Blue Cross Medicare Advantage Basic (HMO)SM offered by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs)

Annual Notice of Changes for 2021

You are currently enrolled as a member of Blue Cross Medicare Advantage Basic (HMO)SM. 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 2021 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. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in

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mind that your plan benefits will determine exactly how much your own drug costs may change.

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

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

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

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

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Blue Cross Medicare Advantage Basic (HMO).
- 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, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Blue Cross Medicare Advantage Basic (HMO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021.** You will be automatically disenrolled from your current plan.

Additional Resources

- This document is available for free in Spanish.
- ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call Customer Service at 1-877-774-8592 (TTY only, call 711) for more information.
- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio al Cliente al 1-877-774-8592 (TTY 711) para recibir más información.
- Please contact our Customer Service number at 1-877-774-8592 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- Para obtener más información por favor póngase en contacto con nuestro número de servicio al cliente en 1-877-774-8592. (Usuarios de TTY deben llamar al 711.) El horario es de 8:00 – 20:00, hora de local, 7 días a la semana. Si usted está llamando desde el 1 de abril hasta el 30 de septiembre, tecnologías alternativas (por ejemplo, correo de voz) se utilizarán los fines de semana y festivos.
- Please contact Blue Cross Medicare Advantage Basic (HMO) if you need this information in another language or format (Spanish, braille, large print or alternate formats).
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Cross Medicare Advantage Basic (HMO)

- HMO plans provided by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC and BlueLincs are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and BlueLincs are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and BlueLincs' plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). When it says "plan" or "our plan," it means Blue Cross Medicare Advantage Basic (HMO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Blue Cross Medicare Advantage Basic (HMO) 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.getblueok.com/plandocs/eoc. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$6,500	$5,900
Doctor office visits	**Primary care visits:** $5 copay per visit **Specialist visits:** $50 copay per visit	**Primary care visits:** $0 copay per visit **Specialist visits:** $45 copay 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.	$372 copay per day for days 1-5 and a $0 copay per day for days 6-90 $0 copay per day for days 91 and beyond	$372 copay per day for days 1-5 and a $0 copay per day for days 6-90 $0 copay per day for days 91 and beyond

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $435 Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: • *Standard cost-sharing:* $5 copay • *Preferred cost-sharing:* $0 copay Drug Tier 2: • *Standard cost-sharing:* $19 copay • *Preferred cost-sharing:* $14 copay Drug Tier 3: • *Standard cost-sharing:* $47 copay • *Preferred cost-sharing:* $42 copay Drug Tier 4: • *Standard cost-sharing:* $100 copay • *Preferred cost-sharing:* $95 copay Drug Tier 5: • *Standard cost-sharing:* 25% of the total cost • *Preferred cost-sharing:* 25% of the total cost	Deductible: $445 Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: • *Standard cost-sharing:* $7 copay • *Preferred cost-sharing:* $0 copay Drug Tier 2: • *Standard cost-sharing:* $20 copay • *Preferred cost-sharing:* $13 copay Drug Tier 3: • *Standard cost-sharing:* $47 copay • *Preferred cost-sharing:* $40 copay Drug Tier 4: • *Standard cost-sharing:* $100 copay • *Preferred cost-sharing:* $93 copay Drug Tier 5: • *Standard cost-sharing:* 25% of the total cost • *Preferred cost-sharing:* 25% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Optional Supplemental Dental, Eyewear, and Hearing Services (Optional supplemental benefit available for *an extra premium)* See Chapter 4, Section 2.2 *(Extra "optional supplemental" benefits you can buy)* of the Evidence of Coverage for details.	$30.50	$24

- 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 6 regarding "Extra Help" from Medicare.

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

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

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,500	$5,900 Once you have paid $5,900 out-of-pocket for covered services, you will pay nothing for your covered services 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 www.getblueok.com/mapd. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2021 *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. 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.getblueok.com/mapd/pharmacies. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2021 *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 *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Acupuncture for Chronic Low Back Pain (Medicare-covered)	**In-Network** You pay a $50 copay for each Medicare-covered visit.	**In-Network** You pay a $45 copay for each Medicare-covered visit.

Cost	2020 (this year)	2021 (next year)
Diabetic Services and Supplies	**In-Network** You pay 0% cost sharing limited to diabetic testing supplies (meters, strips, and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for plan approved non-preferred diabetic testing supplies (meters, strips and lancets). 20% cost sharing for all other diabetic supplies in this category. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy will be subject to prior authorization.	**In-Network** You pay 0% cost sharing limited to diabetic testing supplies (meters, strips, and lancets) obtained through the pharmacy for a LifeScan branded product (OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2). 20% cost sharing for all other diabetic supplies including approved exceptions. All test strips will also be subject to a quantity limit of 204 per 30 days. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy will be subject to prior authorization.

Cost	2020 (this year)	2021 (next year)
Hearing Services (Non-Medicare-covered)	The following optional supplemental hearing benefits are available for an extra premium: **In-Network** You pay a $5 copay for 1 routine hearing exam every year. You pay a $0 copay for 1 hearing aid fitting/evaluation visit every 3 years. **In- and Out-of-Network** $1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in- or out-of-network every three years	The following optional supplemental hearing benefits are available for an extra premium: **In-Network** You pay a $5 copay for 1 routine hearing exam every 3 years. You pay a $0 copay for 3 hearing aid fitting/evaluation visits every 3 years. **In-Network** $1,000 maximum plan coverage limit for hearing aids (both ears combined) purchased in-network every three years
Home Infusion Therapy	Home infusion therapy is not covered.	**In-Network** You pay a $0 copay for home infusion therapy.
Kidney Disease Education Services	Prior authorization is required for Medicare-covered kidney disease education services.	Prior authorization is not required for Medicare-covered kidney disease education services.
Opioid Treatment Program Services	**In-Network** You pay a $75 copay for each Medicare-covered opioid treatment service.	**In-Network** You pay a $0 copay for each Medicare-covered opioid treatment service.
Other Health Care Professionals (e.g. nurse practitioner; physician assistant)	**In-Network** You pay a $5 copay for services performed with a PCP and a $50 copay for services performed with a Specialist for each Medicare-covered visit.	**In-Network** You pay a $0 copay for services performed with a PCP and a $45 copay for services performed with a Specialist for each Medicare-covered visit.

Cost	2020 (this year)	2021 (next year)
Outpatient Blood Services	**In-Network** Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.	**In-Network** Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need.
Outpatient Diagnostic Radiology Services	**In-Network** You pay a $175 copay for services at a free-standing clinic and a $275 copay for services in an outpatient hospital setting for Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans).	**In-Network** You pay a $175 copay for services at a free-standing clinic and a $250 copay for services in an outpatient hospital setting for Medicare-covered outpatient diagnostic radiology services (such as MRIs and CT scans).
Outpatient Hospital Observation Services	Prior authorization is required for Medicare-covered outpatient hospital observation services.	Prior authorization is not required for Medicare-covered outpatient hospital observation services.
Outpatient X-ray Services	**In-Network** You pay a $5 to $50 copay ($5 copay for services provided at a PCP or specialist office, a $50 copay for services provided by a specialist at an outpatient hospital) for Medicare-covered outpatient X-rays.	**In-Network** You pay a $0 to $45 copay ($0 copay for services provided at a PCP or specialist office, a $45 copay for services provided by a specialist at an outpatient hospital) for Medicare-covered outpatient X-rays.

Cost	2020 (this year)	2021 (next year)
Over-the-Counter Items (Non-Medicare-covered)	Over-the-counter items are not covered.	**In-Network** You pay a $0 copay for over-the-counter items. Plan covers up to a $25 allowance every three (months for specific over-the-counter drugs and other health-related products. Unused OTC amounts do not roll over to the next calendar year. Member selects item(s) from catalog and item(s) are shipped to members. No card is issued and no cash is exchanged. This benefit also covers Nicotine Replacement Therapy (NRT).
Physician Specialist Services	**In-Network** You pay a $50 copay for each Medicare-covered specialist visit.	**In-Network** You pay a $45 copay for each Medicare-covered specialist visit.
Primary Care Physician Visits	**In-Network** You pay a $5 copay for each Medicare-covered primary care doctor visit.	**In-Network** You pay a $0 copay for each Medicare-covered primary care doctor visit.
Skilled Nursing Facility (SNF) Care	**In-Network** You pay a $0 copay per day for days 1-20 and a $178 copay per day for days 21-100 for each Medicare-covered SNF stay.	**In-Network** You pay a $0 copay per day for days 1-20 and a $184 copay per day for days 21-100 for each Medicare-covered SNF stay.
Vision Care (Non-Medicare-covered Eye Exams)	**In- and Out-of-Network** $40 plan coverage limit for eye exam every year.	**In-Network** No maximum plan benefit coverage amount for eye exam.

Cost	2020 (this year)	2021 (next year)
Vision Care (Non-Medicare-covered - Eyewear)	The following optional supplemental eyewear benefit is available for an extra premium: **In-Network** 1 pair of eyeglass frames every year (Single-vision, lined bifocal, trifocal or lenticular lenses only)	The following optional supplemental eyewear benefit is available for an extra premium: **In- and Out-of-Network** 1 pair of eyeglass frames every year (Standard lenses only. Progressive lenses excluded)

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 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 formulary exceptions may still be covered, depending on the circumstance. You can call Customer Service to confirm coverage duration.

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.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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 have included 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 didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider."

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

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

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $435. During this stage, you pay $0-$19 cost sharing for drugs on Tier 1 Preferred Generic and Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Brand, Tier 5 Specialty Tier until you have reached the yearly deductible.	The deductible is $445. During this stage, you pay $0-$20 cost sharing for drugs on Tier 1 Preferred Generic and Tier 2 Generic and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier 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*.

	2020 (this year)	2021 (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.	Your cost for a one-month supply at a network pharmacy: **Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $5 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $7 copay per prescription. *Preferred cost sharing:* You pay $0 copay per prescription.

	2020 (this year)	2021 (next year)
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.	**Tier 2 – Generic:** *Standard cost sharing:* You pay $19 copay per prescription. *Preferred cost sharing:* You pay $14 copay per prescription. **Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 copay per prescription. *Preferred cost sharing:* You pay $42 copay per prescription. **Tier 4 – Non-Preferred Brand:** *Standard cost sharing:* You pay $100 copay per prescription. *Preferred cost sharing:* You pay $95 copay per prescription. **Tier 5 – Specialty:** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	**Tier 2 – Generic:** *Standard cost sharing:* You pay $20 copay per prescription. *Preferred cost sharing:* You pay $13 copay per prescription. **Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 copay per prescription. *Preferred cost sharing:* You pay $40 copay per prescription. **Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay $100 copay per prescription. *Preferred cost sharing:* You pay $93 copay per prescription. **Tier 5 – Specialty:** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. _____ Once your total drug costs have reached $4,130, 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 Administrative Changes

Description	2020 (this year)	2021 (next year)
Diabetic testing supplies	Diabetic testing supplies are limited to these LifeScan branded products: OneTouch Verio Flex, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2.	You have an additional product offered through LifeScan for diabetic testing supplies: OneTouch Verio Flex, OneTouch Verio Reflect, OneTouch Verio, OneTouch Ultra Mini and OneTouch Ultra 2.
Long-term supply of a covered Part D prescription drug **(Tier 1-Preferred Generic)**	For Tier 1 drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply.	For Tier 1 drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Blue Cross Medicare Advantage Basic (HMO)

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

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 2021 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 *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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

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 Basic (HMO).
- 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 Basic (HMO).
- 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, 2021.

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, 2021, 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, 2021. 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 Oklahoma, the SHIP is called Senior Health Insurance Counseling Program.

Senior Health Insurance Counseling Program 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 Health Insurance Counseling Program 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 the Senior Health Insurance Counseling Program at 1-800-763-2828. You can learn more about Senior Health Insurance Counseling Program by visiting their website (www.oid.ok.gov/consumers/information-for-seniors/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 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 HIV/STD Services Division, Oklahoma State Department of Health, 1000 N.E. Tenth, Mail Drop 0308, Oklahoma City, OK 73117-1299; https://www.ok.gov/health/Disease,_Prevention,_Preparedness/HIV_STD_Service/Care_Delivery_(Ryan_White_ADAP_Hepatitis)/index.html. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-405-271-4636.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Cross Medicare Advantage Basic (HMO)

Questions? We're here to help. Please call Customer Service at 1-877-774-8592. (TTY only, call 711). We are available for phone calls 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Blue Cross Medicare Advantage Basic (HMO). 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.getblueok.com/plandocs/eoc. 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.getblueok.com/mapd. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Medicare Advantage Basic (HMO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.