BlueCare Plus Tennessee

BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association

BlueCare Plus Choice (HMO D-SNP)*SM* offered by Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee)

Annual Notice of Changes for 2023

You are currently enrolled as a member of BlueCare Plus Choice. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at bluecareplus.bcbst.com. You may also call Member Service to ask us to mail you an *Evidence of Coverage*.

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

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2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in BlueCare Plus Choice.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with BlueCare Plus Choice.
- Look in Section 2.2, page 14 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Service number at 1-800-332-5762 for additional information. (TTY users should call 711.) Hours are from **October 1 to March 31**, you may call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to September 30**, you may call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside these hours and during holidays.
- This material is also available in 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 *BlueCare Plus Choice*

- BlueCare Plus Tennessee is an HMO Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal.

- When this document says “we,” “us,” or “our,” it means BlueCare Plus Tennessee. When it says “plan” or “our plan,” it means BlueCare Plus Choice.

Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for BlueCare Plus Choice in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost sharing assistance under TennCare (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$27.20** (Note: Because you receive "Extra Help", your premium is **$0**.)	**$32.80** (Note: Because you receive "Extra Help", your premium is **$0**.)
Doctor office visits	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit	Primary care visits: **$0** copay per visit Specialist visits: **$0** copay per visit
Inpatient hospital stays	**$0** copay per stay	**$0** copay per stay
Part D prescription drug coverage (Tier 1) (See Section 1.5 for details.)	Deductible: **$0** Copayment during the Initial Coverage Stage: • Generic: **$0 to $3.95** copay • Brand: **$0 to $9.85** copay	Deductible: **$0** Copayment during the Initial Coverage Stage: • Generic: **$0 to $4.30** copay • Brand: **$0 to $10.35** copay
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See section 1.2 for details.)	**$7,550** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$8,300** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by TennCare (Medicaid).)	**$27.20** (Note: Because you receive "Extra Help", your premium is **$0**.)	**$32.80** (Note: Because you receive "Extra Help", your premium is **$0**.)

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. 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.	**$7,550**	**$8,300** Once you have paid **$8,300** 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 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at bluecareplus.bcbst.com. You may also call Member Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023(next year)
Chiropractic Services - Routine Visits	**Not Covered**	**$0** copay **20** routine chiropractic visits per year
Dental Services	**Preventive** & **Comprehensive** Dental Services: **$5,000** Allowance / yearly	**Not Covered**
Flex Card	**Not Covered**	**$3,000** combined flex card yearly allowance See the Benefits Chart in

Cost	2022 (this year)	2023(next year)
		Chapter 4 of the plan's Evidence of Coverage for more details. This combined allowance is loaded on an easy-to-use flex card. The card comes prepaid by the plan. And you can use it to pay for vision and hearing services covered by the plan.
Hearing Services	**$2,500** Allowance yearly	**$3,000** combined yearly allowance may be used to pay for a routine hearing exam and hearing aids Benefit is limited to one per ear, per year (maximum two hearing aids per year) and is limited to hearing aids available in the applicable TruHearing catalog. You must see a TruHearing provider to use this benefit. This combined allowance is added to your flex card.
Housing Utilities	**Not Covered**	**$100** monthly allowance for housing utilities (including water, gas, electric and cable/internet) Your housing and utilities allowance is added to a reloadable card you can use to pay your bills.

Cost	2022 (this year)	2023(next year)
		Any unused amount does not roll over. This is part of a special supplemental benefit and is available only to members who meet eligibility requirements.
Meals	**14** Meals Delivered following discharge from an acute inpatient hospital or skilled nursing facility stay to a home setting. This is coordinated during the discharge planning process, or you can call Member Service. There is not a limit to the number of discharges for meals. Must use designated vendor.	**56** Meals Delivered following discharge from an acute inpatient hospital or skilled nursing facility stay to a home setting. This is coordinated during the discharge planning process, or you can call Member Service. There is not a limit to the number of discharges for meals. Must use designated vendor.
Over-the-counter (OTC) / Healthy Food We provide a debit card that gives you a fixed dollar amount each month to buy certain OTC products and health food at participating retail locations. You can also get these items by mail, phone, or web. **Over-the-counter (OTC):** This benefit helps you get products you need to stay well – things like bandages, pain	**$150** monthly benefit allowance This allowance doesn't roll over. Any remaining balance will expire at the end of each month.	**$280** monthly benefit allowance This allowance doesn’t roll over. Any remaining balance will expire at the end of each month.

Cost	2022 (this year)	2023(next year)
relievers, cold remedies, toothpaste and much more. You can pick generic or brand-name items. **Healthy Food:** This benefit also covers healthy food, like fruits and vegetables, for members. This is part of a special supplemental benefit and is available only to members who meet eligibility requirements. See the Benefits Chart in Chapter 4 of the Evidence of Coverage (EOC) for more details.		
Podiatry Services - Routine Foot Care	**Not Covered**	**$0** copay **6** routine podiatry visits per year
Transportation Services	**100** one-way trips per year Travel is limited to 50 miles from pick-up location.	**60** one-way trips to Plan-approved locations per year Travel is limited to 50 miles from pick-up location.
Vision Care	**Routine eye exam** and **Glasses/Contacts:** **$400** Allowance / year	**Routine eye exam** and **Glasses/Contacts:** **$3,000** combined yearly allowance may be used to pay for these covered supplemental vision services: • routine vision exams

Cost	2022 (this year)	2023(next year)
		• glasses (lens and/or frames) • contact lenses This combined allowance is added to your flex card.

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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Service for more information.

Changes to Prescription Drug Costs

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: 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 that provides standard cost sharing. 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*.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic Drugs:** You pay **$0 to $3.95** per prescription **Brand Drugs:** You pay **$0 to $9.85** per prescription _____ Once you have paid **$7,050** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Generic Drugs:** You pay **$0 to $4.30** per prescription **Brand Drugs:** You pay **$0 to $10.35** per prescription _____ Once you have paid **$7,400** out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in BlueCare Plus Choice

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 BlueCare Plus Choice.

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 plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *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.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from BlueCare Plus Choice.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueCare Plus Choice.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Service if you need more information on how to do so.
  - – *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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with TennCare (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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and TennCare (Medicaid)

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Tennessee, the SHIP is called the Tennessee State Health Insurance Assistance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Tennessee State Health Insurance Assistance 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 Tennessee State Health Insurance Assistance Program at 1-877-801-0044 (Toll-Free). You can learn more about Tennessee State Health Insurance Assistance Program by visiting their website (www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html).

For questions about your TennCare (Medicaid) benefits, contact TennCare (Medicaid) at 1-800-342-3145, Monday through Friday, 8 a.m. to 5 p.m. in all time zones. Offices are closed on state holidays. TTY users should call 1-877-779-3103. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have TennCare (Medicaid), you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State TennCare (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 Ryan White Program (Tennessee's AIDS Drug Assistance program). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Ryan White Program (Tennessee's AIDS Drug Assistance program) at 1-615-741-7500.

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueCare Plus Choice

Questions? We're here to help. Please call Member Service at **1-800-332-5762**. (TTY only, call **711**.) We are available for phone calls from **Oct. 1 to March 31,** seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30,** you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside these hours and during holidays. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for BlueCare Plus Choice. 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 bluecareplus.bcbst.com. You may also call Member Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at bluecareplus.bcbst.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Section 6.3 – Getting Help from TennCare (Medicaid)

To get information from TennCare (Medicaid), you can call TennCare (Medicaid) at 1-855-259-0701. TTY users should call 1-877-779-3103.