MASSACHUSETTS

2024 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 (EOC). You can also access the EOC online at our website, bluecrossma.com/medicare.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

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, Medicare PPO Blue ValueRx,** or **Medicare PPO Blue PlusRx)**.

TIPS FOR COMPARING YOUR MEDICARE CHOICES

- This *Summary of Benefits* booklet gives you an overview of what **Medicare PPO Blue SaverRx, Medicare PPO Blue ValueRx,** and **Medicare PPO Blue PlusRx** 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, Medicare PPO Blue ValueRx,** and **Medicare PPO Blue PlusRx**
- 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, Medicare PPO Blue ValueRx, or Medicare PPO Blue PlusRx, 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, Medicare PPO Blue ValueRx, and Medicare PPO Blue PlusRx 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, Medicare PPO Blue ValueRx, and Medicare PPO Blue PlusRx 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 prior authorization 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, 2024 – December 31, 2024

	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: **$72, per month** Worcester County: **$82, per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$238, per month** Worcester County: **$238, 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:** $275/visit **Out-of-Network:** 45% of the total cost	**In-Network:** $200/visit **Out-of-Network:** 40% of the total cost	**In-Network:** $100/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: (telehealth services are only available at in-network providers)			
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) • Annual 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 Out-of-Network: $375 copay per day	In-Network: $250 copay per day Out-of-Network: $325 copay per day	In-Network: $150 copay per day Out-of-Network: 40% of the cost per day
	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	**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. Telehealth services are only available at in-network providers.		
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:** $20 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:** 0-20% co-insurance	**In and Out-of-Network:** 0-20% co-insurance	**In and Out-of-Network:** 0-10% 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
	Authorization rules may apply.		

*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 Authorization rules may apply.	**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
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
Additional Allowances			
Over-the-counter items (OTC)	Our plan pays up to $250 per quarter (up to $1,000 per year) toward the purchase of personal health and wellness items from our participating retailers. The quarterly allowance does not roll over from quarter to quarter. Funds will be available on the Flex Card.	Not covered.	Not covered.
Fitness:	$250 per calendar year on your Flex Card	$250 per calendar year on your Flex Card	$250 per calendar year on your Flex Card
Weight Loss:	$250 per calendar year on your Flex Card	$250 per calendar year on your Flex Card	$150 per calendar year on your Flex Card
Dental/Vision/Hearing Allowance:	Our plan covers up to $600 per year for additional dental, vision and/or hearing expenses. Funds will be loaded to the Flex Card.	Our plan covers up to $700 per year for additional dental, vision and/or hearing expenses. Funds will be loaded to the Flex Card.	Not covered.

WELLNESS PROGRAMS

Medicare PPO Blue SaverRx, Medicare PPO Blue ValueRx, Medicare PPO Blue PlusRx

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. Funds will be automatically loaded onto your Flex Card.

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 IS THE WEIGHT-LOSS BENEFIT?

Enroll in a qualified weight-loss program and receive up to $250 per calendar year toward your program fees. Employer group benefits may vary. Funds will be automatically loaded onto your Flex Card.

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

Enroll in qualified fitness and weight-loss programs and get up to $500 in combined fitness and weight-loss allowance.

$250

Fitness Allowance

$150-$250

Weight-Loss Allowance

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 $5,030. 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.		

	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
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)	33% of the cost	N/A	N/A	33% of the cost	N/A	N/A	29% of the cost	N/A	N/A
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

	Medicare PPO Blue SaverRx (PPO)			Medicare PPO Blue ValueRx (PPO)			Medicare PPO Blue PlusRx (PPO)		
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
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)	33% of the cost	N/A	N/A	33% 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
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)	33% of the cost	N/A	N/A	33% 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 $5,030. 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 $8,000, 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 $8,000, you pay nothing for your covered Part D 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, 2025.
☐	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.
Effect on Current Coverage	
☐	Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

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™

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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