Basic Blue® Rx (PDP)
A Medicare Prescription Drug Plan

2019
ANNUAL NOTICE OF CHANGES

Basic Blue Rx (PDP) offered by
MII Life Insurance, Inc.

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Basic Blue Rx (PDP) offered by MII Life Insurance, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of Basic Blue Rx. 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, 1.2 and 1.3 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.3 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 **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.

☐ 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 the **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** Basic Blue Rx, you don't need to do anything. You will stay in Basic Blue Rx.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

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

Additional Resources

- Please contact our Customer Service number at **1-877-376-2185** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., daily, local time.

About Basic Blue Rx

- MII Life Insurance, Inc. is the underwriter for Basic Blue Rx, a prescription drug plan with a Medicare contract. Enrollment in Basic Blue Rx depends on contract renewal. MII Life Insurance, Inc. and each Blue Cross® and/or Blue Shield® plan are independent licensees of the Blue Cross® and Blue Shield® Association.
- When this booklet says “we,” “us,” or “our,” it means MII. When it says “plan” or “our plan,” it means Basic Blue Rx.

Summary of Important Costs for 2019

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

<table>
<tr><th>Cost</th><th colspan="2">2018 (this year)</th><th colspan="2">2019 (next year)</th></tr>
<tr><td rowspan="3">Monthly plan premium*
*Your premium may be higher or lower than this amount. See Section 1.1 for details.</td><td>Region</td><td>Premium</td><td>Region</td><td>Premium</td></tr>
<tr><td>North Carolina</td><td>$27.00</td><td>North Carolina</td><td>$29.00</td></tr>
<tr><td>Pennsylvania/ West Virginia</td><td>$27.20</td><td>Pennsylvania/ West Virginia</td><td>$27.40</td></tr>
<tr><td rowspan="3">Part D prescription drug coverage

(See Section 1.3 for details.)</td><td colspan="2">Deductible: $0 for Tier 1 and 2 drugs; $405 for Tiers 3, 4 and 5 drugs

Copayment/Coinsurance during the Initial Coverage Stage:

Drug Tier 1

Standard retail cost sharing: You pay $16 per prescription.

Preferred retail cost sharing: You pay $4 per prescription.</td><td colspan="2">Deductible: $415

Copayment/Coinsurance during the Initial Coverage Stage:

Drug Tier 1

Standard retail cost sharing: You pay $6 per prescription.

Preferred retail cost sharing: You pay $2 per prescription.</td></tr>
<tr><td colspan="2">Drug Tier 2

Standard retail cost sharing: You pay $20 per prescription.

Preferred retail cost sharing: You pay $9 per prescription.</td><td colspan="2">Drug Tier 2

Standard retail cost sharing: You pay $10 per prescription.

Preferred retail cost sharing: You pay $6 per prescription.</td></tr>
<tr><td colspan="2">Drug Tier 3

Standard retail cost sharing: You pay 21% of the total cost.

Preferred retail cost sharing: You pay 15% of the total cost.</td><td colspan="2">Drug Tier 3

Standard retail cost sharing: You pay 20% of the total cost.

Preferred retail cost sharing: You pay 15% of the total cost.</td></tr>
</table>

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (continued) (See Section 1.3 for details.)	**Drug Tier 4** *Standard retail cost sharing:* You pay 46% of the total cost. *Preferred retail cost sharing:* You pay 30% of the total cost.	**Drug Tier 4** *Standard retail cost sharing*: You pay 35% of the total cost. *Preferred retail cost sharing:* You pay 32% of the total cost.
	Drug Tier 5 *Standard retail cost sharing:* You pay 25% of the total cost. *Preferred retail cost sharing:* You pay 25% of the total cost.	**Drug Tier 5** *Standard retail cost sharing:* You pay 25% of the total cost. *Preferred retail cost sharing:* You pay 25% of the total cost.

Annual Notice of Changes for 2019

Table of Contents

SECTION 1
Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)		2019 (next year)	
Monthly premium **(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)**	**Region**	**Premium**	**Region**	**Premium**
	North Carolina	**$27.00**	**North Carolina**	**$29.00**
	Pennsylvania/ West Virginia	**$27.20**	**Pennsylvania/ West Virginia**	**$27.40**

- 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 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 **BasicBlueRx.com**. You may also call Customer Service for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2019 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.3 – 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 7 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days' supply provided in all other cases: 31-day supply of medication rather than the amount provided in 2018 (90 to 98-day supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 3, 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.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- Perhaps you can find a different drug covered by the plan that might work just as well for you. You can call Customer Service for assistance with alternative medications that treat the same medical condition(s). This list can help your doctor or other prescriber to find a covered drug that might work for you.
- You and your doctor can ask the plan to make an exception for you and cover the drug. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. To learn what you must do to ask for an exception, see Chapter 7 of the separately mailed *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).
- If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in

advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can submit a formulary exception request asking that the drug be covered in 2019 beginning November 1, 2018, and we will notify you of the decision within 72 hours from the time we receive the request.

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

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand-name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand-name drug that is being replaced by the new generic (or the tier or restriction on the brand-name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand-name drug at a network pharmacy. If you are taking the brand-name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 3, 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 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 4, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The following information 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 4, Sections 6 and 7, in the separately mailed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	The deductible is **$405.** During this stage, you pay $0 cost sharing for drugs on Tiers 1 & 2, and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.	The deductible is **$415.**

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 4, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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 4, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy:	Your cost for a one-month supply filled at a network pharmacy:
	Tier 1 Preferred Generic *Standard cost sharing:* You pay $16 per prescription. *Preferred cost sharing:* You pay $4 per prescription.	**Tier 1 Preferred Generic** *Standard cost sharing:* You pay $6 per prescription. *Preferred cost sharing:* You pay $2 per prescription.
	Tier 2 Generic *Standard cost sharing:* You pay $20 per prescription. *Preferred cost sharing:* You pay $9 per prescription.	**Tier 2 Generic** *Standard cost sharing:* You pay $10 per prescription. *Preferred cost sharing:* You pay $6 per prescription.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage (continued) Once you pay the yearly deductible, you move to the 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 4, Section 5 of your *Evidence of Coverage*.	**Tier 3 Preferred Brand** *Standard cost sharing:* You pay 21% of the total cost. *Preferred cost sharing:* You pay 15% of the total cost.	**Tier 3 Preferred Brand** *Standard cost sharing:* You pay 20% of the total cost. *Preferred cost sharing:* You pay 15% of the total cost.
	Tier 4 Non-Preferred drug *Standard cost sharing:* You pay 46% of the total cost. *Preferred cost sharing:* You pay 30% of the total cost.	**Tier 4 Non-Preferred drug** *Standard cost sharing:* You pay 35% of the total cost. *Preferred cost sharing:* You pay 32% of the total cost.
	Tier 5 Specialty *Standard cost sharing*: You pay 25% of the total cost. *Preferred cost sharing*: You pay 25% of the total cost.	**Tier 5 Specialty** *Standard cost sharing*: You pay 25% of the total cost. *Preferred cost sharing*: You pay 25% of the total cost.
	Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).
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.		

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 4, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2
Administrative Changes

Process	2018 (this year)	2019 (next year)
Your plan's preferred pharmacy network is changing for 2019. An updated *Pharmacy Directory* is located on our website at **BasicBlueRx.com.** You may also call Customer Service for updated pharmacy information or to ask us to mail you a *Pharmacy Directory.*	Over 23,000 pharmacies nationwide offer preferred cost sharing for covered drugs.	Over 36,000 pharmacies nationwide offer preferred cost sharing for covered drugs.
Your plan's name	Basic Blue Rx	Basic Blue Rx Standard

SECTION 3
Deciding Which Plan to Choose

Section 3.1 – If You Want to Stay in Basic Blue Rx Standard

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan by December 7, you will automatically stay enrolled as a member of our plan for 2019.

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 2019, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare prescription drug plan;
- – *OR*– You can change to a Medicare health plan. Some Medicare health plans also include Part D prescription drug coverage;
- – *OR*– You can keep your current Medicare health coverage and drop your Medicare prescription drug coverage.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 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 **medicare.gov** and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare prescription drug plan**, enroll in the new plan. You will automatically be disenrolled from Basic Blue Rx Standard.
- To **change to a Medicare health plan,** enroll in the new plan. Depending on which type of plan you choose, you may automatically be disenrolled from Basic Blue Rx Standard.
    - You will automatically be disenrolled from Basic Blue Rx Standard if you enroll in any Medicare health plan that includes Part D prescription drug coverage. You will also automatically be disenrolled if you join a Medicare HMO or Medicare PPO, even if that plan does not include prescription drug coverage.

  - If you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep Basic Blue Rx Standard for your drug coverage. Enrolling in one of these plan types will not automatically disenroll you from Basic Blue Rx Standard. If you are enrolling in this plan type and want to leave our plan, you must ask to be disenrolled from Basic Blue Rx Standard. To ask to be disenrolled, you must send us a written request or contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week (TTY users should call **1-877-486-2048**).

- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, seven 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 prescription drug plan or to a Medicare health plan for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage.*

Note: If you are in a drug management program, you may not be able to change plans.

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. See the list that follows for the SHIP in your state.

The SHIP programs are independent (not connected with any insurance company or health plan). They are state programs that get money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP 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 SHIPs at the information below.

North Carolina Seniors' Health Insurance Information Program (SHIIP) NC Department of Insurance 1201 Mail Service Center Raleigh, NC 27699-1201 Toll-free: **1-855-408-1212** **ncdoi.com/SHIIP**	**Pennsylvania** Apprise Health Insurance Counseling Program Pennsylvania Department of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 Toll-free: **1-800-783-7067** **aging.pa.gov**	**West Virginia** West Virginia SHIP 1900 Kanawha Blvd. East Charleston, WV 25305 Toll-free: **1-877-987-4463** **www.wvship.org**

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 percent 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, seven 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 state-specified programs in the list that follows. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state's program (listed next).

North Carolina Communicable Disease Branch Epidemiology Section Division of Public Health North Carolina Department of Health and Human Services 1902 Mail Service Center Raleigh, NC 27699-1902 Toll-free (in state): **1-877-466-2232** **epi.publichealth.nc.gov/cd/hiv/hmap.html**	**Pennsylvania** Pennsylvania Department of Health, Special Pharmaceutical Benefits Program 625 Forster Street H&W Bldg., Rm 611 Harrisburg, PA 17120 Toll-free: **1-800-922-9384** **adap.directory/pennsylvania**	**West Virginia** West Virginia AIDS Drug Assistance Program 350 Capitol Street, Room 125 Charleston, WV 25301 **304-558-2195** Toll-free HIV/AIDS & STD Hotline: **1-800-642-8244** **dhhr.wv.gov/oeps/std-hiv-hep/HIV_AIDS/caresupport/Pages/ADAP.aspx**

SECTION 7
Questions?

Section 7.1 – Getting Help from Basic Blue Rx Standard

Questions? We're here to help. Please call Customer Service at **1-877-376-2185**. (TTY only, call **711**.) We are available for phone calls 8 a.m. to 8 p.m., daily, local time. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Basic Blue Rx Standard. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* will be separately mailed to you.

Visit our website

You can also visit our website at **BasicBlueRx.com**. As a reminder, our website has the most up-to-date information about our pharmacy network (*Pharmacy 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, seven days a week. TTY users should call **1-877-486-2048**.

Visit the Medicare Website

You can visit the Medicare website (**medicare.gov**). It has information about cost, coverage, and quality ratings to help you compare Medicare prescription drug 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 **medicare.gov** and click on "Review and Compare Your Coverage Options.")

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (**medicare.gov**) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

Basic Blue® Rx (PDP)

A Medicare Prescription Drug Plan

NOTICE OF RIGHTS
NONDISCRIMINATION AND ACCESSIBILITY

Basic Blue® Rx (PDP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Basic Blue Rx does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Basic Blue Rx:

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

If you need these services call customer service at **1-877-376-2185**, daily, 8:00 a.m. to 8:00 p.m. local time (TTY: **711**).

If you believe that Basic Blue Rx 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 in writing to:

Basic Blue Rx Privacy
1750 Yankee Doodle Road, S120
Eagan, MN 55121

You can file a grievance by mail. If you need help filing a grievance, Basic Blue Rx Privacy is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, through one of the following methods:

Electronically through the Office of Civil Rights Complaint Portal	https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
By Mail	U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201
By Phone	1–800–368–1019 800–537–7697 (TDD)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-376-2185 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-376-2185（TTY：711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-376-2185 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-376-2185 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-376-2185 (TTY: 711)번으로 전화해 주십시오.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-376-2185 (رقم هاتف الصم والبكم: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-376-2185 (телетайп: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-376-2185 (TTY (հեռատիպ)՝ 711):

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-376-2185 (TTY: 711) تماس بگیرید.

Japanese: 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。1-877-376-2185（TTY:711）まで、お電話にてご連絡ください。

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-376-2185 (TTY: 711).

Mon-Khmer, Cambodian: របយ័តន៖ បើសិនជាអនកនិយាយ ភាសាខែមរ, សេវាជំនួយែផនកភាសា ដោយមិនគិតឈនួល គឺអាចមានសំរាប់បំរើអនក។ ចូរ ទូរស័ពទ 1-877-376-2185 (TTY: 711)។

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-376-2185 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-376-2185 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-376-2185 (TTY: 711) पर कॉल करें।

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