BlueJourney Value (HMO) offered by Keystone Health Plan Central®

Annual Notice of Changes for 2019

You are currently enrolled as a member of BlueJourney Value 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 1.5 and 1.6 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 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit 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 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

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

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your *Medicare & You* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan

- If you want to **keep** BlueJourney Value HMO, you don't need to do anything. You will stay in BlueJourney Value 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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in BlueJourney Value HMO.
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Customer Service number at 1-800-779-6962 for additional information. (TTY users should call 711). Hours are Monday through Friday, 8 a.m. to 8 p.m., with extended hours October 1 through March 31. After these hours, you may leave a message on our secure voice messaging system.
- This information may be available in different formats, including CD. Please call Customer Service at the number printed on the back cover of this booklet if you need plan information in another format.

- **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 BlueJourney Value HMO

- BlueJourney Value HMO is offered by Keystone Health Plan Central®, a Medicare Advantage organization with a Medicare contract. Keystone Health Plan Central is an independent licensee of the BlueCross BlueShield Association. Enrollment in BlueJourney Value HMO depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Keystone Health Plan Central®. When it says "plan" or "our plan," it means BlueJourney Value HMO.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for BlueJourney Value HMO 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 separately mailed *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 1.1 for details.	$48	$50
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.)	$3,400	$3,400
Doctor office visits	Primary care visits: $10 copay per visit Specialist visits: $25 copay per visit	Primary care visits: $10 copay per visit Specialist visits: $25 copay per visit

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.	$100 Copayment per day for days 1 - 5 for Medicare-covered inpatient hospital stays. Our plan covers an unlimited number of days for an inpatient hospital stay. Cost-sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.**	$115 Copayment per day for days 1 - 5 for Medicare-covered inpatient hospital stays. Our plan covers an unlimited number of days for an inpatient hospital stay. Cost-sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization is required.**

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment and Coinsurance during the Initial Coverage Stage: **Drug Tier 1 - Preferred Generic Drugs:** *Standard cost-sharing:* You pay $9 copay per prescription *Preferred cost-sharing:* You pay $4 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $17 copay per prescription *Preferred cost-sharing:* You pay $12 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $42 copay per prescription **Drug Tier 4 – Non Preferred Drugs:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $95 copay per prescription **Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost	Deductible: $0 Copayment and Coinsurance during the Initial Coverage Stage: **Drug Tier 1 - Preferred Generic Drugs:** *Standard cost-sharing:* You pay $9 copay per prescription *Preferred cost-sharing:* You pay $4 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $17 copay per prescription *Preferred cost-sharing:* You pay $12 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $42 copay per prescription **Drug Tier 4 – Non Preferred Drugs:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $95 copay per prescription **Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – 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.)	$48	$50

- 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 1.2 – 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 amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 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 Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.CapitalBlueMedicare.com. You may also call Customer Service 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 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.CapitalBlueCross.com. You may also call Customer Service for updated provider 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 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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Skilled Nursing Facility	You pay $0 copay per day for days 1 through 5 $20 copay per day for days 6 through 20 $167 copay per day for days 21 through 100 A benefit period begins the day you enter a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. **Prior authorization required.**	You pay $0 copay per day for days 1 through 5 $20 copay per day for days 6 through 20 $172 copay per day for days 21 through 100 A benefit period begins the day you enter a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. **Prior authorization required.**
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	Not covered.	You pay a $10 copay per visit
Emergency Room	You pay $100 copay per visit	You pay $120 copay per visit

Cost	2018 (this year)	2019 (next year)
Worldwide Coverage – Emergency Care (outside the U.S)	$100 copay per visit	$120 copay per visit
Worldwide Urgently Needed Care (outside the U.S.)	$35 copay per visit $1,000,000 annual maximum allowance for emergency care services or urgently needed care received worldwide. Annual maximum allowance is combined for both Emergency and Urgently Needed Care received outside the U.S.	$35 copay per visit $20,000 annual maximum allowance for emergency care services or urgently needed care received worldwide. Annual maximum allowance is combined for both Emergency and Urgently Needed Care received outside the U.S.
Outpatient Diagnostic Test and Procedures, Labs, and Therapeutic Radiological services	If a member receives multiple services of Outpatient Diagnostic Test and Procedures, Labs, and Therapeutic Radiological services at the same location on the same day, a copayment per service type will apply. **Prior authorization may be required.**	You pay the highest cost-share for multiple services performed on the same day. **Prior authorization may be required.**
Health Education	Not covered.	$0 copay per session Health Coaches provide personalized expert advice and coaching to support members. Our Health Coaches have backgrounds in a variety of health fields and are trained and certified in health coaching. Three 30-minute sessions are provided.

Cost	2018 (this year)	2019 (next year)
Inpatient mental health care	$100 Copayment per day 1 – 5 for Medicare-covered inpatient mental health hospital care. Our plan covers an unlimited number of days for an inpatient acute hospital stay. Cost sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization required by Magellan Health Services®, Inc. at 1-800-216-9748.**	$115 Copayment per day 1 – 5 for Medicare-covered inpatient mental health hospital care. Our plan covers an unlimited number of days for an inpatient acute hospital stay. Cost sharing is charged for each inpatient stay. If you are admitted to an out-of-network hospital after receiving care and your condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital. **Prior authorization required by Magellan Health Services®, Inc. at 1-800-216-9748.**

Cost	2018 (this year)	2019 (next year)
Dental Services	$25 copay for Medicare-covered dental benefits. $10 copay for **one** routine dental visit per calendar year includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded. 50% Coinsurance applied to plan allowed amounts for the following services: • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics $1,500 maximum plan allowance per calendar year for non-routine dental services. **Prior authorization required for non-routine dental services.** **Pre-Treatment Estimates are recommended before service is performed.**	$25 copay per visit for Medicare-covered dental benefits. $10 copay per visit for **two** routine dental visit per calendar year includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded. 50% Coinsurance applied to plan allowed amounts for the following services: • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics $2,000 maximum plan allowance per calendar year for non-routine dental services. **Prior authorization required for non-routine dental services.** **Pre-Treatment Estimates are recommended before service is performed.**

Cost	2018 (this year)	2019 (next year)
Prostate cancer screening exams	There is no coinsurance, copayment, or deductible for an annual PSA test.	There is no coinsurance, copayment, or deductible for an annual PSA test and digital rectal exam with Prostate cancer screening exam.
"Welcome to Medicare" Preventive Visit	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit and Medicare-Covered EKG following Welcome Visit.

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. 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: 30-day supply of medication rather than the amount provided in 2018 (31-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.

If you are a current member of the plan, and one of your drugs will no longer be covered, you should work with your doctor (or other prescriber) to find an appropriate alternative therapy on our new formulary. If there is no appropriate alternative therapy available, you can request a formulary exception beginning December 1, 2018. For more information, please see Chapter 9 of your *Evidence of Coverage* or call Customer Service.

If you currently have a formulary exception in place, the plan will allow you to continue to receive your drug for the length of time indicated in your formulary exception approval letter. Please be aware that you may be responsible for a different cost share than you were paying last year.

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, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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 sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 6.1 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 separately mailed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage	The deductible is $0. Because we have no deductible, this payment stage does not apply to you.	The deductible is $0. 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; at a network pharmacy that offers preferred cost-sharing; 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: **Drug Tier 1 - Preferred Generic Drugs:** *Standard cost-sharing:* You pay $9 copay per prescription *Preferred cost-sharing:* You pay $4 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $17 copay per prescription *Preferred cost-sharing:* You pay $12 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $42 copay per prescription **Drug Tier 4 – Non Preferred Drugs:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $95 copay per prescription **Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost Once you have paid $3,750 out-of-pocket for Part D drugs, 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: **Drug Tier 1 - Preferred Generic Drugs:** *Standard cost-sharing:* You pay $9 copay per prescription *Preferred cost-sharing:* You pay $4 copay per prescription **Drugs Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay $17 copay per prescription *Preferred cost-sharing:* You pay $12 copay per prescription **Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay $47 copay per prescription *Preferred cost-sharing:* You pay $42 copay per prescription **Drug Tier 4 – Non Preferred Drugs:** *Standard cost-sharing:* You pay $100 copay per prescription *Preferred cost-sharing:* You pay $95 copay per prescription **Drug Tier 5 – Specialty Drugs:** You pay 33% of the cost Once you have paid $3,820 out-of-pocket for Part D drugs, 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 BlueJourney Value 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 stay enrolled as a member of our plan for 2019.

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 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 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to 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, Keystone Health Plan Central® 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 BlueJourney Value HMO.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueJourney Value HMO.

- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 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 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 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 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called APPRISE.

APPRISE 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. APPRISE 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 APPRISE at 1-800-783-7067. You can learn more about APPRISE by visiting their website (www.aging.state.pa.us).

SECTION 5 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.** Pennsylvania has a program called PACE 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).
- **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 Pennsylvania Department of ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Pennsylvania Department of Health at 1-977-PA-HEALTH (1-877-724-3258).

SECTION 6 Questions?

Section 6.1 – Getting Help from BlueJourney Value HMO

Questions? We're here to help. Please call Customer Service at 1-800-779-6962. (TTY only, call 711). We are available for phone calls Monday through Sunday, 8 a.m. to 8 p.m., with extended hours October 1 through March 31. After these hours, you may leave a message on our secure voice messaging system.

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 BlueJourney Value 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 and prescription drugs. A copy of the *Evidence of Coverage* will be separately mailed to you.

Visit our Website

You can also visit our website at www.CapitalBlueMedicare.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

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.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2020.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This information is not a complete description of benefits. Call 1-800-779-6962 (TTY: 711) for more information.

Capital BLUE

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NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital BlueCross 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 our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital BlueCross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our 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
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interpete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

 દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្តាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).