BlueCross BlueShield of North Carolina

Blue Medicare Essential Plus℠ (HMO) offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC)

Annual Notice of Changes for 2020

You are currently enrolled as a member of **Blue Medicare Essential℠ (HMO)**. 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 2.1, 2.2 and 2.5 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?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 2.6 for information about changes to our drug coverage.

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- 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 https://go.medicare.gov/drugprices. 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 2.3 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 https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 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 want to **keep Blue Medicare Essential Plus**, you don't need to do anything. You will stay in Blue Medicare Essential Plus.
- 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, 2019**

- If you **don't join another plan by December 7, 2019**, you will be enrolled in Blue Medicare Essential Plus.

- If you **join another plan by December 7, 2019**, your new coverage will start on January 1, 2020.

Additional Resources

- This document is available in languages other than English, in Braille, or in large print. Please call Customer Service for additional information (phone numbers are in Section 8.1 of this booklet).
- **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 Essential Plus

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

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Blue Medicare Essential Plus 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	2019 (this year)	2020 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 2.1 for details.	$57.60	$39.00
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 2.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $10 per visit Specialist visits: $50 per visit	Primary care visits: $0 per visit Specialist visits: $50 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $310 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.	You pay a $310 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital. You pay $0 for additional days at a network hospital.

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $375 Copayment/ Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $3 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: $10 for a 30-day supply at preferred retail pharmacy or 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	Deductible: $195 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 c pharmacy • Drug Tier 2: $10 for a 30-day supply at preferred retail pharmacy or 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

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (continued)	pharmacy or 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% for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 4: 50% for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 5: 25% for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 5: 25% for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or	pharmacy or 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% for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 4: 50% for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy • Drug Tier 5: 25% for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 5: 25% for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (continued)	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: $3 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy	of-network pharmacy • Drug Tier 6: $0 for a 30-day supply at preferred retail pharmacy or preferred mail-order pharmacy • Drug Tier 6: $3 for a 30-day supply at standard retail pharmacy, standard mail-order pharmacy, or out-of-network pharmacy

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SECTION 1 We are Changing the Plan's Name

On January 1, 2020, our plan name will change from Blue Medicare Essential (HMO) to Blue Medicare Essential Plus (HMO).

You will receive a new membership card in December 2019 with your new plan name and group number on it. All 2020 communications should have your new plan name on them.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$57.60	$39.00

- 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.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

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

Cost	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.bluecrossnc.com/medicare-members. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2020 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, 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 and managing your care.

Section 2.4 – 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/medicare-members. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network.**

Section 2.5 – 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 *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Cardiac rehabilitation services	Prior approval is required from plan for cardiac rehabilitation services after 36 visits.	Prior approval is NOT required for cardiac rehabilitation services.
Dental services	Preventive dental services not covered.	You receive a $300 allowance per year for preventive dental services. **** Please note that this service does not apply to your In-Network Out-of-Pocket Maximum***

Cost	2019 (this year)	2020 (next year)
Diagnostic testing	Covered: Prior approval from plan is required. Neuropsychological Testing for medical reasons Psychological Evaluations for medical reasons	Covered: Prior approval from plan is required. Neuropsychological Testing for medical **and mental health** reasons Psychological Evaluations for medical **and mental health** reasons
Durable medical equipment (DME) and related supplies	Prior approval is required from plan if equipment is rented or if the item's purchase price is greater than $600. Prior approval is required for DME maintenance or repair.	Prior approval is required from plan if equipment is rented or if the item's purchase price is greater than $1,200. Prior approval is required for DME maintenance or repair.
Hearing services	You pay a $45 copayment for one routine hearing exam by a TruHearing provider per year. No option for hearing aid rechargeability. ***Routine hearing exam and hearing aid copayments are not subject to the out-of-pocket maximum.***	You pay a $0 copayment for one routine hearing exam by a TruHearing provider per year. You pay a $75 additional cost per aid for optional hearing aid rechargeability. ***Routine hearing exam and hearing aid copayments are not subject to the out-of-pocket maximum.***

Cost	2019 (this year)	2020 (next year)
Opioid Treatment Program Services	Not covered.	You pay a $10 copayment for each Medicare-covered opioid treatment program service.
Outpatient mental health care	Prior approval is required for: • intensive outpatient services • intensive outpatient substance abuse services	Prior approval is NOT required for: • intensive outpatient services • intensive outpatient substance abuse services
Outpatient substance abuse services	Prior approval required for: Intensive outpatient substance abuse services in a facility and other approved places of service	Prior approval is NOT required. Intensive outpatient substance abuse services in a facility and other approved places of service
Over-the-Counter (OTC) **QuitlineNC**	Not offered.	**QuitlineNC** Quitline Program for smoking cessation. You may be eligible for Nicotine Replacement Therapy (NRT) with QuitlineNC Program for smoking cessation at no additional cost to you. For more information, call 1-844-862-7848, TTY: 1-877-777-6543. Up to twelve week supply of NRT (patches, gum, or lozenges) for up to two quit attempts per year.

Cost	2019 (this year)	2020 (next year)
Partial hospitalization services	Prior approval is required.	Prior approval is NOT required.
Physician/Practitioner services, including doctor's office visits	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 $0 copayment for each Primary Care Provider or other health care professional visit for Medicare-covered benefits in a PCP setting.
Podiatry services	Prior approval is required from plan for certain major joint surgeries of the feet.	Prior approval is NOT required from plan for certain major joint surgeries of the feet.
Prior authorization for nonparticipating providers and services –surgery	Prior approval is required for: Spinal Surgery: Arthrodesis, Arthroplasty, Diskectomy, Kyphectomy, Kyphoplasty, Laminectomy, Laminoplasty, Laminotomy, Spinal Fusion, Spinal Instrumentation, Spinal Osteoplasty, Vertebral Corpectomy, Vertebroplasty and Kyphoplasty and Insertion/Removal of Instrumentation. Includes All Approaches, Cervical, Thoracic, Lumbar, Sacral and Presacral.	Prior approval is ONLY required for: Spinal Surgery: Vertebroplasty and Kyphoplasty Inpatient major joint surgery ***Note:*** *Prior approval is required if other services that no longer require prior approval are performed inpatient.*

Cost	2019 (this year)	2020 (next year)
Prior authorization for nonparticipating providers and services –surgery (continued)	Implantation of Infusion Catheter, Pump, or Reservoir Inpatient and outpatient major joint surgery	
Pulmonary rehabilitation services	Prior approval is required for pulmonary rehabilitation services after 36 visits.	Prior approval is NOT required for pulmonary rehabilitation services.
Skilled nursing facility (SNF) care	You pay: $0 each day for days 1-20 a $172.00 copayment each day for days 21-60 $0 each day for days 61-100 for a Medicare-covered admission to a Skilled Nursing Facility.	You pay: $0 each day for days 1-20 a $178.00 copayment each day for days 21-60 $0 each day for days 61-100 for a Medicare-covered admission to a Skilled Nursing Facility.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	No additional coverage.	We cover two additional smoking cessation quit attempts each year. It includes up to four phone counseling sessions with QuitlineNC. For additional Information, call 1-844-862-7848; TTY call 1-877-777-6543.
Speech therapy	Prior approval is required from plan for speech therapy.	Prior approval is NOT required from plan for speech therapy.

Cost	2019 (this year)	2020 (next year)
Vision care	$100 limit per year for routine eye exams.	You receive a $200 allowance per year for routine eye exams and eyewear combined. **** Please note that this service does not apply to your In-Network Out-of-Pocket Maximum***

Section 2.6 – 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.

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. If you receive "Extra Help" and haven't received this insert by September 30, 2019, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 8.1 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 *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	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage During this stage, you **pay the full cost** of your Tier 3 Preferred Brand drugs, Tier 4 Non-preferred drugs, and Tier 5 Specialty drugs until you have reached the yearly deductible.	The deductible is $375. During this stage, you pay $3 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $15 cost-sharing-for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 1; you pay $10 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $20 cost-sharing for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 2; you pay $0 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $3 cost-sharing for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 6; and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.	The deductible is $195. During this stage, you pay $0 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $15 cost-sharing-for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 1; you pay $10 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $20 cost-sharing for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 2; you pay $0 cost-sharing for a 30-day supply at a preferred retail or preferred mail-order pharmacy, and $3 cost-sharing for a 30-day supply at a standard retail or standard mail-order pharmacy, for drugs on Tier 6; and the full cost of drugs on Tiers 3, 4, and 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

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	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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 $15 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. ***Tier 2 Generic Drugs*:** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $10 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.	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. *Preferred cost-sharing:* You pay $10 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.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage (continued)	*Preferred cost-sharing:* You pay 45% of the total cost.	*Preferred cost-sharing:* You pay 45% of the total cost.
	***Tier 5 Specialty Drugs*:** *Standard cost-sharing:* You pay 25% of the total cost.	***Tier 5 Specialty Drugs*:** *Standard cost-sharing:* You pay 25% of the total cost.
	Preferred cost-sharing: You pay 25% of the total cost.	*Preferred cost-sharing:* You pay 25% of the total cost.
	Tier 5 is limited to a 30-day supply per fill.	Tier 5 is limited to a 30-day supply per fill.
	***Tier 6 Select Care Drugs*:** *Standard cost-sharing:* You pay $3 per prescription.	***Tier 6 Select Care Drugs*:** *Standard cost-sharing:* You pay $3 per prescription.
	Preferred cost-sharing: You pay $0 per prescription.	*Preferred cost-sharing:* You pay $0 per prescription.
	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,020, 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 3 Administrative Changes

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

Process	2019 (this year)	2020 (next year)
Changing PCP online	You are unable to change your Primary Care Physician (PCP) online.	You may change your PCP online at www.bluecrossnc.com/medicare-members by registering for Blue Connect and clicking on "Make Changes to Your Plan," then "Primary Care Provider."
Membership Card	Membership cards are only mailed to members who change plans or request a replacement card for their current plan.	New membership cards will be mailed this December since your plan name will change from Blue Medicare Essential (HMO) to Blue Medicare Essential Plus (HMO) and your group number will change from 011900 to BH2304 on your membership card.
Plan Service Area	45 NC counties in your segment of Blue Medicare Essential.	41 NC counties in your segment of Blue Medicare Essential Plus. Alleghany Ashe Avery Beaufort Bertie Bladen Caldwell Chowan Cleveland Columbus Davie Duplin Edgecombe Gaston Jones Lee Lincoln Martin Nash Northampton Pamlico Pender Pitt Richmond Robeson Sampson Scotland Tyrrell

Process	2019 (this year)	2020 (next year)
Plan Service Area (continued)		Gates Greene Halifax Harnett Hertford Hyde Iredell Washington Watauga Wayne Wilkes Wilson Yadkin
Quality Improvement Organization, KEPRO	Phone number: 1-844-455-8708	NEW phone number: 1-888-317-0751
TTY phone number	1-888-451-9957	Dial 711. Give the operator the number you want to call. 1-888-310-4110 is the Customer Service number. Hours of operation are 8 am to 8 pm daily. This number requires special telephone equipment and is only for people who have difficulties with hearing or Speaking. Calls to this number are free.
Ways to pay your premium	For part of this year you were unable to pay by phone or pay with a credit card.	**Pay by phone** If you choose to receive a monthly invoice, you can pay by **calling our toll-free automated pay-by-phone number at 1-844-395-4535.** You can use your bank account and routing number or credit card to pay. This feature is for one-time payments only. If you choose to use this payment option, you will need to call the pay-by-phone number each month to make your payment and can either pay the balance forward or the total

Process	2019 (this year)	2020 (next year)
Ways to pay your premium (continued)		amount due. **Pay online using a credit card** If you choose to receive a monthly invoice, you can pay online using your bank account and routing number **or credit card** via our member portal, BlueConnect, by visiting www.bluecrossnc.com/medicare-members. You must register for a member account or log in to use this feature. If you choose this option, you will need to log in to BlueConnect to pay each invoice you receive and may only pay the exact amount due on the date you make the payment.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If You Want to Stay in Blue Medicare Essential Plus

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 2020.

Section 4.2 – If You Want to Change Plans

We hope to keep you as a member next year but if you want to change for 2020 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 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://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, 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 Essential Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Medicare Essential Plus.
- 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 8.1 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 5 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, 2020.

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, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 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 7 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 http://epi.publichealth.nc.gov/cd/hiv/adap.html.

SECTION 8 Questions?

Section 8.1 – Getting Help from Blue Medicare Essential Plus

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

Read your 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Blue Medicare Essential Plus. 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 8.2 – 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 (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* 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 (https://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.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
E-mail: civilrightscoordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。
顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTIONₒ: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM:Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ ક ઉપલ ધ છે. તમારા સ યપદ ઓળખપ ૨ની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណាំ៖ ប្រសិនប្រាកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយម្តភាសាមានឥល់ជូនសបមាប្រាកអ្នកដោយមិនគិតថ្លៃ។សូមដៅដៅកា ន់បស វាអត្ថិជនដោយបប្របលទូរស័ព្ទដៅខាងក្រកាតសមាជិករ្យស់ដោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服或 TTY號的電話號碼。

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