Annual Notice of Changes for 2022

BlueCross Total℠ Upstate (PPO)

Jan. 1, 2022 – Dec. 31, 2022

855-204-2744 | TTY 711

Seven Days a Week, 8 a.m. to 8 p.m.
(October 1 to March 31)

Monday-Friday, 8 a.m. to 8 p.m.
(All other times)

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South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

12337M-2022

BlueCross Total℠ Upstate (PPO) offered by BlueCross BlueShield of South Carolina

Annual Notice of Changes for 2022

You are currently enrolled as a member of BlueCross Total Upstate. 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 www.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 BlueCross Total Upstate.
- 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 BlueCross Total Upstate.
- 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 1-855-204-2744 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays, and holidays. From October 1 through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week.

- Customer Service has free language interpreter services available for non-English speakers. This information is available in alternate formats, including large print. Please call Customer Service if you need plan information in other 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 BlueCross Total Upstate

- BlueCross Total Upstate is a Medicare Advantage Preferred Provider Organization plan with a Medicare contract. Enrollment in BlueCross Total Upstate depends on contract renewal.
- When this booklet says "we," "us," or "our," it means BlueCross BlueShield of South Carolina. When it says "plan" or "our plan," it means BlueCross Total Upstate.

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for BlueCross Total Upstate 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.SCBluesMedAdvantage.com/marx22. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$19	$19
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $6,900 From network and out-of-network providers combined: $10,000	From network providers: $6,500 From network and out-of-network providers combined: $10,000
Doctor office visits	Primary care visits from in-network providers: $10 per visit Primary care visits from out-of-network providers: $30 per visit Specialist visits from in-network providers: $45 per visit Specialist visits from out-of-network providers: $55 per visit	Primary care visits from in-network providers: $5 per visit Primary care visits from out-of-network providers: $30 per visit Specialist visits from in-network providers: $45 per visit Specialist visits from out-of-network providers: $55 per visit

Cost	2021 (this year)	2022 (next year)
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.	In-network: You pay $450 per day for days 1 through 4. You pay $0 per day for days 5 through 90. Out-of-network: You pay 30% coinsurance.	In-network: You pay $420 per day for days 1 through 4. You pay $0 per day for days 5 through 90. Out-of-network: You pay 30% coinsurance.

Part D prescription drug coverage (See Section 1.6 for details.) To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the letters "SI" next to the drug. If you have questions about the Drug List, you can also call Customer Service (Phone numbers for Customer Services are printed on the back cover of this booklet).	Deductible: You pay a $100 deductible on Tiers 3, 4 and 5. Tier 1 and 2 drugs are excluded from the deductible during the Initial Coverage Stage: Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $37 • Drug Tier 4: 45% • Drug Tier 5: 31% Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**90-day** supply): • Drug Tier 1: $0 • Drug Tier 2: $45 • Drug Tier 3: $111 • Drug Tier 4: 45% • Drug Tier 5: 31%	Deductible: You pay a $50 deductible on Tiers 3, 4 and 5. Tier 1 and 2 drugs are excluded from the deductible during the Initial Coverage Stage: Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $5 • Drug Tier 2: $20 • Drug Tier 3: $44 • Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 32% Copayment/Coinsurance Standard Retail during the Initial Coverage Stage (**90-day** supply): • Drug Tier 1: $15 • Drug Tier 2: $60 • Drug Tier 3: $132 • Select Insulins: $105 • Drug Tier 4: $300 • Drug Tier 5: 32% Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (**30-day** supply): • Drug Tier 1: $0 • Drug Tier 2: $15 • Drug Tier 3: $37 • Select Insulins: $35 • Drug Tier 4: $100 • Drug Tier 5: 32%

Cost	2021 (this year)	2022 (next year)
		Copayment/Coinsurance Preferred Retail during the Initial Coverage Stage (**90-day** supply): • Drug Tier 1: $0 • Drug Tier 2: $45 • Drug Tier 3: $111 • Select Insulins: $105 • Drug Tier 4: $300 • Drug Tier 5: 32%

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$19	$19

- 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 7 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.

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount 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.	$6,900	$6,500 Once you have paid $6,500 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.

Cost	2021 (this year)	2022 (next 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.	$10,000	$10,000 Once you have paid $10,000 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 www.SCBluesMedAdvantage.com/marx22. 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. 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.SCBluesMedAdvantage.com/marx22. 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

Cost	2021 (this year)	2022 (next year)
Skilled nursing facility	**In-network:** Less than 3 day inpatient hospital stay prior to SNF admission not allowed.	**In-network**: Less than 3 day inpatient hospital stay prior to SNF admission is allowed.
Inpatient hospital stays	**In-network:** You pay a $450 copay per day for days 1 through 4. You pay a $0 copay per day for days 5 - 90.	**In-network:** You pay a $420 copay per day for days 1 through 4. You pay a $0 copay per day for days 5 - 90.

Cost	2021 (this year)	2022 (next year)
Primary care physician services	**In-network:** You pay a $10 copay per visit.	**In-network:** You pay a $5 copay per visit.
Ambulatory Surgical Center (ASC) services	**Out-of-network:** You pay 30% coinsurance.	**Out-of-network:** You pay 40% coinsurance.
Ambulance services - air	You pay 20% coinsurance for air ambulance.	You pay a $295 copay for air ambulance.
Comprehensive dental (non-Medicare-covered)	**In-network:** You pay 0% coinsurance, except for crowns you pay 50% coinsurance. **Out-of-network:** You pay 50% coinsurance.	**In-network:** You pay 50% coinsurance. **Out-of-network:** You pay 50% coinsurance. Restorative services, Endodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (i.e., Dentures, Root Canals) Limit - $1,000 (**In-network services receive the BCBS discount**)
Comprehensive dental (Medicare-covered)	**Out-of-network:** You pay 30% coinsurance	**Out-of-network**: You pay 40% coinsurance.
Hearing aids	Hearing aid purchase includes: 3 provider visits within the first year, a 45-day trial period and 48 batteries per aid.	Hearing aid purchase includes: First year of follow-up visits, 60-day trial period and 80 batteries per aid for the non-rechargeable models.
Hearing exams (Medicare-covered)	**Out-network**: You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Over-the-Counter (OTC) items	Benefit is a $25 per quarter for a total of a $100 per year.	Benefit is a $40 per quarter for a total of a $160 per year.

Cost	2021 (this year)	2022 (next year)
Mental health specialty services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Podiatry services	**In-network:** You pay a $50 copay **Out-of-network:** You pay 30% coinsurance	**In-network:** You pay a $55 copay **Out-of-network:** You pay 40% coinsurance
Other health care professional services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Psychiatric services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Outpatient hospital services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Outpatient substance abuse	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Cardiac rehabilitation services	**Out-of-network**: You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Intensive cardiac rehabilitation services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Pulmonary rehabilitation services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
SET for PAD services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Partial hospitalization	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance

Cost	2021 (this year)	2022 (next year)
Home health services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Opioid treatment program services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Diagnostic procedures/tests	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Lab services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Diagnostic radiological services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Therapeutic radiological services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Outpatient X-Ray services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Observation services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Outpatient blood services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Durable medical equipment (DME)	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Prosthetics/medical supplies	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Diabetic supplies and services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance

Cost	2021 (this year)	2022 (next year)
Dialysis services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Kidney disease education services	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Medicare Part B Rx drugs	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Annual physical exam	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance
Fitness Benefit	**Out-of-network:** You pay 30% coinsurance	**Out-of-network:** You pay 40% coinsurance

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.

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" and 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 www.SCBluesMedAdvantage.com/marx22. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, 4 and 5 drugs until you have reached the yearly deductible. There is no deductible for BlueCross Total Upstate Select Insulins. You pay $35 for a 30-day supply for Select Insulins.	The deductible is $100. During this stage, you pay $5 cost-sharing for drugs on Tier 1 and $15 on Tier 2 and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.	The deductible is $50. During this stage, you pay $5 standard cost-sharing for drugs on Tier 1 and $0 preferred cost-sharing for drugs on Tier 1. You pay the $20 standard cost-sharing for drugs on Tier 2 and $15 preferred cost-sharing for drugs on Tier 2 and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. You pay $35 for a 30-day supply of Select Insulins. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 (preferred generic):** You pay $5 per prescription. **Tier 2 (generic):** You pay $15 per prescription. **Tier 3 (preferred brand):** You pay $37 per prescription. **Tier 4 (non-preferred drug):** You pay 45% of the total cost. **Tier 5 (specialty):** You pay 31% of the total cost. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply at a network pharmacy: **Tier 1 (preferred generic):** *Standard cost-sharing:* You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 (generic):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (preferred brand):** *Standard cost-sharing:* You pay $44 per prescription. *Preferred cost-sharing:* You pay $37 per prescription. **Tier 4 (non-preferred drug):** *Standard cost-sharing:* You pay $100 of the total cost. *Preferred cost-sharing:* You pay $100 of the total cost. **Tier 5 (specialty):** *Standard cost-sharing:* You pay 32% of the total cost. *Preferred cost-sharing:* You pay 32% of the total cost. _____ Once your total drug costs have reached $4,430, 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. BlueCross Total Upstate offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a 30-day supply. 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 BlueCross Total Upstate

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 BlueCross Total Upstate.

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 2.1 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 www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, BlueCross Blue Shield of South Carolina 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 BlueCross Total Upstate.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueCross Total Upstate.

- 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 South Carolina, the SHIP is called Insurance Counseling Assistance and Referrals for Elders (I-CARE).

I-CARE 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. I-CARE 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 I-CARE at (803) 734-9900 or 1-800-868-9095. You can learn more about I-CARE by visiting their website (www.aging.sc.gov).

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 South Carolina AIDS Drug Assistance Program (administered by the South Carolina Department of Health and Environmental Control). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-856-9954.

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueCross Total Upstate

Questions? We're here to help. Please call Customer Service at 1-855-204-2744. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 p.m. and on Saturdays, Sundays and holidays. From October 1 through March 31, we are available 8 a.m. to 8 p.m., Eastern Time, seven days a week. 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 BlueCross Total Upstate. 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.SCBluesMedAdvantage.com/marx22. 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.SCBluesMedAdvantage.com/marx22. 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 (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 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 (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.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

South Carolina

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is an independent licensee of the
Blue Cross and Blue Shield Association