MASSACHUSETTS

2023 SUMMARY OF BENEFITS

Medicare PPO Blue SaverRx (PPO)

Medicare PPO Blue ValueRx (PPO)

Medicare PPO Blue PlusRx (PPO)

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This booklet gives you a summary of drug and health services covered by Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), and Medicare PPO Blue PlusRx (PPO), and what you pay.

This information is not a complete description of benefits. Call 1-800-200-4255 (TTY: 711) for more information.

To get a complete list of services covered by Blue Cross Blue Shield of Massachusetts, call our Member Service department and ask for the "Evidence of Coverage." You can also access the "Evidence of Coverage" online at our website, bluecrossma.com/medicare.

SUMMARY OF BENEFITS

January 1, 2023 - December 31, 2023

CHOOSE HOW YOU GET YOUR MEDICARE BENEFITS

You can choose to:

- Get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Get your Medicare benefits by joining a Medicare health plan **(such as Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO),** or **Medicare PPO Blue PlusRx (PPO))**.

TIPS FOR COMPARING YOUR MEDICARE CHOICES

- This *Summary of Benefits* booklet gives you an overview of what **Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO),** and **Medicare PPO Blue PlusRx (PPO**) cover, and what you pay.
- To compare our plan with other Medicare health plans' representatives, ask the other plans for their *Summary of Benefits* booklets. Or, use the Medicare Plan Finder on **medicare.gov**.
- To learn more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at **medicare.gov** or get a copy 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**.

SECTIONS IN THIS BOOKLET

- Things to Know About **Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO),** and **Medicare PPO Blue PlusRx (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call Member Service at the number shown in the next section.

THINGS TO KNOW ABOUT OUR PLANS

Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), Medicare PPO Blue PlusRx (PPO)

Contact Information and Hours of Operation	
Members	
October 1–March 31 **1–800–200–4255 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 7 days a week	April 1–September 30 **1–800–200–4255 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 5 days a week, Monday–Friday
If you call after business hours, you may leave a message that includes your name, phone number, and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Service also has free language interpreter services available for non-English speakers.	
Non-Members	
October 1–March 31 **1–800–678–2265 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 7 days a week	April 1–September 30 **1–800–678–2265 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 5 days a week, Monday–Friday
Our website: bluecrossma.com/medicare	

WHO CAN JOIN?

To join Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), or Medicare PPO Blue PlusRx (PPO), you must be eligible for Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You must continue to pay your Medicare Part B premium.

Our service area includes the following counties in Massachusetts: Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), and Medicare PPO Blue PlusRx (PPO) have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

Depending on your plan, you may pay more if you use providers that are not in our network. Out-of-network/non-contracted providers are under no obligation to treat Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), and Medicare PPO Blue PlusRx (PPO) members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can view our plan's provider directory at **bluecrossma.com/medicare**.
- You can view our plan's pharmacy directory at **bluecrossma.com/medicare**.
- Or, call us and we will send you a copy of the provider and pharmacy directories. The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

WHAT DO WE COVER?

We cover everything that Original Medicare covers—and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can view the complete plan formulary (list of Part D prescription drugs) and any restrictions at **bluecrossma.com/medicare-options**.
- Or, call us and we will send you a copy of the formulary. The formulary may change at any time. You will receive notice when necessary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if applicable).

Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call us if you would like more information.

SUMMARY OF BENEFITS:

January 1, 2023 – December 31, 2023

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Monthly Plan Premium	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$0 per month** Worcester County: **$0 per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$75, per month** Worcester County: **$85, per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$254, per month** Worcester County: **$254, per month**
	You must continue to pay your Medicare Part B premium.		
Deductibles			
Medical:	These plans do not have a medical deductible.		
Prescription Drugs:	$0 per year	$0 per year	$200 per year for Tiers 3, 4, 5
Maximum Out-of-Pocket Responsibility (does not include costs related to prescription drugs)	Your yearly limit(s) in this plan: $5,600 for services you receive from in-network providers. $8,950 for services you receive from any provider.	Your yearly limit(s) in this plan: $4,900 for services you receive from in-network providers. $4,900 for services you receive from any provider.	Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers. $5,100 for services you receive from any provider.
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your Medicare Part B premium, your plan premium, and any cost sharing for your Part D prescription drugs.		

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Inpatient Hospital Coverage (Per Admission Benefit)	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-Network:** $390 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond **Out-of-Network:** $440 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-Network:** $325 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond **Out-of-Network:** $350 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day or days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-Network:** $125 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond **Out-of-Network:** 20% of the cost per stay
	Authorization rules may apply.		
Outpatient Hospital Coverage	**In-Network:** $325/visit **Out-of-Network:** 45% of the total cost	**In-Network:** $250/visit **Out-of-Network:** 40% of the total cost	**In-Network:** $150/visit **Out-of-Network:** 20% of the total cost
	Authorization rules may apply.		
Ambulatory Surgery Center	**In-Network:** $275/visit **Out-of-Network:** 45% of the total cost	**In-Network:** $250/visit **Out-of-Network:** 40% of the total cost	**In-Network:** $150/visit **Out-of-Network:** 20% of the total cost
	Authorization rules may apply.		
Doctor's Office Visits: (including telehealth visits)			
Primary Care Provider:	**In-Network:** $0 copay **Out-of-Network:** $25 copay	**In-Network:** $0 copay **Out-of-Network:** $20 copay	**In-Network:** $0 copay **Out-of-Network:** $45 copay

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Specialist:	**In-Network:** $45 copay* **Out-of-Network:** $55 copay	**In-Network:** $40 copay* **Out-of-Network:** $50 copay	**In-Network:** $35 copay* **Out-of-Network:** $45 copay
	*You pay nothing for Medicare-covered specialist services performed in the home furnished by a network provider.		
Preventive Care	You pay nothing	You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** $45 copay or 20% of the cost, depending on the service
	Our plans cover many preventive services, including:		
	• Abdominal aortic aneurysm screening • Alcohol use counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)** • Depression screening • Diabetes screenings • Flu shots, pneumococcal shots, Hepatitis B shots (limitations may apply) • HIV screening • Lung cancer screening (low-dose computed tomography (LDCT))		• Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco-use cessation counseling (counseling for people with no sign of tobacco-related disease) • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit • Any additional preventive services approved by Medicare during the contract year will be covered. You pay $0 for a supplemental annual physical exam. Includes a detailed medical/family history and a head to toe assessment with hands-on examination of all body systems to assess overall general health.
	Authorization rules may apply.		

**If any other medical condition including polyp or other tissue is found and removed during the procedure this would be considered minimally invasive surgery. Refer to the Outpatient Surgery category for appropriate member cost share.

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Emergency Care	$90 copay	$90 copay	$75 copay
	Your copay is waived if you are admitted to the hospital within 24 hours or held overnight for observation.		
Urgently Needed Services (including telehealth visits)	In-Network: $0-$45 copay* Out-of-Network: $55 copay	In-Network: $0-$40 copay* Out-of-Network: $50 copay	In-Network: $0-$35 copay* Out-of-Network: $45 copay
	*You pay nothing for Medicare-covered specialist services performed in the home furnished by a network provider.		
Diagnostic Services/Labs/Imaging			
Diagnostic Radiology (such as MRIs, CT scans):	In-Network: $365 copay per day per category Out-of-Network: $375 copay per day per category	In-Network: $250 copay per day per category Out-of-Network: $325 copay per day per category	In-Network: $150 copay per day per category Out-of-Network: 40% of the cost per day per category
	Authorization rules may apply.		
Diagnostic Tests and Procedures	In-Network: $0 copay per day* Out-of-Network: 45% of the cost	In-Network: $0 copay per day* Out-of-Network: 40% of the cost	In-Network: $10 copay per day* Out-of-Network: 20% of the cost
	*You pay nothing for covered services performed at home by a network provider. Authorization rules may apply.		
Lab Services:	In-Network: $0 copay per day* Out-of-Network: 45% of the cost	In-Network: $0 copay per day* Out-of-Network: 40% of the cost	In-Network: $10 copay per day* Out-of-Network: 20% of the cost
	*You pay nothing for Medicare-covered services performed at home by a network provider Authorization rules may apply.		
Outpatient X-rays:	In-Network: $10 copay per day Out-of-Network: 45% of the cost	In-Network: $10 copay per day Out-of-Network: 40% of the cost	In-Network: $10 copay per day Out-of-Network: 20% of the cost
	Authorization rules may apply.		
Therapeutic Radiology Services:	In-Network: $60 copay per visit Out-of-Network: 45% of the cost	In-Network: You pay nothing Out-of-Network: 40% of the cost	In-Network: You pay nothing Out-of-Network: 20% of the cost
	Authorization rules may apply.		

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Hearing Services			
Routine Exam: (up to 1 every 12 months)	**In-Network:** $0 copay **Out-of-Network:** $45 copay	**In-Network:** $0 copay **Out-of-Network:** $45 copay	**In-Network:** $0 copay **Out-of-Network:** $45 copay
Non-Routine Exam:	**In-Network:** $0-$45 copay **Out-of-Network:** $25-$55 copay	**In-Network:** $0-$40 copay **Out-of-Network:** $20-$50 copay	**In-Network:** $0-$35 copay **Out-of-Network:** $45 copay
Hearing Aids:	$699-$999 copay per hearing aid per year	$699-$999 copay per hearing aid per year	$699-$999 copay per hearing aid per year
	You must use a TruHearing™ network provider for all routine hearing exams and the purchase of covered hearing aids. There is no coverage for out-of-network providers.		
Dental Services			
Limited Medicare-Covered Dental Services:	**In-Network:** $45 copay. **Out-of-Network:** $55 copay.	**In-Network:** You pay $40 copay. **Out-of-Network:** You pay a $50 copay.	**In-Network:** $35 copay **Out-of-Network:** You pay $45 copay.
Dental services—Non-Medicare Covered	**Non-Medicare Covered Dental Services:**		
	In-Network: $0 copay for covered preventive services 50% coinsurance for covered comprehensive services **Out-of-Network:** $60 copay for covered preventive services 50% coinsurance for covered comprehensive services	**In-Network:** $0 copay for covered preventive services 50% coinsurance for covered comprehensive services **Out-of-Network:** $50 copay for covered preventive services 50% coinsurance for covered comprehensive services	**In-Network:** You pay $0 copay. **Out-of-network:** You pay a $45 copay. Coverage for preventive services only. Maximum of two visits each calendar year. See Evidence of Coverage for more details.
	$1,000 maximum per calendar year for preventive and comprehensive services combined. See Evidence of Coverage for more details.		

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Vision Services			
Medicare-Covered Eye Exam:	In-Network: $0-$45 copay Out-of-Network: $25-$55 copay	In-Network: $0-$40 copay Out-of-Network: $20-$50 copay	In-Network: $0-$35 copay Out-of-Network: $45 copay
Eyewear After Cataract Surgery: (for Medicare-covered standard eyewear)	In and Out-of-Network: $0 copay	In and Out-of-Network: $0 copay	In and Out-of-Network: $0 copay
Routine Eye Exam: (up to 1 per 12 months)	In-Network: $0 copay Out-of-Network: $45 copay	In-Network: $0 copay Out-of-Network: $45 copay	In-Network: $0 copay Out-of-Network: $45 copay
	You must use an EyeMed network provider for covered in-network services.		
Eyewear: (For Covered Eyewear, you pay any balance in excess of the $200 limit.)	In and Out-of-Network: Our plan pays up to $200 every 24 months for eyewear	In and Out-of-Network: Our plan pays up to $200 every 24 months for eyewear	In and Out-of-Network: Our plan pays up to $200 every 24 months for eyewear
	You must use an EyeMed® network provider for covered in-network services.		
Mental Health Services			
Inpatient Visit: (per admission)	In-Network: $300 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Out-of-Network: $400 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	In-Network: $275 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Out-of-Network: $325 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	In-Network: $125 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Out-of-Network: 20% of the cost per stay
	Authorization rules may apply per admission.		

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Outpatient Group Therapy Visit:	**In-Network:** $30 copay **Out-of-Network:** $40 copay	**In-Network:** $30 copay **Out-of-Network:** $40 copay	**In-Network:** $25 copay **Out-of-Network:** 20% of the cost
	Authorization rules may apply.		
Outpatient Individual Therapy Visit: (including telehealth visits)	**In-Network:** $30 copay* **Out-of-Network:** $40 copay	**In-Network:** $30 copay* **Out-of-Network:** $40 copay	**In-Network:** $25 copay* **Out-of-Network:** 20% of the cost
	*You pay nothing for Medicare-covered services performed at home by a network provider. Authorization rules may apply.		
Additional Services			
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. **In-Network:** You pay nothing per day for days 1 through 20 $170 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100 **Out-of-Network:** 20% of the cost per stay	Our plan covers up to 100 days in a SNF. **In-Network:** You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100 **Out-of-Network:** 20% of the cost per stay	Our plan covers up to 100 days in a SNF. **In-Network:** You pay nothing per day for days 1 through 20 $100 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100 **Out-of-Network:** 20% of the cost per stay
	Authorization rules may apply.		
Physical Therapy	**In-Network:** $40 copay **Out-of-Network:** 45% of the cost	**In-Network:** $20 copay **Out-of-Network:** 40% of the cost	**In-Network:** $15 copay **Out-of-Network:** 20% of the cost
Ambulance	**In-Network:** $275 copay per trip **Out-of-Network:** $275 copay per trip	**In-Network:** $225 copay per trip **Out-of-Network:** $225 copay per trip	**In-Network:** $100 copay per trip **Out-of-Network:** $100 copay per trip
	If you are admitted to the hospital, you do not have to pay for the ambulance services. Authorization rules may apply.		
Transportation (Including chair vans)	Not covered	Not covered	Not covered

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Medicare Part B Drugs (Including chemotherapy)	**In and Out-of-Network:** 20% co-insurance	**In and Out-of-Network:** 20% co-insurance	**In and Out-of-Network:** 10% co-insurance
	Authorization rules may apply. Select Part B drugs are subject to step therapy restrictions.		
Foot Care (Podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-Network:** $0-$45 copay **Out-of-Network:** $25-$55 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-Network:** $0-$40 copay **Out-of-Network:** $20-$50 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **In-Network:** $0-$35 copay **Out-of-Network:** $45 copay
Diabetes Supplies and Services*			
Diabetes Monitoring Supplies:	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** 20% of the cost
	Authorization rules may apply.		
Diabetes Self-Management Training:	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** 20% of the cost
Therapeutic Shoes or Inserts:	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** You pay nothing	**In-Network:** You pay nothing **Out-of-Network:** 20% of the cost

*There is no co-insurance or copayment for the One Touch®′ blood glucose test strips and blood glucose monitors purchased at participating retail and mail service pharmacies; otherwise you pay all costs. Test strips and blood glucose monitors are also available at DME suppliers with no co-insurance or copayment. There is no co-insurance or copayment for members eligible for covered therapeutic molded shoes and inserts, diabetes self-management training preventive benefit, or fasting plasma glucose tests.

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 10% of the cost **Out-of-Network:** 20% of the cost
	Authorization rules may apply.		
Prosthetic Devices (braces, artificial limbs, etc.)			
Prosthetic Devices:	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 10% of the cost **Out-of-Network:** 20% of the cost
Related Medical Supplies:	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 20% of the cost	**In-Network:** 10% of the cost **Out-of-Network:** 20% of the cost
Over-the-counter items (OTC)	**In-network:** Our plan pays up to $65 per quarter (up to $260 per year) changes, towards over-the-counter health & wellness products. **Out-of-network:** The in-network provider must be used for the OTC items benefit.	Not covered.	Not covered.
	CVS will manage the OTC benefit. See the OTC catalog for a list of eligible items. Be sure to use your benefits amount before the end of each quarter (March, June, September, December). Remaining benefit does not roll over. Purchase OTC items by mail, phone, or in participating CVS retail stores. You can find the catalog at **cvs.com/otchs/bcbsma.** If you have questions or to order by phone, please call **1-888-628-2770** (TTY:**711**) Monday – Friday 9:00 a.m. to 8:00 p.m. ET.		
Wellness Programs (See back of this booklet for more details)			
Fitness:	$150 per calendar year	$150 per calendar year	$250 per calendar year
Weight Loss:	$150 per calendar year	$150 per calendar year	$150 per calendar year

WELLNESS PROGRAMS

Medicare PPO Blue SaverRx (PPO), Medicare PPO Blue ValueRx (PPO), Medicare PPO Blue PlusRx (PPO)

Take Control of Your Health With Our Fitness and Weight-Loss Benefits

WHAT IS THE FITNESS BENEFIT?

Enroll in a qualified health club or fitness facility and receive up to $250 per calendar year toward your club membership fees and exercise classes.

WHAT IS THE WEIGHT-LOSS BENEFIT?

Enroll in a qualified weight-loss program and receive up to $150 per calendar year toward your program fees. Employer group benefits may vary.

WHAT PROGRAMS QUALIFY?

- Virtual/online fitness memberships, subscriptions, programs, or classes that provide cardiovascular and strength training using a digital platform
- Home Fitness Equipment like stationary bikes, weights, exercise bands, treadmills, fitness machines.
- Home Fitness Equipment WILL NOT cover wearable fitness trackers or items that are considered "Recreational Equipment" or "Sports Equipment" examples include kayaks, inline skates, bicycles, ice skates, trampolines, fitness clothing, sneakers
- Health clubs with a variety of cardiovascular and strength-training exercise equipment, e.g., traditional health clubs, YMCAs, YWCAs, and community fitness centers or facilities that only have a pool.
- Fitness classes at participating Councils on Aging (COA) facilities; fitness studios with instructor-led groups such as yoga, Pilates, Zumba®, kickboxing, CrossFit®, and indoor cycling/spinning and other exercise classes.
- Programs that DO NOT qualify: Martial arts centers; gymnastics facilities; country clubs; tennis, aerobic; social clubs; and sports teams/leagues. You cannot receive the Fitness Benefit for personal training, lessons, coaching, or clothing.

WHAT KINDS OF PROGRAMS QUALIFY?

- Traditional WW (formerly known as Weight Watchers®) meetings, WW Online and At Work programs, hospital-based and other non-hospital-based weight-loss programs that combine healthy eating, exercise, and coaching sessions.
- Programs that DO NOT qualify: Individual nutrition counseling sessions, pre-packaged meals, books, videos, scales, or other items and supplies.

REWARDING YOU FOR HEALTHY CHOICES

GET REIMBURSED UP TO $300 PER YEAR WHEN YOU ENROLL IN QUALIFIED FITNESS AND WEIGHT-LOSS PROGRAMS.

$150-250

FITNESS REIMBURSEMENT

$150

WEIGHT-LOSS REIMBURSEMENT

PRESCRIPTION DRUG BENEFITS

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRX (PPO)
Deductible	$0 per year	$0 per year	$200 per year for Tiers 3, 4, 5
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail service pharmacies.		
Tier 1 = Preferred Generic Tier 2 = Generic Tier 3 = Preferred Brand Tier 4 = Non-Preferred Drug		Tier 5 = Specialty Tier Note: Cost sharing may differ relative to the pharmacy's status as preferred or standard, mail service, Long-Term Care (LTC) or home infusion, and 30-day or 90-day supply.	

	Medicare PPO Blue SaverRx (PPO)			Medicare PPO Blue ValueRx (PPO)			Medicare PPO Blue PlusRx (PPO)		
Preferred Retail Cost Sharing									
Drug Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$30 copay	$6 copay	$12 copay	$18 copay	$5 copay	$10 copay	$15 copay
Tier 3 (Preferred Brand)	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay
Select Insulin	$35	$70	$105	$35	$70	$105	$35	$70	$105
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
Tier 5 (Specialty Tier)	30% of the cost	N/A	N/A	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A

	Medicare PPO Blue SaverRx (PPO)			Medicare PPO Blue ValueRx (PPO)			Medicare PPO Blue PlusRx (PPO)		
Standard Retail Cost Sharing									
Drug Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$10 copay	$20 copay	$30 copay	$8 copay	$16 copay	$24 copay	$6 copay	$12 copay	$18 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay	$12 copay	$24 copay	$36 copay	$10 copay	$20 copay	$30 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Select Insulin	$35	$70	$105	$35	$70	$105	$35	$70	$105
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	30% of the cost	N/A	N/A	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A
Mail Service Cost Sharing									
Drug Tier	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$20 copay	$6 copay	$12 copay	$12 copay	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$42 copay	$84 copay	$84 copay	$42 copay	$84 copay	$84 copay	$42 copay	$84 copay	$84 copay
Select Insulin	$35	$70	$70	$35	$70	$70	$35	$70	$70
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay
Tier 5 (Specialty Tier)	30% of the cost	N/A	N/A	28% of the cost	N/A	N/A	29% of the cost	N/A	N/A
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy.								
	You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.								

	Medicare PPO Blue SaverRx (PPO)	Medicare PPO Blue ValueRx (PPO)	Medicare PPO Blue PlusRx (PPO)
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it's important that you fully understand our benefits and rules. We've put together the checklist below to help you. If you have any questions, you can call and speak to a customer service representative.

Understanding the Benefits	
☐	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **bluecrossma.com/medicare** or call **1-800-678-2265** (TTY: **711**) April 1 through September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday. October 1 through March 31, 8:00 a.m. to 8:00 p.m. ET, seven days a week to view a copy of the EOC.
☐	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
☐	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
☐	Review the formulary to make sure your drugs are covered.
Understanding Important Rules	
☐	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
☐	Benefits, premiums, and/or copayments/co-insurance may change on January 1, 2024.
☐	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

CALL US: 1-800-678-2265 (TTY: 711)

April 1 through September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.
October 1 through March 31, 8:00 a.m. to 8:00 p.m. ET, seven days a week.

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Contact Information and Hours of Operation

Members

October 1–March 31
1–800–200–4255 (TTY: 711)
8:00 a.m. to 8:00 p.m., 7 days a week

April 1–September 30
1–800–200–4255 (TTY: 711)
8:00 a.m. to 8:00 p.m., 5 days a week, Monday–Friday

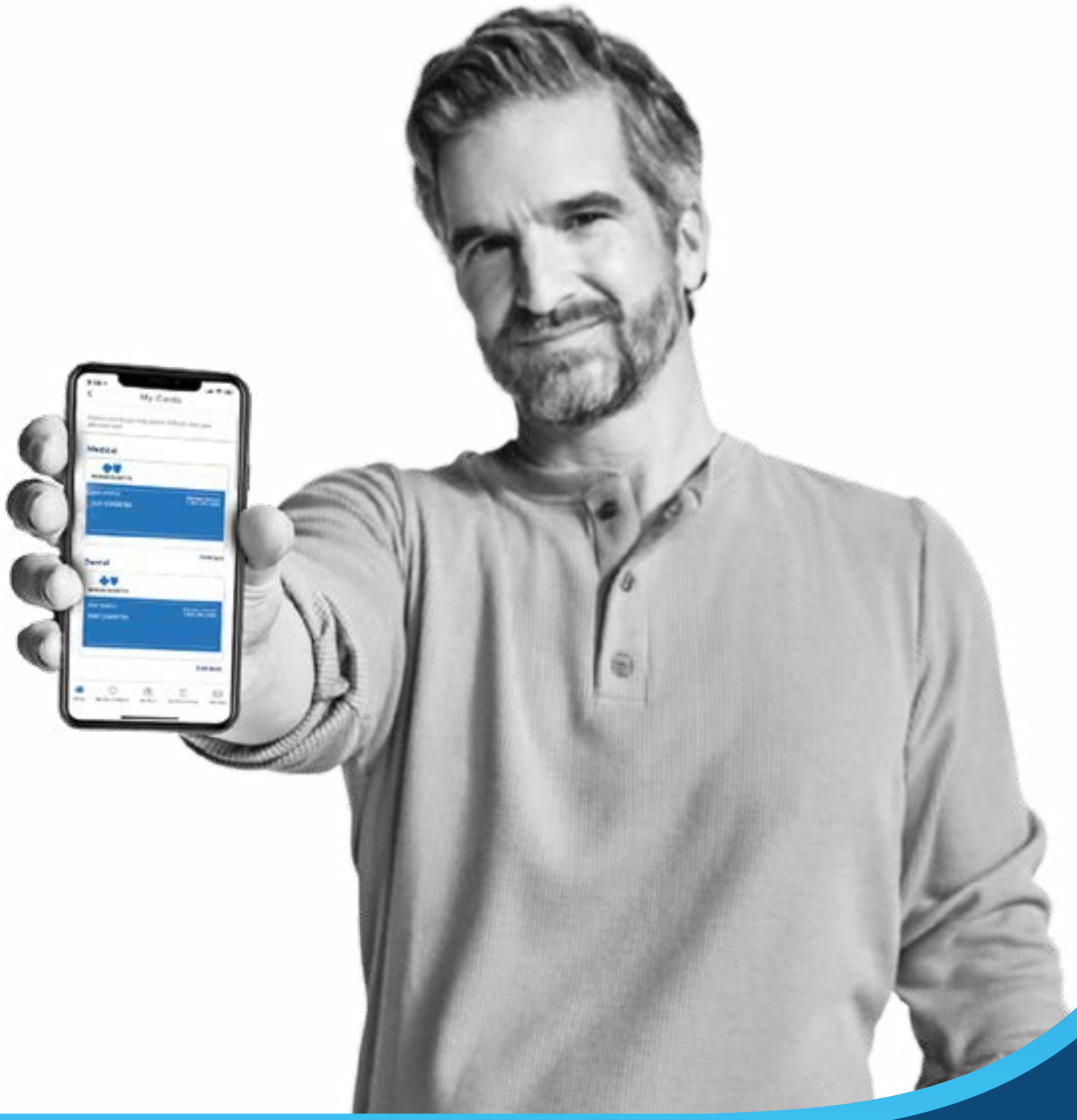
If you call after business hours, you may leave a message that includes your name, phone number, and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Service also has free language interpreter services available for non-English speakers.

Non-Members

October 1–March 31
1–800–678–2265 (TTY: 711)
8:00 a.m. to 8:00 p.m., 7 days a week

April 1–September 30
1–800–678–2265 (TTY: 711)
8:00 a.m. to 8:00 p.m., 5 days a week, Monday–Friday

Our website: bluecrossma.com/medicare



GET THE MYBLUE APP

YOU CAN DOWNLOAD THE MYBLUE APP FROM THE APP STORE℠ OR GOOGLE PLAY™

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Medicare Advantage Appeals and Grievance Manager.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Medicare Advantage Appeals and Grievance Manager by mail at P.O. Box 55007, Boston, MA 02205; phone at **1-800-200-4255** (TTY: **711**) from April 1 through September 30, 30, 8:00 a.m. to 8:00 p.m., Monday through Friday, or October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week; fax at **617-246-8506**; or email at **MedicareAdvantageRXAppeals@bcbsma.com**. You can file a grievance in person, by mail, fax, email, or you can call **1-800-200-4255** (TTY: **711**).

If you need help filing a grievance, the Medicare Advantage Appeals and Grievance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697** (TDD).

Complaint forms are available at **hhs.gov**.

MASSACHUSETTS

TRANSLATION RESOURCES

Form Approved OMB# 0938-1421

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-200-4255**. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-200-4255**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-200-4255。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-200-4255**。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-200-4255**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-200-4255**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-200-4255** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-200-4255**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-200-4255** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-200-4255**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-200-4255** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-200-4255** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-200-4255**. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-200-4255**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-200-4255**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-200-4255**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-200-4255** にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

NOTES

FOR MORE INFORMATION OR HELP WITH ENROLLMENT

Medicare Plan Sales

1-800-678-2265 (TTY: **711**)

April 1 through September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

October 1 through March 31, 8:00 a.m. to 8:00 p.m. ET, seven days a week.

bluecrossma.com/medicare

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

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