Blue Medicare Advantage Access (PPO) offered by Blue Cross and Blue Shield of Kansas City

Annual Notice of Changes for 2020

You are currently enrolled as a member of Blue Medicare Advantage Access. 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 through 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 2020 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, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider/Pharmacy Directory.

☐ Think about your overall healthcare 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 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** Blue Medicare Advantage Access, you don't need to do anything. You will stay in Blue Medicare Advantage Access.
- 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, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Blue Medicare Advantage Access.
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- Please contact our Customer Service number at 1-866-508-7140 for additional information. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day.
- This document may be available in other formats such as Braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.IRS.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Blue Medicare Advantage Access

- Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. All products are offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City's Blue Medicare Advantage Access is a PPO with a Medicare contract. Enrollment in Blue Medicare Advantage Access depends on contract renewal
- When this booklet says "we," "us," or "our," it means Blue Cross and Blue Shield of Kansas City. When it says "plan" or "our plan," it means Blue Medicare Advantage Access.

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Blue Medicare Advantage Access in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our member website at www.MyBlueKCMA.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$49	$49
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.)	**In-Network Providers**: $5,500 In-network and out-of-network providers combined: $10,000	**In-Network Providers**: $5,500 In-network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network** Primary care visits: $0 per visit Specialist visits: $35 per visit **Out-Of-Network** 20% co-insurance	**In-Network** Primary care visits: $0 per visit Specialist visits: $35 per visit **Out-Of-Network** 20% co-insurance
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 $285 per day, per stay: Days 1-6 $0 per day, per stay: Day 7 and beyond **Out-Of-Network** 20% co-insurance per day, per stay for Medicare-covered inpatient hospital care (based on Medicare allowable amount).	**In-Network** You pay a $285 per day, per stay: Days 1-6 $0 per day, per stay: Day 7 and beyond **Out-Of-Network** 20% co-insurance per day, per stay for Medicare-covered inpatient hospital care (based on Medicare allowable amount).

Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Co-insurance during the Initial Coverage Stage: **Standard Cost Share Pharmacy 30-day Supply** • Drug Tier 1: $3 copay • Drug Tier 2: $12 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% co-insurance **Standard Cost Share Pharmacy 60-day Supply** • Drug Tier 1: $6 copay • Drug Tier 2: $24 copay • Drug Tier 3: $94 copay • Drug Tier 4: $200 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only	Deductible: $0 Copayment/Co-insurance during the Initial Coverage Stage: **Standard Cost Share Pharmacy 30-day Supply** • Drug Tier 1: $3 copay • Drug Tier 2: $12 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% co-insurance **Standard Cost Share Pharmacy 60-day Supply** • Drug Tier 1: $6 copay • Drug Tier 2: $24 copay • Drug Tier 3: $94 copay • Drug Tier 4: $200 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (continued)	**Standard Cost Share Pharmacy 90-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $0 copay • Drug Tier 3: $141 copay • Drug Tier 4: $300 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only **Mail Order Cost Share Pharmacy 90-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $0 copay • Drug Tier 3: $117.50 copay • Drug Tier 4: $250 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only	**Standard Cost Share Pharmacy 90-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $0 copay • Drug Tier 3: $141 copay • Drug Tier 4: $300 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only **Mail Order Cost Share Pharmacy 90-day Supply** • Drug Tier 1: $0 copay • Drug Tier 2: $0 copay • Drug Tier 3: $117.50 copay • Drug Tier 4: $250 copay • Drug Tier 5: Not offered 33% co-insurance for a (30) day supply only

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$49	$49

- 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 Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (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.	$5,500	$5,500 Once you have paid $5,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2019 (this year)	2020 (next 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. There is no change for the upcoming benefit year.	$10,000	$10,000 Once you have paid $10,000 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider/Pharmacy Directory is located on our member website at www.MyBlueKCMA.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2020 Provider/Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your healthcare 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.

There are changes to our network of pharmacies for next year. An updated Provider/Pharmacy Directory is located on our member website at www.MyBlueKCMA.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider/Pharmacy Directory. **Please review the 2020 Provider/Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay),* in your *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Acupuncture	Acupuncture services are not covered.	**In-Network** You pay a $20 copay for each treatment. Treatments are limited to 20 visits per calendar year. You must use an American Specialty Health (ASH) provider. **Out-Of-Network** You pay 50% of the total cost for acupuncture services.
Dental services (preventive & comprehensive)	**In-Network** You pay a $40 copay for preventive services.	**In-Network & Out-Of-Network** $750 annual benefit allowance – combined for preventive dental services and non-Medicare-covered

Cost	2019 (this year)	2020 (next year)
Dental services (preventive & comprehensive) (continued)	Non-Medicare-covered comprehensive services are not covered. **Out-Of-Network** You pay a $40 copay for preventive services (based on the Medicare allowable amount). Non-Medicare-covered comprehensive services are not covered.	comprehensive dental services.
Diabetes prevention program virtual visit	Diabetes prevention program virtual visit is not covered.	**In-Network** You pay a $0 copay for diabetes prevention program virtual visits. You must use Solera Health. **Out-Of-Network** Not covered
Fall risk – strength and balance training	Fall risk - strength and balance training services are not covered.	**In-Network** Eligible members pay $0 for covered fall risk - strength and balance training program offered through Solera Health. See EOC for eligibility information. **Out-Of-Network** Not covered
Hearing services	**In-Network** You pay a $40 copay for routine exam through TruHearing (limited to 1 per calendar year). Rechargeable hearing aids are not covered.	**In-Network** You pay a $0 copay for routine exam through TruHearing (limited to 1 per calendar year). A rechargeable hearing aid option is offered.

Cost	2019 (this year)	2020 (next year)
Meal benefit	Meals are not covered.	**In-Network** You pay a $0 copay for up to 7 days or 14 pre-cooked, refrigerated meals following discharge from any inpatient stay. You must use Mom's Meals. **Out-Of-Network** Not covered
Opioid treatment program services	Opioid treatment program services are not covered.	**In-Network** You pay a $40 copay per visit for Medicare-covered opioid treatment program services. **Out-Of-Network** You pay 20% of the total cost for Medicare-covered opioid treatment program services (based on the Medicare allowable amount).
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** You pay a $20 copay for Medicare-covered x-rays. You pay a $225 copay for Medicare-covered diagnostic radiology services (not including x-rays).	**In-Network** You pay a $5 copay for Medicare-covered x-rays. You pay a $0 copay for Medicare-covered diagnostic mammograms. CT Services: You pay a $80 copay for CT services in an outpatient hospital setting. You pay a $40 copay for CT services in a provider office / freestanding facility.

Cost	2019 (this year)	2020 (next year)
Outpatient diagnostic tests and therapeutic services and supplies (continued)		MRI Services: You pay a $180 copay for MRI services in an outpatient hospital setting. You pay a $90 copay for MRI services in a provider office / freestanding facility. You pay a $180 copay for all other Medicare-covered diagnostic radiology services (not including x-rays). You pay a $0 copay for Medicare-covered diagnostic procedures and tests.
	20% co-insurance for Medicare-covered diagnostic procedures and tests.	
Outpatient hospital observation	**In-Network** You pay a $275 copay for Medicare-covered outpatient hospital observation services.	**In-Network** You pay a $285 copay for Medicare-covered outpatient hospital observation services.
Outpatient substance abuse services	**In-Network** You pay a $45 copay for each Medicare-covered individual visit. You pay a $45 copay for each Medicare-covered group visit.	**In-Network** You pay a $40 copay for each Medicare-covered individual visit. You pay a $40 copay for each Medicare-covered group visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $275 copay for each Medicare-covered surgery at an outpatient hospital facility or ambulatory surgical center.	**In-Network** You pay a $285 copay for each Medicare-covered surgery at an outpatient hospital facility or ambulatory surgical center.

Cost	2019 (this year)	2020 (next year)
Over-the-counter items	Over the counter items are not covered.	You have a $25 allowance for CMS approved non-prescription OTC drug and health-related items, per month (online, in-store and home delivery options). Unused balance does not carry over month to month.
Skilled nursing facility (SNF) care	**In-Network** You pay a $0 copay per day for days 1-20. You pay a $160 copay per day for days 21-100. **Out-Of-Network** You pay 20% of the total cost for Medicare-covered skilled nursing facility (SNF) stay (based on the Medicare allowable amount).	**In-Network** You pay a $0 copay per day for days 1-20. You pay a $178 copay per day for days 21-100. **Out-Of-Network** You pay 5% of the total cost for Medicare-covered skilled nursing facility (SNF) stay (based on the Medicare allowable amount).
Social connection program	Social connection program is not covered.	**In-Network** Eligible members pay $0 for covered social connection program offered through Solera Health. See EOC for eligibility information. **Out-Of-Network** Not covered
Transportation (non-emergent)	Non-emergent transportation services are not covered.	You pay a $0 copay for 12 one-way trips to plan approved health-related locations per calendar year. You must use ALC for transportation services.

Cost	2019 (this year)	2020 (next year)
Vision care (diabetic eye exam)	**In-Network** You pay a $40 copay for a Medicare-covered diabetic eye exam. **Out-Of-Network** You pay 20% of the total cost for a Medicare-covered diabetic eye exam (based on the Medicare allowable amount).	**In-Network** You pay a $0 copay for a Medicare-covered diabetic eye exam. **Out-Of-Network** You pay 20% of the total cost for a Medicare-covered diabetic eye exam (based on the Medicare allowable amount).
Vision care (routine)	**In-Network** You pay a $10 copay for up to 1 routine eye exam every calendar year (through EyeMed only). You have a $75 allowance for one pair of eyeglass frames or contact lenses per calendar year. Eyeglass lenses are not included in this allowance. Allowance is combined In-Network and Out-Of-Network. You pay a $20 copay for single, bifocal, trifocal or lenticular lenses. You pay a $85 copay for standard progressive lenses. **Out-Of-Network** You pay 50% of the total cost for up to 1 routine eye exam every calendar year. You have a $75 allowance for one pair of eyeglass frames or contact lenses per calendar year. Eyeglass	**In-Network** You pay a $0 copay for up to 1 routine eye exam every calendar year (through EyeMed only). You have a $300 allowance per calendar year for eyeglasses (lenses and frames) or contact lenses. Allowance is combined In-Network and Out-Of-Network. You must use an EyeMed network provider for in-network benefits. **Out-Of-Network** You pay 50% co-insurance for up to 1 routine eye exam every calendar year. You have a $300 allowance per calendar year for eyeglasses (lenses and frames) or contact lenses.

Cost	2019 (this year)	2020 (next year)
Vision care (routine) (continued)	lenses are not included in this allowance. Allowance is combined In-Network and Out-Of-Network. You pay 50% of the total cost for single, bifocal, trifocal, lenticular, or standard progressive lenses.	Allowance is combined In-Network and Out-Of-Network.

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.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2, of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exception approvals are typically valid for 12 months.

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 2020, 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, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply 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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6, of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs 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 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 *Evidence of Coverage*, which is located on our member website at www.MyBlueKCMA.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (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 co-insurance 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	2019 (this year)	2020 (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:** You pay $3 per prescription **Generic:** You pay $12 per prescription **Preferred Brand:** You pay $47 per prescription **Non-Preferred Brand:** You pay $100 per prescription **Specialty Tier:** 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).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generic:** You pay $3 per prescription **Generic:** You pay $12 per prescription **Preferred Brand:** You pay $47 per prescription **Non-Preferred Brand:** You pay $100 per prescription **Specialty Tier:** You pay 33% of the total cost _____ Once your total drug costs have reached $4,020, 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 Medicare Advantage Access

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 2020.

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 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, 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, Blue Cross and Blue Shield of Kansas City 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 Blue Medicare Advantage Access.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Blue Medicare Advantage Access.
- 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 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 through December 7.** The change will take effect on January 1, 2020.

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, 2020, 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, 2020. 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 Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK). In Missouri, the SHIP is called Community Leaders Assisting the Insured of Missouri (CLAIM)

SHICK and CLAIM are 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. SHICK and CLAIM 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 (SHICK) at 1-785-296-4986 or toll free 1-800-860-5260 (TTY: 711). You can call CLAIM at 1-573-817-8320 or toll free 1-800-390-3330 (TTY: 711). You can learn more about SHICK by visiting their website www.KDADS.KS.gov. You can learn more about CLAIM by visiting their website www.MissouriClaim.org.

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 co-insurance. 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).
- **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 Kansas Ryan White Part B Program in Kansas and Missouri Department of Health and Senior Services in Missouri. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

  In Kansas –

  The Kansas Ryan White Part B Program
  1000 SW Jackson, Ste. 210
  Topeka, KS 66612

  Phone: 1-785-296-6174 (TTY: 711)
  Fax: 1-785-559-4225

  In Missouri –
  HIV/AIDS Case Management Program Bureau of HIV, STD, and Hepatitis
  Missouri Department of Health and Senior Services
  P.O. Box 570
  Jefferson City, MO 65102-0570

  Phone: 1-573-751-6439 (TTY: 711)
  Fax: 1-573-751-6447
  Email: info@health.mo.gov

SECTION 6 Questions?

Section 6.1 – Getting Help from Blue Medicare Advantage Access

Questions? We're here to help. Please call Customer Service at 1-866-508-7140. (TTY only, call 711.) We are available for phone calls seven days a week from 8 a.m. to 8 p.m. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. Calls to these numbers are free.

Read your 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Blue Medicare Advantage Access. 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 located on our member website at www.MyBlueKCMA.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our member website at www.MyBlueKCMA.com. As a reminder, our website has the most up to information about our provider network (Provider/Pharmacy 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 2020*

You can read *Medicare & You 2020* 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.