Blue Cross Medicare Advantage Core (PPO) offered by Blue Cross and Blue Shield of Minnesota

Annual Notice of Changes for 2022

You are currently enrolled as a member of Blue Cross Medicare Advantage Core. Next year, there will be some changes to the plan’s costs and benefits. This booklet tells about the changes.

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

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
   - It’s important to review your coverage now to make sure it will meet your needs next year.
   - Do the changes affect the services you use?
   - Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.
   - Will your drugs be covered?
   - Are your drugs in a different tier, with different cost sharing?
   - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
   - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
   - Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
• Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the “dashboards” link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.
  • Are your doctors, including specialists you see regularly, in our network?
  • What about the hospitals or other providers you use?
  • Look in Section 1.3 for information about our Provider Directory.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.
  • Use the personalized search feature on the Medicare Plan Finder at medicare.gov/plan-compare website.
  • Review the list in the back of your Medicare & You 2022 handbook.
  • Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. CHOOSE: Decide whether you want to change your plan
  • If you don’t join another plan by December 7, 2021, you will be enrolled in Blue Cross Medicare Advantage Core.
  • To change to a different plan that may better meet your needs, you can switch plans between October 15 and December 7.
4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**
   - If you don’t join another plan by **December 7, 2021**, you will be enrolled in Blue Cross Medicare Advantage Core.
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

**Additional Resources**
- Please contact our Customer Service number at 1-800-711-9865 for additional information. (TTY users should call 711.) Hours are between 8:00 a.m. and 8:00 p.m., Central Time. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
- Upon request, we can give you information in braille, in large print, or other alternate formats if you need it.
- **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 [irs.gov/Affordable-Care-Act/Individuals-and-Families](https://irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

**About Blue Cross Medicare Advantage Core**
- Blue Cross Medicare Advantage is a PPO Plan with a Medicare Contract. Enrollment in Blue Cross Medicare Advantage depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Minnesota. When it says “plan” or “our plan,” it means Blue Cross Medicare Advantage Core.
## Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Blue Cross Medicare Advantage Core 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 bluecrossmnonline.com. You may also call Customer Service to ask us to mail you an Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amounts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From network providers: $5,900</td>
<td>From network providers: $5,500</td>
<td></td>
</tr>
<tr>
<td>From in-network and out-of-network providers combined: $10,000</td>
<td>From in-network and out-of-network providers combined: $7,900</td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $0 copayment per visit.</td>
<td>Primary care visits: $0 copayment per visit.</td>
<td></td>
</tr>
<tr>
<td>Specialist visits: $50 copayment per visit.</td>
<td>Specialist visits: $40 copayment per visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Medicare-covered hospital stays: $400 copayment per day for days 1 through 4.</td>
<td>For Medicare-covered hospital stays: $300 copayment per day for days 1 through 5.</td>
<td></td>
</tr>
<tr>
<td>$0 copayment per day for days 5 through 90.</td>
<td>$0 copayment per day for days 6 through 90.</td>
<td></td>
</tr>
</tbody>
</table>
### Part D prescription drug coverage

(See Section 1.6 for details.)

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductible: $445 for Tier 2-5 drugs</td>
<td>Deductible: $350 for Tier 3-5 drugs</td>
</tr>
<tr>
<td></td>
<td>Copayment/coinsurance during the Initial Coverage Stage:</td>
<td>Copayment/coinsurance during the Initial Coverage Stage:</td>
</tr>
<tr>
<td></td>
<td><img src="#" alt="Drug Tier 1" /></td>
<td><img src="#" alt="Drug Tier 1" /></td>
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<tr>
<td></td>
<td><img src="#" alt="Drug Tier 2" /></td>
<td><img src="#" alt="Drug Tier 2" /></td>
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<td></td>
<td><img src="#" alt="Drug Tier 3" /></td>
<td><img src="#" alt="Drug Tier 3" /></td>
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<td></td>
<td><img src="#" alt="Drug Tier 4" /></td>
<td><img src="#" alt="Drug Tier 4" /></td>
</tr>
<tr>
<td></td>
<td><img src="#" alt="Drug Tier 5" /></td>
<td><img src="#" alt="Drug Tier 5" /></td>
</tr>
</tbody>
</table>
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs. Please see Section 5 regarding “Extra Help” from Medicare.

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

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

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network maximum out-of-pocket amount</td>
<td>$5,900</td>
<td>$5,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Once you have paid $5,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount

Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined maximum out-of-pocket amount</td>
<td>$10,000</td>
<td>$7,900</td>
</tr>
</tbody>
</table>

Once you have paid $7,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

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

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
Section 1.4 – Changes to the Pharmacy Network

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

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

Section 1.5 – Changes to Benefits and Costs for Medical Services

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

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

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

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous glucose monitoring (CGM) products</td>
<td>Continuous glucose monitoring (CGM) products were covered under “Durable medical equipment (DME) and related supplies”.</td>
<td>Continuous glucose monitoring (CGM) products are covered under “Diabetes self-management training, diabetic services and supplies”.</td>
</tr>
<tr>
<td></td>
<td>Continuous glucose monitoring (CGM)</td>
<td>Continuous glucose monitoring (CGM)</td>
</tr>
<tr>
<td>Cost</td>
<td>2021 (this year)</td>
<td>2022 (next year)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Continuous glucose monitoring (CGM) products (continued)</strong></td>
<td>products were not limited to Dexcom G6 products and Abbott Freestyle Libre products.</td>
<td>products may be subject to quantity limits and coverage is limited to Dexcom G6 products and Abbott Freestyle Libre products.</td>
</tr>
<tr>
<td><strong>Dental services</strong></td>
<td><strong>In- and Out-of-Network:</strong></td>
<td><strong>In- and Out-of-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>You pay a $0 copayment for up to two (2) oral exams per calendar year.</td>
<td>You pay a $0 copayment for up to two (2) oral exams per calendar year.</td>
</tr>
<tr>
<td></td>
<td>You pay a $0 copayment for up to two (2) cleanings (prophylaxis) per calendar year.</td>
<td>You pay a $0 copayment for up to two (2) cleanings (prophylaxis) per calendar year.</td>
</tr>
<tr>
<td></td>
<td>You pay a $0 copayment for one (1) dental x-ray per calendar year.</td>
<td>You pay a $0 copayment for one (1) dental x-ray per calendar year.</td>
</tr>
<tr>
<td></td>
<td>You pay a $0 copayment for one (1) periodontal cleaning per calendar year.</td>
<td>You pay a $0 copayment for one (1) periodontal cleaning per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Fluoride treatments are not covered.</td>
<td>Fluoride treatments are not covered.</td>
</tr>
<tr>
<td></td>
<td>The maximum plan benefit for both In- and Out-of-Network services is $2,250.</td>
<td>The maximum plan benefit for both In- and Out-of-Network services is $2,000.</td>
</tr>
<tr>
<td><strong>Hearing services</strong></td>
<td><strong>In-Network:</strong></td>
<td><strong>In-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>You pay a $50 copayment for each Medicare-covered diagnostic hearing exam.</td>
<td>You pay a $0 copayment for each Medicare-covered diagnostic hearing exam.</td>
</tr>
</tbody>
</table>
### Hearing services (continued)

<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In- and Out-of-Network: Hearing aids:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit is combined In- and Out-of-Network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $0 copayment for one (1) non-Medicare-covered hearing screening.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $0 copayment for one (1) non-Medicare-covered hearing aid exam per year.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $699 copayment per aid for Advanced Hearing Aids.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $999 copayment per aid for Premium Hearing Aids.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $0 copayment per aid for optional hearing aid rechargeability on premium aids.*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* **TruHearing provider must be used for in- and out-of-network hearing aid exam and hearing aid benefit.**

Purchases include:

- 3 provider visits within first year of hearing aid purchase
- 45-day trial period
- Unlimited follow-up provider visits within first year of hearing aid purchase
- 60-day trial period

You pay a $0 copayment for one (1) non-Medicare-covered hearing aid exam per year.*
You pay a $699 copayment per aid for Advanced Hearing Aids.*
You pay a $999 copayment per aid for Premium Hearing Aids.*
You pay a $0 copayment per aid for optional hearing aid rechargeability on premium aids.*

* **TruHearing provider must be used for in- and out-of-network hearing aid exam and hearing aid benefit.**

Purchases include:

- Unlimited follow-up provider visits within first year of hearing aid purchase
- 60-day trial period
### Hearing services (continued)

- 3-year extended manufacturer’s warranty for repairs
- 48 batteries per aid for non-rechargeable models
- No additional charge for optional hearing aid rechargeability (Premium model only)

- 3-year extended manufacturer’s warranty for repairs
- 80 batteries per aid for non-rechargeable models
- No additional charge for optional hearing aid rechargeability (Premium model only)

### Inpatient hospital care

**In-Network:**
You pay a $400 copayment per day for days 1-4; $0 copayment for days 5-90 for Medicare-covered hospital stays.

**In-Network:**
You pay a $300 copayment per day for days 1-5; $0 copayment for days 6-90 for Medicare-covered hospital stays.

### Inpatient mental health care

**In-Network:**
You pay a $400 copayment per day for days 1-4; $0 copayment for days 5-90 for Medicare-covered hospital stays.

**In-Network:**
You pay a $300 copayment per day for days 1-5; $0 copayment for days 6-90 for Medicare-covered hospital stays.

### Opioid treatment program services

**In-Network:**
You pay $50 for substance abuse counseling and individual & group therapy for opioid treatment services. There may be additional inpatient hospital care, inpatient mental health care and/or outpatient.

**In-Network:**
You pay $40 for substance abuse counseling and individual & group therapy for opioid treatment services. There may be additional inpatient hospital care, inpatient mental health care and/or outpatient.
<table>
<thead>
<tr>
<th>Cost</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>hospital services copayments and/or coinsurance as applicable.</strong></td>
<td><strong>hospital services copayments and/or coinsurance as applicable.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td><strong>In-Network:</strong> You pay a 20% coinsurance for Medicare-covered x-rays. You pay a 20% coinsurance for Medicare-covered radiation therapy services. Examples include, but are not limited to, treatment of cancer. You pay a 20% coinsurance for Medicare-covered surgical supplies, splints and casts. You pay a $0 copayment for Medicare-covered laboratory tests. You pay a $0 copayment for Medicare-covered blood. You pay a 20% coinsurance for Medicare-covered diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms. You pay a 20% coinsurance for Medicare-covered diagnostic tests &amp; procedures. Examples include, but are not</td>
<td><strong>In-Network:</strong> You pay a $10 copayment for Medicare-covered x-rays. You pay a 20% coinsurance for Medicare-covered radiation therapy services. Examples include, but are not limited to, treatment of cancer. You pay a 20% coinsurance for Medicare-covered surgical supplies, splints and casts. You pay a $0 copayment for Medicare-covered laboratory tests. You pay a $0 copayment for Medicare-covered blood. You pay a $95 copayment for Medicare-covered diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms. You pay a $25 copayment for Medicare-covered diagnostic tests &amp; procedures. Examples include, but are not</td>
</tr>
<tr>
<td>Cost</td>
<td>2021 (this year)</td>
<td>2022 (next year)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td>include, but are not limited to, EKG’s, pulmonary function tests, psychological/neuropsychological testing, home or lab-based sleep studies. You pay a 20% coinsurance for each Medicare-covered diagnostic mammogram or colonoscopy.</td>
<td>limited to, EKG’s, pulmonary function tests, psychological/neuropsychological testing, home or lab-based sleep studies. You pay a $0 copayment for each Medicare-covered diagnostic mammogram or colonoscopy.</td>
</tr>
<tr>
<td><strong>Outpatient hospital services</strong></td>
<td><strong>In-Network:</strong> You pay a $375 copayment for Medicare-covered outpatient hospital surgery services. You pay a $15 copayment for all other Medicare-covered outpatient hospital services.</td>
<td><strong>In-Network:</strong> You pay a $350 copayment for Medicare-covered outpatient hospital surgery services. You pay a $20 copayment for all other Medicare-covered outpatient hospital services.</td>
</tr>
<tr>
<td><strong>Outpatient substance abuse services</strong></td>
<td><strong>In-Network:</strong> You pay a $50 copayment for each Medicare-covered individual or group therapy visit.</td>
<td><strong>In-Network:</strong> You pay a $40 copayment for each Medicare-covered individual or group therapy visit.</td>
</tr>
<tr>
<td><strong>Over-the-Counter (OTC) items</strong></td>
<td>$50 allowance per quarter for covered OTC items.* *This is not a reimbursement. Visit cvs.com/otchs/bcbsmn or call 1-888-628-2770, Monday – Friday 9am – 8pm local time for more information. CVS Pharmacy, Inc. d/b/a OTC Health Solutions is</td>
<td>$40 allowance per quarter for covered OTC items.* *This is not a reimbursement. Visit cvs.com/otchs/bcbsmn or call 1-888-628-2770, Monday – Friday 9am – 8pm local time for more information. CVS Pharmacy, Inc. d/b/a OTC Health Solutions is</td>
</tr>
<tr>
<td>Cost</td>
<td>2021 (this year)</td>
<td>2022 (next year)</td>
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<tr>
<td>------</td>
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</tbody>
</table>
| **Over the Counter Items**  
(continued) | an independent company providing OTC supplemental benefit administrative services. | an independent company providing OTC supplemental benefit administrative services. |
| **Physician/Practitioner services, including doctor’s office visits** | **In-Network:**  
You pay a $0 copayment for each Medicare-covered visit with a primary care physician.  
You pay a $50 copayment for each Medicare-covered visit with a specialist.  
You pay a $20 copayment for each Medicare-covered visit with other health care professionals, which provide the professional service of home infusion therapy. | **In-Network:**  
You pay a $0 copayment for each Medicare-covered visit with a primary care physician.  
You pay a $40 copayment for each Medicare-covered visit with a specialist.  
You pay a $20 copayment for each Medicare-covered visit with other health care professionals, which provide the professional service of home infusion therapy. |
| **Podiatry services** | **In-Network:**  
You pay a $50 copayment for each Medicare-covered visit. | **In-Network:**  
You pay a $40 copayment for each Medicare-covered visit. |
| **Skilled nursing facility (SNF) care** | **In-Network:**  
$0 copayment per day for days 1-20.  
$184 copayment per day for days 21-100. | **In-Network:**  
$0 copayment per day for days 1-20.  
$188 copayment per day for days 21-100. |
| **Urgently needed services** | You pay a $50 copayment for each Medicare-covered urgent care visit. | You pay a $45 copayment for each Medicare-covered urgent care visit. |
Vision care

<table>
<thead>
<tr>
<th>In-Network:</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay a $50 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. There is a maximum allowance of $90 per calendar year for non-Medicare-covered eyewear.</td>
<td></td>
<td>You pay a $0 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. There is a maximum allowance of $100 per calendar year for non-Medicare-covered eyewear.</td>
</tr>
</tbody>
</table>

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. We encourage current members to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Customer Service.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

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

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

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

## Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), the information about costs for Part D prescription drugs may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. Because you receive “Extra Help” if you haven’t received this insert by September 30, 2021, please call Customer Service and ask for the “LIS Rider.”

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the Evidence of Coverage, which is located on our website at bluecrossmnonline.com. You may also call Customer Service to ask us to mail you an Evidence of Coverage.)

### Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1: Yearly Deductible Stage</strong></td>
<td>The deductible is $445 for Tier 2-5 drugs.</td>
<td>The deductible is $350 for Tier 3-5 drugs.</td>
</tr>
<tr>
<td>During this stage, you pay the full cost of your Tier 3-5 drugs until you have reached the yearly deductible.</td>
<td>During this stage, you pay: $0 per prescription for drugs on Tier 1 (Preferred Generic).</td>
<td>During this stage, you pay: $0 per prescription for drugs on Tier 1 (Preferred Generic).</td>
</tr>
</tbody>
</table>
### Stage 1: Yearly Deductible Stage (continued)

<table>
<thead>
<tr>
<th>Stage</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay the full cost of drugs on Tiers 2-5 until you have reached the yearly deductible.</td>
<td>$13 per prescription for drugs on Tier 2 (Generic).</td>
<td>You pay the full cost of drugs on Tiers 3-5 until you have reached the yearly deductible.</td>
</tr>
</tbody>
</table>

### 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*.

<table>
<thead>
<tr>
<th>Stage</th>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 2: Initial Coverage Stage</strong></td>
<td>Your cost for a one-month supply at a network pharmacy with standard cost sharing:</td>
<td>Your cost for a one-month supply at a network pharmacy with standard cost sharing:</td>
</tr>
<tr>
<td><strong>Drug Tier 1 (Preferred Generic):</strong></td>
<td>You pay $0 per prescription.</td>
<td>You pay $0 per prescription.</td>
</tr>
<tr>
<td><strong>Drug Tier 2 (Generic):</strong></td>
<td>You pay $13 per prescription.</td>
<td>You pay $13 per prescription.</td>
</tr>
<tr>
<td><strong>Drug Tier 3 (Preferred Brand):</strong></td>
<td>You pay 21% of the total cost.</td>
<td>You pay 21% of the total cost.</td>
</tr>
<tr>
<td><strong>Drug Tier 4 (Non-Preferred drug):</strong></td>
<td>You pay 45% of the total cost.</td>
<td>You pay 45% of the total cost.</td>
</tr>
</tbody>
</table>
Stage 2: Initial Coverage Stage (continued)

<table>
<thead>
<tr>
<th>2021 (this year)</th>
<th>2022 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Tier 5 (Specialty):</td>
<td>Drug Tier 5 (Specialty):</td>
</tr>
<tr>
<td>You pay 25% of the total cost.</td>
<td>You pay 27% of the total cost.</td>
</tr>
<tr>
<td>Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).</td>
<td>Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).</td>
</tr>
</tbody>
</table>

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 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Blue Cross Medicare Advantage Core

To stay in our plan you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in Blue Cross Medicare Advantage Core.

Section 2.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- OR – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.
To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

As a reminder, Blue Cross and Blue Shield of Minnesota 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 Cross Medicare Advantage Core.

- **To change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Blue Cross Medicare Advantage Core.

- **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 6.1 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 3  Deadline for Changing Plans**

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on **January 1, 2022**.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage Plan for January 1, 2022, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*. 
SECTION 4 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 Minnesota, the SHIP is called Senior LinkAge Line®.

Senior LinkAge Line® 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. Senior LinkAge Line® 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 Senior LinkAge Line® at 1-800-333-2433 or TTY at 711. You can learn more about Senior LinkAge Line® by visiting their website (mn.gov/senior-linkage-line/older-adults/medicare).

SECTION 5 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 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 Minnesota Department of Human Services. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (651) 431-2414 (in the Twin Cities Metro Area) or 1-800-657-3761 (Greater Minnesota).
SECTION 6 Questions?

Section 6.1 – Getting Help from Blue Cross Medicare Advantage Core

Questions? We’re here to help. Please call Customer Service at 1-800-711-9865. (TTY only, call 711.) We are available for phone calls between 8:00 a.m. and 8:00 p.m., Central Time. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. Calls to these numbers are free.

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

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 Evidence of Coverage for Blue Cross Medicare Advantage Core. 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 bluecrossmnonline.com. 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 bluecrossmnonline.com. 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 6.2 – 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 (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 medicare.gov/plan-compare).

Read Medicare & You 2022

You can read the Medicare & You 2022 handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this
booklet, you can get it at the Medicare website (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.
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