Blue Cross Medicare Advantage Choice Plus (PPO)℠ offered by Health Care Service Corporation

Annual Notice of Changes for 2017

You are currently enrolled as a member of Blue Cross Medicare Advantage Choice Plus (PPO)℠. 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.**

Additional Resources

- This information is available for free in other languages.
- Please contact our Customer Service number at 1-877-774-8592 for additional information. (TTY/TDD users should call 711). Hours are 8:00 a.m. - 8:00 p.m.., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- Customer Service also has free language interpreter services available for non-English speakers.
- Esta información está disponible en otros idiomas de forma gratuita. Por favor comuníquese a nuestro número de Servicio al Cliente llamando al 1-877-774-8592 para obtener información adicional. (Los usuarios de TTY/TDD deberán llamar al 711). El horario es de 8:00 a.m. a 8:00 p.m., hora local, los siete días de la semana. Si llama del 15 de febrero al 30 de septiembre, se utilizarán tecnologías alternativas (por ejemplo, correo de voz) durante los fines de semana y días festivos. El Servicio al Cliente también tiene a la disposición los servicios de intérpretes para aquellas personas que no hablan inglés.
- Please contact Blue Cross Medicare Advantage if you need this information in another language or format (Spanish, Braille, large print or audio tapes).
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About *Blue Cross Medicare Advantage Choice Plus (PPO)℠*

- Blue Cross Medicare Advantage plans are PPO plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Health Care Service Corporation. When it says "plan" or "our plan," it means Blue Cross Medicare Advantage Choice Plus (PPO)℠.

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **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? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Blue Cross Medicare Advantage Choice Plus (PPO)℠:

If you want to stay with us next year, it's easy – you don't need to do anything.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Blue Cross Medicare Advantage Choice Plus (PPO)℠ 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 enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$33.00	$35.00
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 network providers: $3,500 From network and out-of-network providers combined:$6,700	From network providers: $3,900 From network and out-of-network providers combined:$9,500
Doctor office visits	Primary care visits: $20 copay per visit Specialist visits: $45 copay per visit	Primary care visits: $20 copay per visit Specialist visits: $45 copay per visit

Cost	2016 (this year)	2017 (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** $200 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network** $250 copay per day for days 1-5; $0 copay per day for days 6-90	**In-network** $275 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network** 40% of the total cost per stay

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1:Preferred Generic ➢ *Standard cost-sharing:* $5 copay ➢ *Preferred cost-sharing:* $0 copay • Drug Tier 2: Generic**:** ➢ *Standard cost-sharing:* $11 copay ➢ *Preferred cost-sharing:* $6 copay • Drug Tier 3: Preferred Brand ➢ *Standard cost-sharing:* $44 copay ➢ *Preferred cost-sharing:* $39 copay	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: Preferred Generic ➢ *Standard cost-sharing:* $9 copay ➢ *Preferred cost-sharing:* $0 copay • Drug Tier 2: Generic ➢ *Standard cost-sharing:$15* copay ➢ *Preferred cost-sharing:* $6 copay • Drug Tier 3: Preferred Brand ➢ *Standard cost-sharing:* $47 copay ➢ *Preferred cost-sharing:* $39 copay

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (continue) (See Section 1.6 for details.)	• Drug Tier 4: Non-Preferred Brand: ➢ *Standard cost-sharing:* $95 copay ➢ *Preferred cost-sharing:* $85 copay • Drug Tier 5:Specialty: ➢ *Standard cost-sharing:* 33% of the total cost ➢ *Preferred cost-sharing:* 33% of the total cost	• Drug Tier 4: Non-Preferred Brand: ➢ *Standard cost-sharing:* $99 copay ➢ *Preferred cost-sharing:* $85 copay • Drug Tier 5: Specialty: ➢ *Standard cost-sharing:* 33% of the total cost ➢ *Preferred cost-sharing:* 33% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$33.00	$35.00

- 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 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 services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) 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.	$3,500	$3,900 Once you have paid $3,900 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$6,700	$9,500 Once you have paid $9,500 out-of-pocket for covered services, you will pay nothing for your covered 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 Directory is located on our website at www.getbluemt.com/mapd. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2017 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 specialist (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.

- When possible we will 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 pharmacies within the network.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.getbluemt.com/mapd. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2017 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 *2017 Evidence of Coverage.*

Cost	2016 (this year)	2017 (next year)
Diabetic Supplies and Services	**In-network** 20% of the total cost for Medicare-covered diabetic shoes inserts	**In-network** $0 copay for Medicare-covered diabetic shoes inserts

Cost	2016 (this year)	2017 (next year)
Inpatient Hospital	**In-network** $200 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services **Out-of-network** $250 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services	**In-network** $275 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services **Out-of-network** 40% of the total cost per stay-Medicare-covered services
Inpatient Hospital Psychiatric	**In-network** $200 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services **Out-of-network** $250 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services	**In-network** $250 copay per day for days 1-5; $0 copay per day for days 6-90-Medicare-covered services **Out-of-network** 40% of the total cost per stay-Medicare-covered services
Skilled Nursing Facility	**In-network** $0 copay per day for days 1-20; $100 copay per day for days 21-100-Medicare-covered services **Out-of-network** $0 copay per day for days 1-20; $125 copay per day for days 21-100- Medicare-covered services	**In-network** $0 copay per day for days 1-20; $164.50 copay per day for days 21-100- Medicare-covered services **Out-of-network** 40% of the total cost per stay-Medicare-covered services
Cardiac & Pulmonary Rehab Services	**Out-of-network** 20% of the total cost- Medicare-covered Cardiac services 20% of the total cost- Medicare-covered Intensive Cardiac services	**Out-of-network** 40% of the total cost- Medicare-covered Cardiac services 40% of the total cost- Medicare-covered Intensive Cardiac services

Cost	2016 (this year)	2017 (next year)
	20% of the total cost- Medicare-covered Pulmonary Rehab services	40% of the total cost- Medicare-covered Pulmonary Rehab services
Partial Hospitalization	**In-network** $40 copay- Medicare-covered services **Out-of-network** $60 copay- Medicare-covered services	**In-network** $55 copay- Medicare-covered services **Out-of-network** 40% of the total cost- Medicare-covered services
Occupational Therapy Services	**Out-of-network** 20% of the total cost- Medicare-covered services	**Out-of-network** 40% of the total cost- Medicare-covered services
Outpatient Diagnostic Procedures/Tests/Lab Services	**In-network** $0 copay- Medicare-covered Outpatient Diagnostic procedures $0 copay- Medicare-covered Outpatient lab services **Out-of-network** 20% of the total cost – Medicare-covered Outpatient Diagnostic procedures	**In-network** $0.00 to $25.00 copay for Medicare-covered diagnostic tests and procedures ($0 copay for the Diagnostic Bone Mass Measurement, Diagnostic Colonoscopy and Diagnostic Mammography test performed on the same date of the service as the corresponding preventive test. All other services are covered at a $25 copay.)- Medicare-covered Outpatient Diagnostic procedures $5 copay- Medicare-covered Outpatient lab services **Out-of-network** 40% of the total cost- Medicare-covered Outpatient Diagnostic procedures

Cost	2016 (this year)	2017 (next year)
	20% of the total cost – Medicare-covered Outpatient lab services	40% of the total cost- Medicare-covered Outpatient lab services
Outpatient Diagnostic Therapeutic Radiology Services	**Out-of-network** 20% of the total cost- Medicare-covered Outpatient Diagnostic Radiology 20% of the total cost- Medicare-covered Outpatient Therapeutic Radiology 20% of the total cost- Medicare-covered Outpatient x-ray services	**Out-of-network** 40% of the total cost- Medicare-covered Outpatient Diagnostic Radiology 40% of the total cost- Medicare-covered Outpatient Therapeutic Radiology 40% of the total cost- Medicare-covered Outpatient x-ray services
Outpatient Hospital	**In-network** $225 copay; $0 copay for the diagnostic Bone Mass Measurement, Colonoscopy and Mammography test performed on the same date of service as the corresponding preventive test - Medicare-covered Outpatient hospital services **Out-of-network** $350 copay- Medicare-covered Outpatient hospital services	**In-network** $0 copay to $275 copay ($0 copay for observation stays only)- Medicare-covered Outpatient hospital services **Out-of-network** 40% of the total cost- Medicare-covered Outpatient hospital services
Ambulatory Surgical Center	**In-network** $225 copay; $0 copay for the diagnostic Bone Mass Measurement, Colonoscopy and Mammography test performed on the same date of service as the corresponding preventive test - Medicare-covered services	**In-network** $275 copay- Medicare-covered services

Cost	2016 (this year)	2017 (next year)
	Out-of-network $350 copay- Medicare-covered services	**Out-of-network** 40% of the total cost- Medicare-covered services
Outpatient Substance Abuse	**In-network** $40 copay- Medicare-covered Individual services $40 copay- Medicare-covered group services **Out-of-network** $60 copay-Medicare-covered individual services $60 copay-Medicare-covered group services	**In-network** $100 copay- Medicare-covered Individual services $100 copay- Medicare-covered group services **Out-of-network** $100 copay-Medicare-covered individual services $100 copay-Medicare-covered group services
Ambulance Services	**In-network** $100 copay- Medicare-covered services **Out-of-network** $100 copay- Medicare-covered services	**In-network** $275 copay- Medicare-covered services **Out-of-network** $275 Copay- Medicare-covered services
Prosthetics/Medical Supplies	**Out-of-network** 20% of the total cost- Medicare-covered Prosthetics supplies 20% of the total cost- Medicare-covered Medical Supplies	**Out-of-network** 40% of the total cost- Medicare-covered Prosthetics supplies 40% of the total cost -Medicare-covered Medical Supplies
Dialysis Services	**In-network** $30 copay- Medicare-covered Dialysis services	**In-network** 20% of the total cost- Medicare-covered Dialysis services

Cost	2016 (this year)	2017 (next year)
Other Medicare-covered Preventive Services	**In-network** 20% of the total cost- Medicare-covered Diabetes management training	**In-network** $0 copay- Medicare-covered Diabetes management training
Medicare Part B Rx Drugs	**Out-of-network** 20% of the total cost- Medicare-covered Part B Chemo drugs 20% of the total cost- Medicare-covered Part B Rx Drugs	**Out-of-network** 40% of the total cost- Medicare-covered Part B Chemo drugs 40% of the total cost- Medicare-covered Part B Rx Drugs
Hearing exams & aids	**Out-of-network** 40% of the total cost- Routine hearing exam **In-out-of-network** up to 1 fitting/evaluation for a hearing aid every year	**Out-of-network** $20 copay- Routine hearing exam **In-out-of network** up to 1 fitting/evaluation for hearing aid every 3 years

Cost	2016 (this year)	2017 (next year)
Rewards and Incentives Program	Up to $100 for completing healthy activities*: • Welcome to Medicare/Annual Physical • Body Mass Index • Annual Flu Vaccine • Comprehensive Medication Review • Colorectal Screening • Retinal Exam • Bone Density Screening • Mammogram • 90 day supply of prescription drugs for the treatment of diabetes, high blood pressure, or high cholesterol * This is an all-inclusive list at this time but subject to change	Up to $100 for completing healthy activities*: • Welcome to Medicare/Annual Physical • Annual Flu Vaccine • Colorectal Screening • Retinal Exam • Bone Density Screening • Mammogram • In home assessment * This is list subject to change. To register and determine the current list of healthy activities, go to **www.bcbsmt.healthmine.com.** You will need your member ID card, date of birth and email address to register online if you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account.

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 in this envelope.

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 **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or coverage. (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.

In 2016, some compound drugs were covered as formulary. In 2017, compound drugs will be considered non-formulary. If you cannot switch to a formulary alternative, and require an exception to the formulary, you may need to use the coverage decision process and ask us to make an exception. For additional information on the coverage determination process, see the Evidence of Coverage **Note:** We may or may not agree on the exception request

Current formulary exceptions may still be covered, depending on the circumstance. You can call Customer Service to confirm coverage duration**.**

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. If you get "Extra Help" and didn't receive this insert with this packet, 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 4 and 5, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (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	2016 (this year)	2017 (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. 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 at a network pharmacy: **Preferred Generic:** *Standard cost-sharing:* You pay $5 copay per prescription. *Preferred cost-sharing:* You pay $0 copay per prescription. **Generic:** *Standard cost-sharing:* You pay $11 copay per prescription. *Preferred cost-sharing:* You pay $6 copay per prescription. **Preferred Brand:** *Standard cost-sharing:* You pay $44 copay per prescription. *Preferred cost-sharing:* You pay $39 copay per prescription. **Non-Preferred Brand:** *Standard cost-sharing:* You pay $95 copay per prescription. *Preferred cost-sharing:* You pay $85 copay per	Your cost for a one-month supply at a network pharmacy: **Preferred Generic:** *Standard cost-sharing:* You pay $9 copay per prescription. *Preferred cost-sharing:* You pay $0 copay per prescription. **Generic:** *Standard cost-sharing:* You pay $15 copay per prescription. *Preferred cost-sharing:* You pay $6 copay per prescription. **Preferred Brand:** *Standard cost-sharing:* You pay $47 copay per prescription. *Preferred cost-sharing:* You pay $39 copay per prescription. **Non-Preferred Brand**: *Standard cost-sharing:* You pay $99 copay per prescription. *Preferred cost-sharing:* You pay $85 copay per

	prescription.	prescription.
	Specialty:	**Specialty:**
	Standard cost-sharing: You pay 33% of the total cost of the total cost.	*Standard cost-sharing:* You pay 33% of the total cost of the total cost.
	Preferred cost-sharing: You pay 33% of the total cost of the total cost.	*Preferred cost-sharing:* You pay 33% of the total cost of the total cost.
	Once your total drug costs have reached 3,360, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,700 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 Blue Cross Medicare Advantage Choice Plus (PPO)℠

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 2017.

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 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, 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 http://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, Health Care Service Corporation offers other Medicare health plans *AND* 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 Blue Cross Medicare Advantage Choice Plus (PPO)℠.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Cross Medicare Advantage Choice Plus (PPO)℠.
- 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 6.1 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 Other Changes

Cost	2016 (this year)	2017 (next year)
Preferred Pharmacy Network	In 2016, CVS were one of the preferred pharmacies.	There is a change in your preferred pharmacy network. CVS will not be a preferred pharmacy this year. You can still get your prescriptions at this pharmacy, but for a non-preferred copay.
Diabetic Test Strips	Currently Roche and Ascensia Diabetes Care test strips are available for a $0 copay through your Medicare Part B Benefit at a network pharmacy	There is change in covered diabetic supplies effective January 1st 2017. Starting January 1st 2017, only Ascensia Diabetes Care testing supplies; including the meter, test strips and lancets will be available for $0 copay through your Medicare Part B Benefit at a network pharmacy. Non-preferred diabetic supplies are available.
Preferred Vision Provider	In 2016, Davis Vision was the preferred vision provider	In 2017, Eyemed Vision will become the preferred vision provider. Contact Customer Service for more information.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2017.

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 are 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, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

Montana State Health Insurance Assistance Program 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. Montana State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Montana State Health Insurance Assistance Program at 1-800-551-3191. You can learn more about Montana State Health Insurance Assistance Program by visiting their website (www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage

gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
- Your State Medicaid Office (applications).

- Help from your state's pharmaceutical assistance program. Montana has a program called Big Sky Rx Program 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 Montana AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-406-444-4744.

SECTION 7 Questions?

Section 7.1 – Getting Help from Blue Cross Medicare Advantage Choice Plus (PPO)℠

Questions? We're here to help. Please call Customer Service at 1-877-774-8592. (TTY/TDD only, call 711.) We are available for phone calls 8:00 a.m. - 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Calls to these numbers are free.

Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for Blue Cross Medicare Advantage Choice Plus (PPO)℠. 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 included in this envelope.

Visit our Website

You can also visit our website at www.getbluemt.com/mapd. 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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

You can visit the Medicare website (http://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 http://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2017*

You can read *Medicare & You 2017* 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 (http://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.