Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Medicare Plus Blue PPO – Essential 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.bcbsm.com/medicare**. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. 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.)		
Region 1 Allegan, Barry, Ionia, Kalamazoo, Mason, Muskegon, Newaygo, Oceana and Ottawa counties	$0	$0
Region 2 Berrien, Branch, Calhoun, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Monroe, Montcalm, St. Joseph and Van Buren counties	$0	$0
Region 3 Alcona, Alger, Alpena, Arenac, Baraga, Bay, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Gladwin, Huron, Iosco, Kalkaska, Keweenaw, Luce, Mackinac, Montmorency, Ogemaw, Ontonagon, Oscoda, Presque Isle, Roscommon, Saginaw, Sanilac, Schoolcraft, Shiawassee and Tuscola counties	$10	$10
Region 4 Antrim, Benzie, Cass, Clinton, Delta, Dickinson, Emmet, Genesee, Gogebic, Grand Traverse, Houghton, Iron, Isabella, Kent, Lake, Lapeer, Leelanau, Lenawee, Livingston, Manistee, Marquette, Mecosta, Menominee, Midland, Missaukee, Osceola, Otsego, St.	$0	$0

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* (continued) Clair and Wexford counties **Region 6** Macomb, Oakland, Washtenaw and Wayne counties **Region 5** is not being used at this time	$0	$0
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 in-network providers: $6,000 From in-network and out-of-network providers combined: $6,000	From in-network providers: $6,000 From in-network and out-of-network providers combined: $6,000
Doctor office visits	Primary care visits: In-network: You pay a $0 copay per visit. Specialist visits: In-network: You pay a $45 copay per visit.	Primary care visits: In-network: You pay a $0 copay per visit. Specialist visits: In-network: You pay a $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.	In-network: For Medicare-covered hospital stays you pay: Days 1-6: $325 copay per day Days 7-90: $0 copay per day You pay $0 copay per day beyond 90 days.	In-network: For Medicare-covered hospital stays you pay: Days 1-6: $325 copay per day Days 7-90: $0 copay per day You pay $0 copay per day beyond 90 days.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $100 Copays/Coinsurance for a one-month supply during the Initial Coverage Stage: **Standard** retail pharmacy, **standard**	Deductible: $0 Copays/Coinsurance for a one-month supply during the Initial Coverage Stage: **Standard** retail pharmacy, **standard**

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (continued)	mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: Drug Tier 1: $8 Drug Tier 2: $20 Drug Tier 3: $47 Drug Tier 4: 50% coinsurance Drug Tier 5: 31% coinsurance Drug Tier 6: $5	mail-order pharmacy, network long-term care pharmacies, out-of-network pharmacy: Drug Tier 1: $5 Drug Tier 2: $20 Drug Tier 3: $47 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance Drug Tier 6: Not offered
	Preferred retail and **preferred** mail-order pharmacy: Drug Tier 1: $2 Drug Tier 2: $11 Drug Tier 3: $42 Drug Tier 4: 50% coinsurance Drug Tier 5: 31% coinsurance Drug Tier 6: $0	**Preferred** retail and **preferred** mail-order pharmacy: Drug Tier 1: $0 Drug Tier 2: $11 Drug Tier 3: $42 Drug Tier 4: 50% coinsurance Drug Tier 5: 33% coinsurance Drug Tier 6: Not offered

Cost	2021 (this year)	2022 (next year)
Monthly plan premium (continued) Wayne counties **Region 5** is not being used at this time		
Optional supplemental dental and vision package monthly premium	$21.40	$22.40

- 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 5 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 and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,000	$6,000 Once you have paid $6,000 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 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 and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$6,000	$6,000 Once you have paid $6,000 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/Pharmacy Directory* is located on our website at **www.bcbsm.com/providersmedicare**. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the *2022 Provider/Pharmacy 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 *Provider/Pharmacy Directory* is located on our website at **www.bcbsm.com/medicare**. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *Provider/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)
Ambulance services	May require prior authorization.	Prior authorization not required.

Cost	2021 (this year)	2022 (next year)
Cardiac rehabilitation services	**In-network:** You pay a $0 copay for cardiac rehabilitation services. You pay a $45 copay for intensive cardiac rehabilitation services. May require prior authorization.	**In-network:** You pay a $0 copay for cardiac rehabilitation services. You pay a $0 copay for intensive cardiac rehabilitation services. Prior authorization not required.
Chiropractic services	May require prior authorization.	Prior authorization not required.
Outpatient diagnostic procedures/tests/lab services	**Out-of-network:** You pay 50% of the approved amount for Medicare-covered outpatient diagnostic procedures and tests.	**Out-of-network:** You pay a $0 copay for COVID-19 testing. You pay 50% of the approved amount for Medicare-covered outpatient diagnostic procedures and tests.
Outpatient hospital services	**In-network:** You pay a $250 copay for Medicare-covered outpatient hospital surgical services.	**In-network:** You pay a $275 copay for Medicare-covered outpatient hospital surgical services.
Outpatient substance abuse services	May require prior authorization.	Prior authorization not required.
Pulmonary rehabilitation services	**In-network:** You pay a $30 copay for pulmonary rehabilitation services. May require prior authorization.	**In-network:** You pay a $0 copay for pulmonary rehabilitation services. Prior authorization not required.
Services to treat kidney disease	May require prior authorization.	Prior authorization not required.

Cost	2021 (this year)	2022 (next year)
Skilled Nursing Services (SNF)	**In-network:** For days 1-20: You pay a $0 copay For days 21-100: You pay a $178 copay	**In-network:** For days 1-20: You pay a $0 copay For days 21-100: You pay a $188 copay
Supervised Exercise Therapy (SET)	**In-network:** You pay a $30 copay for Supervised Exercise Therapy (SET) services.	**In-network:** You pay a $0 copay for Supervised Exercise Therapy (SET) services.
Vision care	**In-network:** You pay a $10 copay for routine eye-exam services.	**In-network:** You pay a $0 copay for routine eye-exam services.
Worldwide emergency transportation	**In- and Out-of-network:** You pay 20% of the approved amount for Worldwide Emergency Coverage, Worldwide Urgent Coverage, and Worldwide Emergency Transportation services.	**In- and Out-of-network:** You pay a $90 copay for Worldwide Emergency Coverage services. **In- and Out-of-network:** You pay a $50 copay for Worldwide Urgent Coverage services. **In- and Out-of-network:** You pay a $275 copay for Worldwide Emergency Transportation services.

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.

If you have a current formulary exception approval, please refer to your approval letter to verify the expiration date for your formulary exception. If your formulary exception expires in 2021, you will need to submit a new formulary exception request for review.

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 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. Because you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider."

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at **www.bcbsm.com/medicare**. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. 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	The deductible is $100. During this stage, you pay $8 cost sharing for a 31-day supply at **standard** retail pharmacies, **standard** mail-order pharmacies, network long-term care pharmacies and out-of-network pharmacies for all Tier 1: Preferred Generic drugs, $20 for Tier 2: Generic drugs, and $5 for Tier 6: Select Care Drugs, and the full cost of your Tier 3: Preferred Brand drugs, Tier 4: Non-Preferred Drug and Tier 5: Specialty Tier drugs until you have reached the yearly deductible. During this stage, you pay $2 cost sharing for a 31-day supply at **preferred** retail pharmacies and **preferred** mail-order pharmacies, for all Tier 1: Preferred Generic drugs, $11 for Tier 2: Generic drugs, and	Because we have no deductible, this payment stage does not apply to you.

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage (continued)	$0 for Tier 6: Select Care Drugs and the full cost of your Tier 3: Preferred Brand drugs, Tier 4: Non-Preferred Drug and Tier 5: Specialty Tier drugs 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 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 (31-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.* 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 31-day supply filled at a network pharmacy: **Tier 1 – Preferred Generic:** *Standard cost sharing:* You pay $8 per prescription *Preferred cost sharing:* You pay $2 per prescription **Tier 2 – Generic:** *Standard cost sharing:* You pay $20 per prescription *Preferred cost sharing:* You pay $11 per prescription	Your cost for a 31-day supply filled 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 $11 per prescription

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription **Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost *Preferred cost sharing:* You pay 50% of the total cost **Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 31% of the total cost *Preferred cost sharing:* You pay 31% of the total cost **Tier 6 – Select Care Drugs:** *Standard cost sharing:* You pay $5 per prescription *Preferred cost sharing:* You pay $0 per prescription	**Tier 3 – Preferred Brand:** *Standard cost sharing:* You pay $47 per prescription *Preferred cost sharing:* You pay $42 per prescription **Tier 4 – Non-Preferred Drug:** *Standard cost sharing:* You pay 50% of the total cost *Preferred cost sharing:* You pay 50% of the total cost **Tier 5 – Specialty Tier:** *Standard cost sharing:* You pay 33% of the total cost *Preferred cost sharing:* You pay 33% of the total cost **Tier 6 – Select Care Drugs:** Not offered

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	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**. 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 Medicare Plus Blue PPO – Essential

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 Medicare Plus Blue PPO – Essential.

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 1.1 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).