Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Medicare Blue Choice® Value Plus (HMO-POS) offered by Excellus BlueCross BlueShield

Annual Notice of Changes for 2019

You are currently enrolled as a member of Medicare Blue Choice Value Plus (HMO-POS). 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 and 3 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 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.

OMB Approval 0938-1051(Pending OMB Approval)

- 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 https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors 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 https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 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 want to **keep** Medicare Blue Choice Value Plus (HMO-POS), you don't need to do anything. You will stay in Medicare Blue Choice Value Plus (HMO-POS).
- 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, 2018**
   - If you **don't join by December 7, 2018**, you will stay in Medicare Blue Choice Value Plus (HMO-POS).
   - If you **join by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Customer Care number at 1-877-883-9577 for additional information. (TTY users should call 1-800-421-1220.) Hours are Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.
- This information may be available in a different format, including large print, audio tapes and Braille.
- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Medicare Blue Choice Value Plus (HMO-POS)

- Excellus BlueCross BlueShield contracts with the Federal Government and is an HMO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Excellus BlueCross BlueShield. When it says "plan" or "our plan," it means Medicare Blue Choice Value Plus (HMO-POS).

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Medicare Blue Choice Value Plus in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. (See Section 2.1 for details.)	$152	$152
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:** You pay a $10 copayment in-network per visit. **Specialist visits:** You pay a $45 copayment in-network per visit.	**Primary care visits:** You pay a $10 copayment in-network per visit. You pay 30% coinsurance of the total cost out-of-network per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. **Specialist visits:** You pay a $45 copayment in-network per visit. You pay 30% coinsurance of the total cost out-of-network per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.

Cost	2018 (this year)	2019 (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 a $310 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission.	**In-network:** You pay a $310 copayment per day for days 1 through 5 for covered hospital care. Thereafter, you pay a $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-network:** You pay 30% coinsurance of the total cost. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copayments/Coinsurance during the Initial Coverage Stage: □ Drug Tier 1: You pay a $0 copayment. □ Drug Tier 2: You pay a $15 copayment. □ Drug Tier 3: You pay a $47 copayment. □ Drug Tier 4: You pay a $100 copayment. □ Drug Tier 5: You pay a 33% coinsurance.	Deductible: $0 Copayments/Coinsurance during the Initial Coverage Stage: □ Drug Tier 1: You pay a $0 copayment. □ Drug Tier 2: You pay a $15 copayment. □ Drug Tier 3: You pay a $47 copayment. □ Drug Tier 4: You pay a $100 copayment. □ Drug Tier 5: You pay a 33% coinsurance.

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SECTION 1 We are Changing the Plan's Name

On January 1, 2019, our plan name will change from Medicare Blue Choice Value Plus (HMO) to Medicare Blue Choice Value Plus (HMO-POS).

You will receive a new member card in December. Please use this new member card beginning January 1, 2019 for your Health Plan services. This card replaces your 2018 Medicare Blue Choice Value Plus (HMO) member card.

Beneficiary materials including member newsletters and publications such as your Evidence of Coverage, Drug Formulary, Provider Directories and all other Health Plan materials will contain the new plan name Medicare Blue Choice Value Plus (HMO-POS) as appropriate.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$152	$152

- 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.

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	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for

Cost	2018 (this year)	2019 (next year)
amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Part A and Part B covered services, you will pay nothing for your Part A and Part B covered 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.ExcellusMedicare.com. You may also call Customer Care for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 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, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.ExcellusMedicare.com. You may also call Customer Care at

1-877-883-9577 for updated pharmacy information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – 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 2019 *Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Ambulance	You pay a $150 copayment for each ambulance service.	You pay a $200 copayment for each ambulance service.
Chiropractic Care	You pay a $10 copayment per visit.	You pay a $9 copayment per visit.
Emergency Room	You pay a $80 copayment for each Emergency Room visit.	You pay a $90 copayment for each Emergency Room visit.
Observation Services	You pay a $380 copayment per visit.	You pay a $400 copayment per visit.
Outpatient Hospital and Ambulatory Surgical Center	You pay a $380 copayment per visit.	You pay a $400 copayment per visit.
Point of Service Benefit	Point of Service Benefit is not covered.	The Point of Service (POS) benefit covers medically necessary services you receive from out-of-network providers. The POS plan coverage limit is $3,000 per calendar year. The POS benefit for out-of-network covered services is 30% coinsurance. Not all benefits are covered under the POS benefit. See the Medical Benefits Chart in Chapter 4, Section 2.1 of the Evidence of Coverage for more details.

Cost	2018 (this year)	2019 (next year)
Preventive Dental	There is no dental network for these benefits. We will pay 100% of the allowance or dentist charges, whichever is less, You will be responsible for the balance. When you receive preventive dental services, you are responsible for making payment to your dentist and filing a claim with us to be reimbursed for these costs.	There is a dental network for these benefits. For in-network providers, you will have a $0 copayment for covered services and the provider will submit the claim for you. For out-of-network providers, we will pay 100% of the allowance or dentist charges, whichever is less, You will be responsible for the balance. You are responsible for making payment to your dentist and filing a claim with us to be reimbursed for these costs. See section 1.3 of this booklet on how to locate our provider directory to view a list of our in-network providers.
Skilled Nursing Facility	You pay a $167.50 copayment per day for days 21 through 100.	You pay a $172 copayment per day for days 21 through 100.

Cost	2018 (this year)	2019 (next year)
Supervised Exercise Therapy (SET)	Supervised Exercise Therapy not covered.	You pay a $30 copayment per session in-network. You pay a 30% coinsurance out-of-network. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. The Supervised Exercise Therapy (SET) benefit is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physican responsbile for PAD treatment. You can be covered up to 36 sessions over a 12 week period if the SET program requirements are met. See Chapter 4, Section 2.1 of the Evidence of Coverage for more information.
Telemedicine	You pay a $10 copayment for each MDLive® telemedicine visit.	You pay a $10 copayment for each MDLive® telemedicine visit. You pay a $45 copayment for each Behavior Health related MDLive® visit.

Section 2.6 – 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. You can get the complete Drug List by visiting our website (www.ExcellusMedicare.com) or calling Customer Care at 1-877-883-9577. (TTY only, call 1-800-421-1220.) We are available for phone calls Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31.

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 Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care 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. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31-day supply of medication rather than the amount provided in 2018 (91-day supply of medication). (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.

Approved formulary exceptions are valid one year from the day the plan grants the exception. Please refer to the coverage determination letter you and your physician received when the exception was approved by the plan. When the exception expires, if you still require the drug, your physician will need to request a new exception for the drug on your behalf.

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.

Starting in 2019, before we make changes during the year to our Drug List that requires us to provide you with advanced notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30- day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this

notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see 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 have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are in Section 8.1 of this booklet.

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*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (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

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	2018 (this year)	2019 (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*. 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: **Preferred Generic (Tier 1):** You pay $0 per prescription. **Generic (Tier 2):** You pay $15 per prescription. **Preferred Brand (Tier 3):** You pay $47 per prescription. **Non-Preferred Drug (Tier 4):** You pay $100 per prescription. **Specialty (Tier 5):** You pay 33% of the total cost. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic (Tier 1):** You pay $0 per prescription. **Generic (Tier 2):** You pay $15 per prescription. **Preferred Brand (Tier 3):** You pay $47 per prescription. **Non-Preferred Drug (Tier 4):** You pay $100 per prescription. **Specialty (Tier 5):** You pay 33% of the total cost. Once your total drug costs have reached $3,820, 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 3 Administrative Changes

Cost	2018 (this year)	2019 (next year)
90-day supply of Prescription Drugs	For a 90-day supply, you pay 2.5 times the copayment for a 30-day supply of your prescription.	For a 90-day supply, you pay 2 times the copayment for a 30-day supply of your prescription.
Customer Care Correspondence Address	PO Box 546, Buffalo, NY 14201	PO Box 211316, Eagan, MN 55121
Outpatient Rehabilitation Services	Outpatient Rehabilitation Services such as physical therapy, occupational therapy and speech therapy does not require prior authorization.	Outpatient Rehabilitation Services such as physical therapy, occupational therapy and speech therapy requires prior authorization from your doctor or other network provider.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Medicare Blue Choice Value Plus (HMO-POS)

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 stay enrolled as a member of our plan for 2019.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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, read *Medicare & You* 2019 call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, *Excellus BlueCross BlueShield* offers other Medicare health 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 Medicare Blue Choice Value Plus (HMO-POS).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Medicare Blue Choice Value Plus (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this (phone numbers are in 8.1 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 5 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, 2019.

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, 2019, 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, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 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, the SHIP is called Health Insurance Information Counseling and Assistance Program (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://www.aging.ny.gov/HealthBenefits/Index.cfm).

SECTION 7 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 has a program called Elderly Pharmaceutical Insurance Program (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 5 of this booklet).
- **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 HIV Uninsured Care Programs, Empire Station, P.O. Box 2052, Albany, NY 12220-0052.
  For information on eligibility criteria, covered drugs, or how to enroll in the program, please call In-State - Toll Free 1-800-542-2437; Out of State - 1-518-459-1641;
  TDD - 1-518-459-0121 Monday through Friday, 8:00 am - 5:00 pm.

SECTION 8 Questions?

Section 8.1 – Getting Help from Medicare Blue Choice Value Plus (HMO-POS)

Questions? We're here to help. Please call Customer Care at 1-877-883-9577. (TTY only, call 1-800-421-1220.) We are available for phone calls Monday - Friday, 8:00 a.m. - 8:00 p.m. Representatives are also available 8:00 a.m. - 8:00 p.m., Monday - Sunday, from October 1 - March 31. Calls to these numbers are free.

Read your 2019 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 2019. For details, look in the 2019 *Evidence of Coverage* for Medicare Blue Choice Value Plus (HMO-POS). 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 available on our website at www.ExcellusMedicare.com or by calling Customer Care at 1-877-883-9577.

Visit our Website

You can also visit our website at www.ExcellusMedicare.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 8.2 – 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 (https://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 (https://www.medicare.gov) and click on "Find health & drug plans").

Read Medicare & You 2019

You can read the *Medicare & You* 2019 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 (https://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.

Discrimination is Against the Law

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

Our Health 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 formats)

Provides 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, contact our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-421-1220). Monday - Friday, 8 a.m. - 8 p.m.
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health 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:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone Number: 1-800-614-6575 (TTY: 1-800-421-1220)
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. 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:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-421-1220).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-421-1220).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-883-9577

(TTY：1-800-421-1220）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-883-9577 (телетайп: 1-800-421-1220).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-883-9577 (TTY: 1-800-421-1220).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-883-9577 (TTY: 1-800-421-1220)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-883-9577 (TTY: 1-800-421-1220).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-883-9577 (TTY: 1-800-421-1220).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-877-883-9577 (TTY: ১-800-421-1220)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-883-9577 (TTY: 1-800-421-1220).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-883-9577 (رقم هاتف الصم والبكم: 1-800-421-1220).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-883-9577 (ATS : 1-800-421-1220).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-883-9577 (TTY: 1-800-421-1220).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-883-9577 (TTY: 1-800-421-1220).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-883-9577 (TTY: 1-800-421-1220).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-883-9577 (TTY: 1-800-421-1220).

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