outpatient hospital facility visit.	**In-Network:** You pay a $130 copayment for each Medicare-covered ambulatory surgical center visit. You pay a $130 copayment for each Medicare-covered outpatient hospital facility visit. You may be charged a separate copayment for physician services. **Out-of-Network:** You pay 20% of the cost for each Medicare-covered ambulatory surgical center visit or outpatient hospital facility visit.

	2012 (this year)	2013 (next year)
Physician/Practitioner services, including doctor's office visits	**In-Network:** You pay a $15 copayment for each Primary Care Provider visit for Medicare-covered benefits. You pay a $40 copayment for each specialist or any other physician visit for Medicare-covered benefits. You pay a $40 copayment for each visit to a participating walk-in convenience care clinic. **Out-of-Network:** You pay 20% of the cost for each physician and walk-in convenience care clinic visit for Medicare-covered benefits.	**In-Network:** You pay a $20 copayment for each Primary Care Provider visit for Medicare-covered benefits. You pay a $40 copayment for each specialist or any other physician visit for Medicare-covered benefits. You pay a $40 copayment for each visit to a participating walk-in convenience care clinic. **Out-of-Network:** You pay 20% of the cost for each physician and walk-in convenience care clinic visit for Medicare-covered benefits.
Prostate cancer screening exams	**In-Network:** You pay $0 for Medicare-covered prostate cancer screening exams. **Out-of-Network:** You pay 20% of the cost for Medicare-covered prostate cancer screening exams.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered prostate cancer screening exams.

	2012 (this year)	2013 (next year)
Screening and counseling to reduce alcohol misuse	**In-Network:** You pay $0 for Medicare-covered screenings and counseling to reduce alcohol misuse. **Out-of-Network:** You pay 20% of the cost for Medicare-covered screenings and counseling to reduce alcohol misuse.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered screenings and counseling to reduce alcohol misuse.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	**In-Network:** You pay $0 for Medicare-covered screenings for sexually transmitted infections (STIs) and counseling to prevent STIs. **Out-of-Network:** You pay $20% of the cost for Medicare-covered screenings for sexually transmitted infections (STIs) and counseling to prevent STIs.	**In-Network and Out-of-Network:** You pay $0 for Medicare-covered screenings for sexually transmitted infections (STIs) and counseling to prevent STIs.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	**In-Network:** You pay $0. **Out-of-Network:** You pay 20%.	**In-Network and Out-of-Network:** You pay $0.

	2012 (this year)	2013 (next year)
Vision care (glaucoma test)	**In-Network:** You pay $0 for each Medicare-covered glaucoma test. **Out-of-Network:** You pay 20% for each Medicare-covered glaucoma test.	**In-Network and Out-of-Network:** You pay $0 for each Medicare-covered glaucoma test.

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." We sent you a copy of our Drug List in this envelope.

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. You can ask for an exception before next year and we will give you an answer before the change takes effect. 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.
- **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 will cover a **one-time**, temporary supply. (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 a formulary exception for the current plan year will continue to receive the drug until the 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 a refill or new prescription to continue using the approved drug during the remainder of the current plan year as long as the following apply: The member remains enrolled in the plan, the prescribing provider continues to prescribe 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.

Changes to Prescription Drug Costs

There are four drug payment stages. Which "Drug Payment Stage" you are in affects how much you pay for a Part D drug.

The information below shows the four drug payment stages. You can also look in Chapter 6 of your *Evidence of Coverage* for more information about the stages.

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 coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because we have no deductible, this payment stage does not apply to you.	You begin in this payment stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your total drug costs reach the limit for the Initial Coverage Stage.	Most people do not reach the Coverage Gap Stage. If you do reach this stage, **your share of the costs for your drugs will change.** You stay in this stage until your total "out-of-pocket costs" (your payments) reach the limit for the Coverage Gap Stage.	Most people do not reach the Catastrophic Coverage Stage. If you do reach this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2013).

Stage 1: "Yearly Deductible Stage"

Because Blue Medicare PPO Enhanced has no deductible, this stage does not apply to you.

Stage 2: "Initial Coverage Stage"

In this stage, how much you pay for a drug depends on which "tier" the drug is in.

We moved some of the drugs on the Drug List to a lower or higher drug tier. To see if your drugs will be in a different tier, look them up on the Drug List.

The table below shows your costs for drugs in each of our 5 drug tiers. These amounts apply *only* during the time when you are in the Initial Coverage Stage.

	2012 (this year)	2013 (next year)
Retail Network or Non-Preferred Mail-order Pharmacy		
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 1 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $7 per prescription.	You pay $8 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 2 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $25 per prescription.	You pay $25 per prescription.
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 3 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $40 per prescription.	You pay $40 per prescription.
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 4 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $80 per prescription.	You pay $80 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 5 (Specialty Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 5 that is filled at a retail network or non-preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 1 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $14 per prescription.	You pay $16 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 2 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $50 per prescription.	You pay $50 per prescription.
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 3 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $80 per prescription.	You pay $80 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 4 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $160 per prescription.	You pay $160 per prescription.
Drugs in Tier 5 (Specialty Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 5 that is filled at a retail network or non-preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 1 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $21 per prescription.	You pay $24 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 2 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $75 per prescription.	You pay $75 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 3 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $120 per prescription.	You pay $120 per prescription.
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 4 that is filled at a retail network or non-preferred mail-order pharmacy	You pay $240 per prescription.	You pay $240 per prescription.
Drugs in Tier 5 (Specialty Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 5 that is filled at a retail network or non-preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.
Long-Term Care Pharmacy		
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **one-month (31-day)** supply of a drug in tier 1 that is filled at a long-term care pharmacy	You pay $7 per prescription.	You pay $8 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **one-month (31-day)** supply of a drug in tier 2 that is filled at a long-term care pharmacy	You pay $25 per prescription.	You pay $25 per prescription.
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **one-month (31-day)** supply of a drug in tier 3 that is filled at a long-term care pharmacy	You pay $40 per prescription.	You pay $40 per prescription.
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **one-month (31-day)** supply of a drug in tier 4 that is filled at a long-term care pharmacy	You pay $80 per prescription.	You pay $80 per prescription.
Drugs in Tier 5 (Specialty Drugs) Cost for a **one-month (31-day)** supply of a drug in tier 5 that is filled at a long-term care pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.

	2012 (this year)	2013 (next year)
Preferred Mail-order Pharmacy		
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 1 that is filled at a preferred mail-order pharmacy	You pay $0 per prescription.	You pay $0 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 2 that is filled at a preferred mail-order pharmacy	You pay $25 per prescription.	You pay $25 per prescription.
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 3 that is filled at a preferred mail-order pharmacy	You pay $40 per prescription.	You pay $40 per prescription.
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 4 that is filled at a preferred mail-order pharmacy	You pay $80 per prescription.	You pay $80 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 5 (Specialty Drugs) Cost for a **one-month (30-day)** supply of a drug in tier 5 that is filled at a preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 1 that is filled at a preferred mail-order pharmacy	You pay $0 per prescription.	You pay $0 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 2 that is filled at a preferred mail-order pharmacy	You pay $50 per prescription.	You pay $50 per prescription.
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 3 that is filled at a preferred mail-order pharmacy	You pay $80 per prescription.	You pay $80 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 4 that is filled at a preferred mail-order pharmacy	You pay $160 per prescription.	You pay $160 per prescription.
Drugs in Tier 5 (Specialty Drugs) Cost for a **two-month (60-day)** supply of a drug in tier 5 that is filled at a preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.
Drugs in Tier 1 (Preferred Generic Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 1 that is filled at a preferred mail-order pharmacy	You pay $0 per prescription.	You pay $0 per prescription.
Drugs in Tier 2 (Non-Preferred Generic Drugs) Cost for a **three-month 90-day)** supply of a drug in tier 2 that is filled at a preferred mail-order pharmacy	You pay $62.50 per prescription.	You pay $62.50 per prescription.

	2012 (this year)	2013 (next year)
Drugs in Tier 3 (Preferred Brand Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 3 that is filled at a preferred mail-order pharmacy	You pay $100 per prescription.	You pay $100 per prescription.
Drugs in Tier 4 (Non-Preferred Brand Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 4 that is filled at a preferred mail-order pharmacy	You pay $200 per prescription.	You pay $200 per prescription.
Drugs in Tier 5 (Specialty Drugs) Cost for a **three-month (90-day)** supply of a drug in tier 5 that is filled at a preferred mail-order pharmacy	You pay 33% of the total cost.	You pay 33% of the total cost.

You will stay in this stage until you reach the limit for the Initial Coverage Stage:

- **In 2013, the limit for the Initial Coverage Stage is $2,970** (this year the limit is $2,930). You stay in the Initial Coverage Stage until your "total drug costs" reach$2,970).
- Once you reach this limit, you move on to the "Coverage Gap Stage."

Stage 3: "Coverage Gap Stage"

Once you reach the Coverage Gap stage, your costs for Part D drugs will change (the 5 drug tiers no longer apply).

In 2013, your costs for drugs in the Coverage Gap Stage will be:

- *Brand name drugs*: You pay **47.5% of the total cost (plus a portion of the dispensing fee)** (this year you pay 50% of the total cost for brand name drugs).
- *Generic drugs*: You pay **79% of the total cost** (this year you pay 86% of the total cost for generic drugs).

You will stay in the Coverage Gap Stage until you pay $4,750) **out-of-pocket** for Part D drugs (this year it is $4,700).

- Once you reach this total amount, you move on to the "Catastrophic Coverage Stage."

Stage 4: "Catastrophic Coverage Stage"

The Catastrophic Coverage Stage is the last of the Drug Payment Stages. Once you are in this stage, you stay in it until the end of the calendar year.

Medicare requires all plans to have the same coverage in the Catastrophic Coverage Stage. So in this stage, all people with Medicare pay the same amount, no matter which plan they are in. In the Catastrophic Coverage Stage, we pay most of the cost for your Part D drugs. You pay the greater of:

- **5% of the total cost**
- -- *or* --**$2.65 copay for generic** (including brand drugs treated as generic) **and a $6.60 copay for all other drugs** (this year you pay a $2.60 copay for generic drugs and a $6.50 copay for other drugs.)

SECTION 2 Other Changes

	2012 (this year)	2013 (next year)
Pharmacy Benefit Manager	Medco Health Solutions, Inc.	Prime Therapeutics, LLC
Plan Service Area	75 counties in NC	7 counties added: Anson, Jones, Madison, McDowell, Mitchell, Pamlico, and Vance counties

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 stay enrolled as a member of our plan for 2013.

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 2013 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2013*, 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 http://www.medicare.gov and click "Compare Drug and Health Plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, BCBSNC 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 can 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, 2013.

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, 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 10, Section 2.3 of the *Evidence of Coverage.*

If you don't like your plan choice for 2013, you can switch to Original Medicare between January 1 and February 14, 2013. 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 at1-919-807-6900 or 1-800-443-9354. 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.

- **"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 seventy-five (75) percent 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 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office.

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/TDD only, call 1-888-451-9957.) We are available for phone calls 8 am to 8 pm daily. Calls to these numbers are free.

Read your 2013 *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 2013. For details, look in the 2013 *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* was included in this envelope.

Visit our Website

You can also visit our Website at www.bcbsnc.com/member/medicare. 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 (http://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 http://www.medicare.gov and click on "Compare Drug and Health Plans.")

Read *Medicare & You 2013*

You can read *Medicare & You 2013* 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 (http://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.