of Tennessee

BlueCross BlueShield of Tennessee Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueAdvantage Sapphire (PPO)SM offered by BlueCross BlueShield of Tennessee

Annual Notice of Changes for 2018

You are currently enrolled as a member of BlueAdvantage Sapphire (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.**

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 1.1 and 1.5 for information about benefit and cost changes for our plans.

❏ 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 2018 Drug List and 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.

H7917_18_SPAN Accepted 08282017
Form CMS 10260-ANOC/EOC
(Approved 05/2017)

OMB Approval 0938-1051 (Expires: May 31, 2020)

❑ 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 3.2 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** BlueAdvantage Sapphire (PPO), you don't need to do anything. You will stay in BlueAdvantage Sapphire (PPO).
- 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, 2017**

- If you **don't join by December 7, 2017**, you will stay in BlueAdvantage Sapphire (PPO).
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- Please contact our Member Service number at **1-800-831-BLUE (2583)** for additional information. (TTY users should call **711**). From **Oct. 1 to Feb. 14**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **Feb. 15 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
- This material is also available in other alternative formats.

- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About BlueAdvantage Sapphire (PPO)

- BlueCross BlueShield of Tennessee, Inc. is a PPO plan with a Medicare contract. Enrollment in BlueCross BlueShield of Tennessee, Inc. depends on contract renewal.
- When this booklet says "we," "us," or "our," it means BlueCross BlueShield of Tennessee. When it says "plan" or "our plan," it means BlueAdvantage Sapphire (PPO).

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for BlueAdvantage Sapphire (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	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	**$0**	**$0**
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: **$6,700** From network and out-of-network providers combined: **$10,000**	From network providers: **$6,700** From network and out-of-network providers combined: **$10,000**
Doctor office visits	Primary care visits: **In-Network:** **$10** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit Specialist visits: **In-Network:** **$40** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit	Primary care visits: **In-Network:** **$10** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit Specialist visits: **In-Network:** **$35** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit

Cost	2017 (this year)	2018 (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: Medicare-covered stay** **$300** copay per day for days 1-5 **$0** copay per day for additional days **Non-Medicare covered stay** Non-Medicare covered stay is not covered. **Out-of-Network: Medicare-covered stay** **50%** of the Medicare-allowed amount per stay **50%** of the Medicare-allowed amount per stay for additional days **Non-Medicare covered stay** Non-Medicare covered stay is not covered.	**In-Network: Medicare-covered stay** **$300** copay per day for days 1-5 **$0** copay per day for additional days **Non-Medicare covered stay** Non-Medicare covered stay is not covered. **Out-of-Network: Medicare-covered stay** **50%** of the Medicare-allowed amount per stay **50%** of the Medicare-allowed amount per stay for additional days **Non-Medicare covered stay** Non-Medicare covered stay is not covered.

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: **$0** Copayments/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: **$3** copay • Drug Tier 2: **$12** copay • Drug Tier 3: **$45** copay • Drug Tier 4: **$90** copay • Drug Tier 5: **33%** coinsurance	Deductible: **$0** Copayments/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Standard cost-sharing: **$6** copay Preferred cost-sharing: **$1** copay • Drug Tier 2: Standard cost-sharing: **$15** copay Preferred cost-sharing: **$10** copay • Drug Tier 3: Standard cost-sharing: **$47** copay Preferred cost-sharing: **$42** copay • Drug Tier 4: Standard cost-sharing: **$95** copay Preferred cost-sharing: **$90** copay • Drug Tier 5: Standard cost-sharing: **33%** coinsurance Preferred cost-sharing: **33%** coinsurance

Annual Notice of Changes for 2018
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$0**	**$0**

- 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 enroll in Medicare prescription drug coverage in the future.
- 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	2017 (this year)	2018 (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 costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$6,700**	**$6,700** Once you have paid **$6,700** 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	2017 (this year)	2018 (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.	**$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 Directory is located on our website at **bcbstmedicare.com**. You may also call Member Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 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 **bcbstmedicare.com**. You may also call Member Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 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 *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Ambulance Services	**In-Network and Out-of-Network** You pay a **$250** copay for Medicare-covered ambulance services, per trip	**In-Network and Out-of-Network** You pay a **$250** copay for Medicare-covered ground travel, per trip You pay **20%** of the Medicare-allowed amount for Medicare-covered air travel, per trip
Diagnostic Tests	**In-Network** You pay a **$40** copay per visit for services at a Specialist's office	**In-Network** You pay a **$35** copay per visit for services at a Specialist's office
Emergency Care	**In-Network and Out-of-Network** You pay a **$75** copay for each Medicare-covered emergency room visit	**In-Network and Out-of-Network** You pay a **$80** copay for each Medicare-covered emergency room visit

Cost	2017 (this year)	2018 (next year)
Health Information Audio Library Index	Covered	Health Information Audio Library is not covered
Hearing Aids	**In-Network** You pay a **$599** copay per aid for Flyte 700 for 1 hearing aid per ear, per year or You pay a **$899** copay per aid for Flyte 900 for 1 hearing aid per ear, per year *Hearing aid copayments do not count toward your in-network or combined maximum out-of-pocket amount. **Out-of-Network** Not covered	**In-Network** You pay a **$599** copay per aid for Flyte 770 model for 1 hearing aid per ear, per year or You pay a **$899** copay per aid for Flyte 990 model for 1 hearing aid per ear, per year *Hearing aid copayments do not count toward your in-network or combined maximum out-of-pocket amount. **Out-of-Network** Not covered
Hearing Services	**In-Network and Out-of-Network** You pay a **$15** copay for each Medicare-covered **diagnostic** hearing exam	**In-Network and Out-of-Network** You pay a **$10** copay for each Medicare-covered **diagnostic** hearing exam
Laboratory Tests	**In-Network** You pay a **$50** copay for services in an Outpatient Hospital Facility You pay a **$40** copay for services at a Specialist's office	**In-Network** You pay a **$40** copay for services in an Outpatient Hospital Facility You pay a **$35** copay for services at a Specialist's office

Cost	2017 (this year)	2018 (next year)
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network and Out-of-Network** Not offered	**In-Network** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network** **50%** of the Medicare-allowed amount
Outpatient Mental Health Care	**In-Network** You pay a **$40** copay per visit	**In-Network** You pay a **$30** copay per visit
Outpatient Substance Abuse Services	**In-Network** You pay a **$45** copay for each Medicare-covered substance abuse outpatient individual or group treatment visit	**In-Network** You pay a **$25** copay for each Medicare-covered substance abuse outpatient individual or group treatment visit
Podiatry Services	**In-Network** You pay a **$40** copay per visit	**In-Network** You pay a **$25** copay per visit
Skilled Nursing Facility (SNF) Care	**In-Network** You pay a **$0** copay per day for days 1-20; **$160** copay per day for days 21-100	**In-Network** You pay a **$0** copay per day for days 1-20; **$167.50** copay per day for days 21-100

Cost	2017 (this year)	2018 (next year)
Sleep Studies	**In-Network** You pay a **$0** copay per visit for each home based sleep study You pay a **$20** copay per visit for each facility based sleep study No limit	**In-Network** You pay a **$10** copay per visit for each home based sleep study You pay a **$40** copay per visit for each facility based sleep study Limit 2 per year
Specialist Doctor Office Visit	**In-Network** You pay a **$40** copay per visit	**In-Network** You pay a **$35** copay per visit
Telehealth	**In-Network and Out-of-Network** Not covered	**In-Network** You pay a **$10** copay per visit **Out-of-Network** Not covered
Worldwide Emergency and Urgent Coverage	**In-Network and Out-of-Network** You pay a **$75** copay for each emergency or urgent visit outside the U.S.	**In-Network and Out-of-Network** You pay a **$80** copay for each emergency or urgent visit outside the U.S.
X-rays	**In-Network** You pay a **$40** copay for services at a Specialist's office per visit	**In-Network** You pay a **$35** copay for services at a Specialist's office per 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." An updated Formulary (Drug List) is located on our website at **bcbstmedicare.com**. You may also call Member Service for updated prescription drug information or to ask us to mail you a Formulary (Drug List). **Please review the 2018 Formulary (Drug List) to see if your drugs are covered.**

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 Member Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member 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 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.

Your current formulary exceptions will still be covered in 2018 if you are still active as a member and the prior authorization is still active.

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 9/30/2017 please call Member Service and ask for the "LIS Rider." Phone numbers for Member Service are in Section 7.1 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 enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (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	2017 (this year)	2018 (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 Drugs:** You pay **$3** per prescription **Generic Drugs:** You pay **$12** per prescription **Preferred Brand Drugs:** You pay **$45** per prescription **Non-Preferred Brand Drugs:** You pay **$90** per prescription	Your cost for a one-month supply at a network pharmacy: **Preferred Generic Drugs:** Standard cost-sharing: You pay **$6** per prescription Preferred cost-sharing: You pay **$1** per prescription **Generic Drugs:** Standard cost-sharing: You pay **$15** per prescription Preferred cost-sharing: You pay **$10** per prescription **Preferred Brand Drugs:** Standard cost-sharing: You pay **$47** per prescription Preferred cost-sharing: You pay **$42** per prescription **Non-Preferred Drugs:** Standard cost-sharing: You pay **$95** per prescription Preferred cost-sharing: You pay **$90** per prescription

Stage	2017 (this year)	2018 (next year)
	Specialty Tier Drugs: You pay **33%** of the total cost Once your total drug costs have reached **$3,700**, you will move to the next stage (the Coverage Gap Stage).	**Specialty Tier Drugs:** Standard cost-sharing: You pay **33%** of the total cost Preferred cost-sharing: You pay **33%** of the total cost Once your total drug costs have reached **$3,750**, you will move to the next stage (the Coverage Gap Stage).

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 Administrative Changes

Process	2017 (this year)	2018 (next year)
Payments of Member Premiums by Non-Profit Organizations	No application process.	Non-profit organizations interested in paying premiums for individuals who purchase health insurance coverage from BlueCross BlueShield of Tennessee must apply for and receive approval from BlueCross BlueShield of Tennessee in order for payments by such organizations to be accepted by BlueCross BlueShield of Tennessee

Process	2017 (this year)	2018 (next year)
		and applied to a member's premium obligation. If BlueCross BlueShield of Tennessee receives a payment from an organization that is not approved by BlueCross BlueShield of Tennessee, we reserve the right to deny the payment from the organization and ask the member to make payment of their premium in full.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BlueAdvantage Sapphire (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 2018.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 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 2018*, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

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, BlueCross BlueShield of Tennessee 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 BlueAdvantage Sapphire (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BlueAdvantage Sapphire (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Member 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 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, 2018.

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, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. 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 Tennessee, the SHIP is called the Tennessee State Health Insurance Assistance Program.

The Tennessee 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. The Tennessee 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 the Tennessee State Health Insurance Assistance Program at 1-877-801-0044 (Toll-Free). You can learn more about Tennessee State Health Insurance Assistance Program by visiting their website (www.tn.gov/aging/topic/ship).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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 am and 7 pm, 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 Ryan White Program (Tennessee's AIDS Drug Assistance Program). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Ryan White Program (Tennessee's AIDS Drug Assistance Program): (615) 741-7500, Monday - Friday 8 a.m. to 4:30 p.m. CT.

SECTION 7 Questions?

Section 7.1 – Getting Help from BlueAdvantage Sapphire (PPO)

Questions? We're here to help. Please call Member Service at **1-800-831-BLUE (2583)**. (TTY only, call **711**.) From **Oct. 1 to Feb. 14**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **Feb. 15 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Calls to these numbers are free.

Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for BlueAdvantage Sapphire (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 **bcbstmedicare.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 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 (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 2018*

You can read *Medicare & You 2018* 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.

of Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries Security Care, Inc. and Volunteer State Health Plan, Inc., dba BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact member service at the number on the back of your Member ID card or call 1-800-831-BLUE (2583) (TTY: 711). From Oct. 1 to Feb. 14, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From Feb. 15 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that 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 ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact member service at the number on the back of your Member ID card or call 1-800-831-BLUE (2583) (TTY: 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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, DC 20201, 1–800–368–1019, 1-800–537–7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi Language Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-831-2583 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-831-2583 (رقم هاتف الصم والبكم: 711.

\注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-831-2583 (TTY:711) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-831-2583 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-831-2583 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-831-2583 (ATS : 711).

[illegible]: [illegible] 1-800-831-2583 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-831-2583 (መስማት ለተሳናቸው: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-831-2583 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-831-2583 (TTY:711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-831-2583 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-831-2583 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-831-2583 (TTY: 711) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-831-2583 (телетайп: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-831-2583 (TTY:711) تماس بگیرید .