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

Annual Notice of Changes for 2015

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 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 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 (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 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 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? 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 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 to change plans:

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, 2015. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2015

The table below compares the 2014 costs and 2015 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.

Cost	2014 (this year)	2015 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$38.00	$57.40
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 in-network providers:** $3,400 **From in-network and out-of network providers combined:** $5,100	**From in-network providers:** $4,900 **From in-network and out-of network providers combined:** $7,350
Doctor office visits	**In-Network:** Primary care visits: $20 per visit Specialist visits: $40 per visit **Out-of Network:** Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit	**In-Network:** Primary care visits: $25 per visit Specialist visits: $50 per visit **Out-of Network:** Primary care visits: 20% of the total cost per visit Specialist visits: 20% of the total cost per visit

Cost	2014 (this year)	2015 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, 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 $220 copayment per day up to **7** 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 total cost for each Medicare-covered admission to an out-of-network hospital.	**In-Network:** You pay a $285 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 total 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: $3 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 1: $8 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 2: $6 for a 30-day supply at preferred retail cost-	Deductible: $0 Copays during the Initial Coverage Stage: • Drug Tier 1: $3 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 1: $8 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 2: $6 for a 30-day supply at preferred retail cost-

Cost	2014 (this year)	2015 (next year)
	sharing or preferred mail-order cost-sharing • Drug Tier 2: $25 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 3: $40 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 3: $45 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 4: $80 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 4: $95 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 5: 33% for a 30-day supply at	sharing or preferred mail-order cost-sharing • Drug Tier 2: $25 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 3: $40 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 3: $45 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 4: $80 for a 30-day supply at preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 4: $95 for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing • Drug Tier 5: 33% for a 30-day supply at

Cost	2014 (this year)	2015 (next year)
	preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 5: 33% for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing	preferred retail cost-sharing or preferred mail-order cost-sharing • Drug Tier 5: 33% for a 30-day supply at standard retail cost-sharing, standard mail-order cost-sharing, or out-of-network cost-sharing

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2014 (this year)	2015 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$38.00	$57.40

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

Cost	2014 (this year)	2015 (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 and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$4,900 Once you have paid $4,900 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	$7,350 Once you have paid $7,350 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 2015 Provider Directory to see if your providers 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, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will 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 managing 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 pharmacies within the network.

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 2015 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 *2015 Evidence of Coverage.*

Cost	2014 (this year)	2015 (next year)
Dental services	**In-Network:** You pay a $40 copayment for each Medicare-covered dental service.	**In-Network:** You pay a $50 copayment for each Medicare-covered dental service.
Hearing services	**In-Network:** You pay a $40 copayment for each Medicare-covered diagnostic hearing exam.	**In-Network:** You pay a $50 copayment for each Medicare-covered diagnostic hearing exam.
Inpatient hospital care	**In-Network:** You pay a $220 copayment per day up to 7 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	**In-Network:** You pay a $285 copayment per day up to 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.

Cost	2014 (this year)	2015 (next year)
Inpatient mental health care	**In-Network:** You pay a $220 copayment per day up to 7 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	**In-Network:** You pay a $250 copayment per day up to 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.
Outpatient mental health care	Certain outpatient mental health services require prior approval from plan's designated mental health vendor for in-network benefits, except in an emergency. Call 1-800-266-6167 (TTY/TDD call 1-877-342-6815.These services include: electroconvulsant therapy (ECT), intensive outpatient services, intensive outpatient substance abuse services, and psychological testing.	Certain outpatient mental health services require prior approval from plan's designated mental health vendor for in-network benefits, except in an emergency. Call 1-800-266-6167 (TTY/TDD call 1-877-342-6815.These services include: electroconvulsant therapy (ECT), Transcranial Magnetic Stimulation (TMS), intensive outpatient services, intensive outpatient substance abuse services, and psychological testing.

Cost	2014 (this year)	2015 (next year)
Physician/Practitioner services, including doctor's office visits	**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.	**In-Network:** You pay a $25 copayment for each Primary Care Provider visit for Medicare-covered benefits. You pay a $50 copayment for each specialist or any other physician visit for Medicare-covered benefits. You pay a $50 copayment for each visit to a participating walk-in convenience care clinic.
Podiatry services	**In-Network:** You pay a $40 copayment for each Medicare-covered visit for medically necessary foot care.	**In-Network:** You pay a $50 copayment for each Medicare-covered visit for medically necessary foot care.
Skilled nursing facility (SNF) care	**In-Network:** You pay: $0 each day for days 1-10 a $50 copayment each day for days 11-100 for a Medicare-covered admission to a Skilled Nursing Facility.	**In-Network:** You pay: $0 each day for days 1-20 a $60 copayment each day for days 21-100 for a Medicare-covered admission to a Skilled Nursing Facility.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to basic rules for the plan's Part D drug coverage

Effective June 1, 2015, before your drugs can be covered under the Part D benefit, CMS will require your doctors and other prescribers to either accept Medicare or to file documentation with CMS showing that they are qualified to write prescriptions.

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is 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. If we approve your request, you'll be able to get your drug at the start of the new plan year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your E*vidence 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 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 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 statement in the approval letter.

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 coverage. If you get "Extra Help" and haven't received this insert by September 30, 2014, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

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 enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Cost	2014 (this year)	2015 (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 Copayments in the Initial Coverage Stage

Cost	2014 (this year)	2015 (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.** 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.	Your cost for a one-month supply at a network pharmacy: ***Tier 1 Preferred Generic Drugs*:** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. ***Tier 2 Non-Preferred Generic Drugs*:** *Standard cost-sharing:* You pay $25 per prescription. *Preferred cost-sharing:* You pay $6 per prescription. ***Tier 3 Preferred Brand Drugs*:** *Standard cost-sharing:* You pay $45 per prescription. *Preferred cost-sharing:* You pay $40 per prescription. ***Tier 4 Non-Preferred Brand and Some Generic Drugs*:** *Standard cost-sharing:* You pay $95 per prescription.	Your cost for a one-month supply at a network pharmacy: ***Tier 1 Preferred Generic Drugs*:** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. ***Tier 2 Non-Preferred Generic Drugs*:** *Standard cost-sharing:* You pay $25 per prescription. *Preferred cost-sharing:* You pay $6 per prescription. ***Tier 3 Preferred Brand Drugs*:** *Standard cost-sharing:* You pay $45 per prescription. *Preferred cost-sharing:* You pay $40 per prescription. ***Tier 4 Non-Preferred Brand and Some Generic Drugs*:** *Standard cost-sharing:* You pay $95 per prescription.

Cost	2014 (this year)	2015 (next year)
	Preferred cost-sharing: You pay $80 per prescription. ***Tier 5 Specialty Drugs*:** *Standard cost-sharing:* You pay 33% per prescription. *Preferred cost-sharing:* You pay 33% per prescription. Once your total drug costs have reached $2,850*,* you will move to the next stage (the Coverage Gap Stage).	*Preferred cost-sharing:* You pay $80 per prescription. ***Tier 5 Specialty Drugs*:** *Standard cost-sharing:* You pay 33% per prescription. *Preferred cost-sharing:* You pay 33% per prescription. Once your total drug costs have reached $2,960*,* 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*.

SECTION 2 Other Changes

Process	2014 (this year)	2015 (next year)
Pharmacies With Preferred Cost-Sharing	Pharmacies with preferred cost-sharing include: CVS Walmart Epic Pharmacies Kerr These may have lower cost-sharing for covered drugs compared to other network pharmacies.	Pharmacies with preferred cost-sharing include: CVS Walmart Epic Pharmacies Walgreens Rite-Aid These may have lower cost-sharing for covered drugs compared to other network pharmacies.
SilverSneakers® Fitness Program	Offered	Not offered
Visitor/Travel Program Service Area	33 states and 1 territory	34 states and 1 territory Added 1 state: Illinois
Urgently Needed Care	Available within the United States.	Available world-wide.

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 2015.

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 2015 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 2015*, 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 "Find health & drug 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 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, 2015.

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 enrolled in a Medicare Advantage plan for January 1, 2015, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2015. 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. There are two basic 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 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
- 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 or visit their website at http://epi.publichealth.nc.gov/cd/hiv/adap.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/TDD only, call 1-888-451-9957.) We are available for phone calls 8 a.m. to 8 p.m. daily. Calls to these numbers are free.

Read your 2015 *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 2015. For details, look in the 2015 *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 "Find health & drug plans.")

Read *Medicare & You 2015*

You can read the *Medicare & You 2015* 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.