HIGHMARK® WESTERN NEW YORK

An Independent Licensee of the Blue Cross Blue Shield Association

Senior Blue 601 (HMO) ***offered by Highmark Blue Cross Blue Shield of Western New York***

Annual Notice of Changes for 2022

You are currently enrolled as a member of *Senior Blue 601 (HMO)*. 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 2.2 and 2.4 for information about benefit and cost changes for our plan.

☐ 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 2.3 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 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, 2021, you will be enrolled in *Senior Blue 601 (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, 2021.**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in *Senior Blue 601 (HMO).*
- 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 Member Services number at 1-800-329-2792 for additional information. (TTY users should call 711.) Hours are October 1st to March 31st from 8 a.m. to 8 p.m. seven days a week. We are available for phone calls April 1st to September 30th from 8 a.m. to 8 p.m. Monday through Friday.
- This information is also available in braille, large print, or other 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 *Senior Blue 601 (HMO)*

- Highmark Blue Cross Blue Shield of Western New York is an HMO plan with a Medicare contract and enrollment depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Highmark Blue Cross Blue Shield of Western New York. When it says "plan" or "our plan," it means *Senior Blue 601 (HMO).*

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Senior Blue 601 (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.bcbswny.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Cost	2021 (this year)	2022 (next year)
Monthly plan premium (See Section 2.1 for details.)	$0	$0
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 2.2 for details.)	$6,700	$6,700
Doctor office visits	**Primary care visits:** $5 copay per visit **Specialist visits:** $45 copay per visit	**Primary care visits:** $5 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**.**	$290 copay per day for days 1-7, $0 copay per day for days 8-90 There is an out-of-pocket maximum of $2,030 per year.	$290 copay per day for days 1-7, $0 copay per day for days 8-90 There is an out-of-pocket maximum of $2,030 per year.

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2022, our plan name will change from BlueCross BlueShield of Western New York Senior Blue 601 (HMO) to Highmark Blue Cross Blue Shield of Western New York Senior Blue 601 (HMO).

You will be receiving a new ID card containing the Highmark logo.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – 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.)	$0	$0
Optional Supplemental Dental Benefit Premium (This premium is paid in addition to your monthly premium in our plan and your Medicare Part B premium.)	If you were enrolled in the optional supplemental dental **Basic** benefit in 2021, your premium was $11. If you were enrolled in the optional supplemental dental **Enhanced** benefit in 2021, your premium was $25. If you did not elect to enroll in this optional benefit, this additional premium does not apply to you.	If you are enrolled in the optional supplemental dental **Basic** benefit in 2022, your premium is $12. If you are enrolled in the optional supplemental dental **Enhanced** benefit in 2022, your premium is $25. If you do not elect to enroll in this optional benefit, this additional premium will not apply to you.

Section 2.2 – 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 Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 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 2.3 – 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.bcbswny.com/medicare. You may also call Member Services 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 2.4 – 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 *2022 Evidence of Coverage.*

Cost	2021 (this year)	2022 (next year)
In-Network Skilled Nursing Facility (SNF)	You pay a $0 copay per day for days 1-20 and a $184 copay per day for days 21-100.	You pay a $0 copay per day for days 1-20 and a $188 copay per day for days 21-100.
In-Network Chiropractic Services	Routine care is not covered.	You pay a $20 copay for each routine visit, up to 6 visits per year.
Mental Health Specialty Services	Prior authorization is required after the first 20 visits.	Prior authorization is not required.
Psychiatric Services	Prior authorization is required after the first 20 visits.	Prior authorization is not required.
Opioid Treatment Program Services	Prior authorization is required.	Prior authorization is not required.
Outpatient Substance Abuse Services	Prior authorization is required after the first 20 visits.	Prior authorization is not required.
Acupuncture (Supplemental Benefit)	Not covered	You have a $250.00 combined annual allowance for acupuncture and massage therapy.
Over-The-Counter Mail-Order Benefit (Supplemental Benefit)	The maximum plan benefit coverage does not carry forward to the next period if it is unused.	The maximum plan benefit coverage does carry forward to the next period if it is unused.
Meal Benefit (Supplemental Benefit)	Your post discharge meal benefit provides access to one meal per day for 7-days following an Inpatient Hospital or Skilled Nursing Facility stay. $0 copay for coordinated meal requests.	Your post discharge meal benefit provides access to one meal per day for 7-days following an Inpatient Hospital, Mental Health Hospital, or Skilled Nursing Facility stay. $0 copay for coordinated meal requests.

Cost	2021 (this year)	2022 (next year)
COVID-19 (Supplemental Benefit)	You pay a $290 copay per day for days 1-7. There is an annual out-of-pocket maximum of $2,030.	If you are admitted for an Inpatient Acute Hospital Care Stay due to COVID-19, the cost-share for this service will be waived. Inpatient rehabilitation is not included.
Massage Therapy (Supplemental Benefit)	Not Covered	You have a $250.00 combined annual allowance for acupuncture and massage therapy.
Routine Hearing Exams; Fitting/Evaluation for Hearing Aid (Supplemental Benefit)	Not Covered	Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid.
Hearing Aids (Supplemental Benefit)	Hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models	Hearing aid purchase includes: - First year of follow-up provider visits - 60-day trial period - 3-year extended warranty - 80 batteries per aid for non-rechargeable models

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *Senior Blue 601 (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 Senior Blue 601 (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 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, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (SHIP) (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.**
As a reminder, Highmark Blue Cross Blue Shield of Western New York offers other Medicare health plans AND/OR 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 *Senior Blue 601 (HMO).*
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from *Senior Blue 601 (HMO).*
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services 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, 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 8, 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 8, 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 New York State, the SHIP is called Health Insurance Information, Counseling and Assistance Program or HIICAP.

HIICAP 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. HIICAP 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 HIICAP at 1-800-701-0501. You can learn more about HIICAP by visiting their website (https://aging.ny.gov/health-insurance-information-counseling-and-assistance).

SECTION 6 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); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York State has a program called Elderly Pharmaceutical Insurance Corporation or EPIC 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 (the name and phone numbers for this organization are in Section 4 of this booklet).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New York State Department of Health. Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. The NYS Department of Health's AIDS Institute/ADAP can be reached by calling 1-800-542-2437 or 1-844-682-4058 (TDD 518-459-0121).

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437 or 1-844-682-4058, Monday through Friday 9 a.m. – 5 p.m.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Senior Blue 601 (HMO)*

Questions? We're here to help. Please call Member Services at 1-800-329-2792. (TTY only, call 711.) We are available for phone calls October 1st to March 31st from 8 a.m. to 8 p.m. seven days a week. We are available for phone calls April 1st to September 30th from 8 a.m. to 8 p.m. Monday through Friday. 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 *Senior Blue 601 (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. A copy of the *Evidence of Coverage* is located on our website at www.bcbswny.com/medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Visit Our Website

You can also visit our website at www.bcbswny.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

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 2022*

You can read *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.

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

.פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

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