MASSACHUSETTS

Medicare HMO Blue (HMO) offered by Blue Cross Blue Shield of Massachusetts

Annual Notice of Changes for 2021

Date
First Name Last Name
Street Address_1
Street Address_2
City, State, Zip

You are currently enrolled as a member of Medicare HMO Blue. Next year, there will be some changes to the plan's costs and benefits. These changes will take effect January 1, 2021 if your employer/union sponsor continues to offer the plan and you remain enrolled in Medicare HMO Blue. *This booklet tells about the changes.*

What to do now

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 Section 1 for information about benefit and cost changes for our plan.

☐ Check any changes to the 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 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 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 1 for information about our Provider Directory.

Additional Resources

- Please contact our Member Services number at 1-800-200-4255 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30.
- This information is available in alternate formats such as large print.
- **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 *Medicare HMO Blue*

- Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.
- When this booklet says "we," "us," or "our," it means *Blue Cross Blue Shield of Massachusetts*. When it says "plan" or "our plan," it means *Medicare HMO Blue*.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Medicare HMO Blue in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services.	$3,400	$3,400
Doctor office visits	Primary care visits: $15 copay per visit Specialist visits: $35 copay per visit	Primary care visits: $15 copay per visit Specialist visits: $35 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, log-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.	Per admission: ▪ Days 1 - 5: $150 copay per day ▪ Days 6 and beyond: $0 copay per day	Per admission: ▪ Days 1-5: $150 copay per day ▪ Days 6 and beyond: $0 copay per day

Annual Notice of Changes for 2021
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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	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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.2 – 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.bluecrossma.com*/findadoctor. You may also call Member 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 and managing your care.

Section 1.3 – 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 *www.bluecrossma.com/medicare-options*. You may also call Member 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 1.4 – 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*.

	2020 (this year)	**2021 (next year)**
Ambulance	You pay a $100 copayment for each one-way trip for Medicare-covered ambulance services.	You pay a $75 copayment for each one-way trip for Medicare-covered ambulance services.
Chiropractic services	You pay a $20 copayment for each visit for Medicare-covered services.	You pay a $15 copayment for each visit for Medicare-covered services.
Dental services – preventive routine services	You pay a $35 copayment for each office visit for covered preventive routine dental services.	There is no coinsurance or copayment for covered preventive dental services. Covered preventive routine services limited to two visits every calendar year.

	2020 (this year)	2021 (next year)
	Covered preventive routine services–limited to one visit every 6 months.	
Hearing Services – routine exams and hearing aids	You pay a $15 copayment for each visit to your PCP or a $35 copayment for each office visit to a specialist for covered routine hearing exams. For hearing aids, you pay any balance in excess of the $400 every 36 months limit.	There is no coinsurance or copayment for covered routine hearing exams by a TruHearing provider. For hearing aids, you pay a $699 copayment per aid for Advanced Aids or a $999 copayment per aid for Premium Aids. Up to two TruHearing-branded hearing aids every 12 months (one per ear). Benefit is limited to TruHearing's Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit.
Immunizations	There is no coinsurance or copayment for the pneumonia, influenza, and Hepatitis B vaccines.	There is no coinsurance or copayment for the pneumonia, influenza, and Hepatitis B vaccines. There is no coinsurance or copayment for a COVID-19 vaccine (when developed and approved for distribution).
Meals Program - Post Hospitalization After a discharge from an inpatient stay at a hospital, you may be eligible to have up to eight weeks (five days per week, two meals per	Not covered.	There is no coinsurance or copayment for Meals Post-Hospitalization.

	2020 (this year)	2021 (next year)
day for 40 days per calendar year) of fully-prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, the Blue Cross Blue Shield (BCBS) care management team will coordinate your meal benefit with your health care provider to determine if it meets the criteria to receive medically tailored meals. (Meals must be ordered by a licensed health care provider or a BCBS care manager). If the criteria is met, meals are prepared and delivered to your home by a plan approved vendor at no cost.		
Opioid Treatment Program	There is no coinsurance or copayment for dispensing and administering of covered Opioid Treatment Program (OTP) medication. You pay a $35 copayment for each visit for Medicare-covered OTP outpatient mental health services.	There is no coinsurance or copayment for each visit for Medicare-covered OTP outpatient mental health services.
Outpatient Mental Health	You pay a $35 copayment each office visit for Medicare-covered outpatient mental health services.	You pay a $35 copayment each office visit or telehealth visit for Medicare-covered outpatient mental health services. You pay nothing for Medicare covered outpatient mental health services performed in the

	2020 (this year)	2021 (next year)
		home by a network provider.
Outpatient diagnostic tests and therapeutic services and supplies	For x-rays you pay a $10 copayment per service date. There is no coinsurance or copayment for radiation therapy and blood	For x-rays you pay a $5 copayment per service date. There is no coinsurance or copayment for covered labs and tests performed in the home by a network physician or nurse practitioner or at a mobile unit. There is no coinsurance or copayment for radiation therapy and blood Prior authorization may be required for certain radiation therapy services.
Physician/Practitioner services, including doctor's office visits	You pay a $15 copayment for each office visit to your PCP or a $35 copayment for each office visit to a specialist.	You pay a $15 copayment for each office visit or telehealth visit to your PCP or a $35 copayment for each office visit or telehealth visit to a specialist. Member cost sharing does not differ from in-person visits for covered telehealth services. You pay nothing for Medicare covered physician specialist services performed in the home.
Services to treat kidney disease	There is no coinsurance or copayment for Medicare-covered outpatient dialysis services to treat kidney disease and conditions.	You pay 20% of the cost for Medicare-covered outpatient dialysis services to treat

	2020 (this year)	2021 (next year)
		kidney disease and conditions.
Urgently needed services	You pay a $15 copayment for each office visit to your PCP, or a $35 copayment for each office visit to other providers, for urgently needed services.	You pay a $15 copayment for each office visit or telehealth visit to your PCP, or a $35 copayment for each office visit or telehealth visit to other providers, for urgently needed services. You pay nothing for covered urgently needed services performed in the home by a network provider.
Vision- Routine exams and Eyewear	For a covered routine eye exam at a network provider, you pay a $35 copayment. For covered eyewear, you pay any balance in excess of the $150 every 24 months limit.	You pay nothing for a covered routine eye exam with EyeMed vision providers. For covered eyewear, you pay any balance in excess of the $200 every 24 months limit. You must see an EyeMed provider to use this benefit.

Section 1.5 – 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 Member Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services 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.

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You and your provider can ask the plan to make an exception for you and cover the drug. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List.

If we approve your formulary exception request your coverage will continue for the duration of the approval and as long as your provider continues to prescribe it for you**.**

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 the changes we may make to the Drug List, see 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 does 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 get "Extra Help" and didn't receive this insert with this packet, please call Member Service and ask for the "LIS Rider."

Your plan has two "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. The information below describes – the Initial Coverage Stage and the Catastrophic Coverage Stage. (Most members do not reach the Catastrophic Coverage Stage. To get additional information about your costs in these stages, refer to the attached *Evidence of Coverage*.)

Drug Payment Stages

	2021 (next year)
Stage 1: Initial Coverage Stage	You begin in this payment stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost** (refer to your *Evidence of Coverage*)**.** Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).
Stage 2: Catastrophic Coverage Stage	During this stage, you pay $3.70 copay for a generic drug or a drug that is treated like a generic; or $9.20 copay for all other drugs.

SECTION 2 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 *Massachusetts*, the SHIP is called SHINE (Serving the Health Information Needs of Everyone).

SHINE 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. SHINE counselors can help you with your Medicare questions or problems. You can call SHINE at 1-800-243-4636.

SECTION 3 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 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Massachusetts has a program called Prescription Advantage that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **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 Massachusetts HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Massachusetts HIV Drug Assistance Program HDAP at 1-800-228-2714. Or write to Community Research Initiative of New England/HDAP, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129.

SECTION 4 Questions?

Section 4.1 – Getting Help from Medicare HMO Blue

Questions? We're here to help. Please call Member Service at 1-800-200-4255. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. 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 Medicare HMO Blue. 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 included in this envelope.

Visit our Website

You can also visit our website at *www.bluecrossma.com/medicare-options.* 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 4.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2021*

You can read *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.