MASSACHUSETTS

Medicare PPO Blue SaverRx (PPO) offered by Blue Cross Blue Shield of Massachusetts

Annual Notice of Changes for 2021

<Date
First Name Last Name
Street Address_1
Street Address_2
City, State, Zip>

You are currently enrolled as a member of Medicare PPO Blue SaverRx. 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 1.5 and 1.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket

costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ 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 www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 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 don't join another plan by December 7, 2020, you will be enrolled in Medicare PPO Blue SaverRx.
- 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, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Medicare PPO Blue SaverRx.

- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021.** You will be automatically disenrolled from your current plan.
- **Additional Resources**
- Please contact our Member Services number at 1-800-200-4255 for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30.
- This information is available in alternate formats such as large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *Medicare PPO Blue SaverRx*

- 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.
- When this booklet says "we," "us," or "our," it means *Blue Cross Blue Shield of Massachusetts*. When it says "plan" or "our plan," it means *Medicare PPO Blue SaverRx*.

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Medicare PPO Blue SaverRx in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.bluecrossma.com/medicare-options. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $6,700 From network and out-of-network providers combined: $6,700	From network providers: $7,550 From network and out-of-network providers combined: $7,550
Doctor office visits	**In-Network and Out-of-Network:** Primary care visits: $25 copay per visit Specialist visits: $45 copay per visit	**In-Network:** Primary care visits: $10 copay per visit Specialist visits: $45 copay per visit **Out-of-Network:** Primary care visits: $25 copay per visit Specialist visits: $55 copay per visit

Cost	2020 (this year)	2021 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-Network and Out-of-Network:** Per admission ▪ Days 1-5: $350 copay per day ▪ Days 6 and beyond: $0 copay per day	**In-Network:** Per admission ▪ Days 1-5: $390 copay per day ▪ Days 6 and beyond: $0 copay per day **Out-of-Network:** Per admission ▪ Days 1-5: $440 copay per day ▪ Days 6 and beyond: $0 copay per day

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $405 for tiers 3, 4, and 5 Copays during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $10 • Drug Tier 2: $16 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 25% coinsurance Preferred cost-sharing: • Drug Tier 1: $4 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 4: $95 • Drug Tier 5: 25% coinsurance	Deductible: $405 for tiers 3, 4, and 5 Copays during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $10 • Drug Tier 2: $16 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 25% coinsurance • Drug Tier 6: $5 Preferred cost-sharing: • Drug Tier 1: $2 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 4: $95 • Drug Tier 5: 25% coinsurance • Drug Tier 6: $0

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you 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. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2020 (this year)	2021 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$6,700	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.bluecrossma.com/findadoctor. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2021 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.bluecrossma.com/medicare-options. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

	2020 (this year)	2021 (next year)
Ambulance services	**In-Network and Out-of-Network:** You pay a $250 copayment for each one-way trip for Medicare-covered ambulance services.	**In-Network and Out-of-Network:** You pay a $275 copayment for each one-way trip for Medicare-covered ambulance services.
Cardiac Rehabilitation services	**In-Network and Out-of-Network:** You pay a $45 copayment for each visit for Medicare-covered cardiac rehabilitation services.	**In-Network:** You pay a $45 copayment for each visit for Medicare-covered cardiac rehabilitation services. **Out-of-Network:** You pay 45% of the cost for Medicare-covered cardiac rehabilitation services.

	2020 (this year)	2021 (next year)
Chiropractic services	**In-Network and Out-of-Network:** You pay a $20 copayment for each visit for Medicare-covered services.	**In-Network:** You pay a $20 copayment for each visit for Medicare-covered services. **Out-of-Network:** You pay 45% of the cost for each visit for Medicare-covered services.
Dental services – preventive routine services	**In-Network and Out-of-Network:** You pay a $60 copayment for each office visit for covered preventive dental services. Covered preventive routine services limited to one visit every six months.	**In-Network** There is no coinsurance or copayment for covered preventive dental services. **Out-of-Network:** You pay a $60 copayment for each office visit for covered preventive dental services. Covered preventive routine services limited to two visits every calendar year.
Hearing Services – routine exams and hearing aids	**In-Network and Out-of-Network:** No coverage for routine hearing exams or hearing aids	**In-Network:** There is no coinsurance or copayment for routine hearing exams or related hearing tests by a TruHearing provider. You must use a TruHearing provider for routine hearing exams and related hearing tests.

	2020 (this year)	2021 (next year)
		For hearing aids, you pay $699 copayment per aid for Advanced Aids or $999 copayment per aid for Premium Aids. Up to two TruHearing-branded hearing aids every 23 months (one per ear).. Benefit is limited to TruHearing's Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit. **Out-of-Network:** You pay a $45 copayment for each office visit for covered routine hearing exams. Hearing aids are not covered.
Home Health agency care	**In-Network and Out-of-Network:** There is no coinsurance or copayment for Medicare-covered home health agency care.	**In-Network:** There is no coinsurance or copayment for Medicare-covered home health agency care. **Out-of-Network:** You pay 45% of the cost for Medicare-covered home health agency care.
Immunization	**In-Network and Out-of-Network:** There is no coinsurance or copayment for the pneumonia, influenza, and	**In-Network and Out-of-Network:** There is no coinsurance or copayment for the pneumonia, influenza, and

	2020 (this year)	2021 (next year)
	Hepatitis B vaccines.	Hepatitis B vaccines. There is no coinsurance or copayment for a COVID-19 vaccine (when developed and approved for distribution.
Inpatient hospital care	**In-Network and Out-of-Network:** You pay a $350 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay.	**In-Network:** You pay a $390 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay. **Out-of-Network:** You pay a $440 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay.
Inpatient mental health care	**In-Network and Out-of-Network:** You pay a $300 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay.	**In-Network:** You pay a $300 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay. **Out-of-Network:** You pay a $400 copayment for each day in a hospital for the first five days; you pay $0 for each day after day 5 for each inpatient stay.

	2020 (this year)	2021 (next year)
Meals Program - Post Hospitalization After a discharge from an inpatient stay at a hospital, you may be eligible to have up to eight weeks (five days per week, two meals per day for 40 days per calendar year) of fully-prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, the Blue Cross Blue Shield (BCBS) care management team will coordinate your meal benefit with your health care provider to determine if it meets the criteria to receive medically tailored meals. (Meals must be ordered by a licensed health care provider or a BCBS care manager). If the criteria is met, meals are prepared and delivered to your home by a plan approved vendor at no cost.	Not covered.	**In-Network:** There is no coinsurance or copayment for Meals Post-Hospitalization. **Out-of-network:** Not covered.
Opioid Treatment Program	**In-Network and Out-of-Network:** There is no coinsurance or copayment for dispensing and administering of Opioid Treatment Program (OTP) covered medications. You pay a $40 copayment for each visit for Medicare-covered OTP outpatient mental health services.	**In-Network and Out-of-Network:** There is no coinsurance or copayment for each visit for Medicare-covered OTP outpatient mental health services.

	2020 (this year)	2021 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network and Out-of-Network:** You pay $60 copayment for each visit for radiation therapy. For x-rays, laboratory and other diagnostic tests you pay a $10 copayment for each category per service date. For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $325 copayment for each category of test for each service date	**In-Network:** You pay $60 copayment for each visit for radiation therapy. Your network provider may be required to obtain prior authorization before you receive radiation therapy services. For x-rays, laboratory and other diagnostic tests you pay a $10 copayment for each category per service date. There is no coinsurance or copayment for covered labs and tests performed in the home by a network physician or nurse practitioner or at a mobile unit. For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $325 copayment for each category of test for each service date. **Out-of-Network:** You pay 45% of the cost of radiation therapy. For x-rays, laboratory and other diagnostic tests you pay 45% of the cost. For CT scans, MRIs, PET scans, and

	2020 (this year)	2021 (next year)
		nuclear cardiac imaging tests, you pay a $375 copayment for each category of test for each service date.
Outpatient hospital observation	**In-Network and Out-of-Network:** There is no coinsurance or copayment for outpatient hospital observation.	**In-Network:** You pay a $325 copayment per visit for outpatient hospital observation. **Out-of-Network:** You pay 45% of the cost for Medicare-covered outpatient hospital observation.
Outpatient mental health	**In-Network:** You pay a $40 copayment for each visit for Medicare-covered outpatient mental health services.	**In-Network:** You pay a $40 copayment for each office visit or telehealth visit for Medicare-covered outpatient mental health services. You pay nothing for Medicare covered outpatient mental health services performed in the home by a network provider.
Outpatient rehabilitation services	**In-Network and Out-of-Network:** You pay a $40 copayment for each visit for Medicare-covered	**In-Network:** You pay a $40 copayment for each visit for Medicare-covered outpatient rehabilitation services.

	2020 (this year)	2021 (next year)
	outpatient rehabilitation services.	**Out-of-Network:** You pay 45% of the cost for Medicare-covered outpatient rehabilitation services.
Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network and Out-of-Network:** You pay a $25 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to a specialist. For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a $300 copayment for the surgical visit.	**In-Network:** You pay a $10 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to a specialist. For Medicare-covered outpatient surgery performed in a hospital you pay a $325 copayment for the surgical visit. For Medicare-covered outpatient surgery performed in an ambulatory surgical center, you pay $275 copayment for the surgical visit. **Out-of-Network:** You pay a $25 copayment for each office visit to a primary care provider, or a $55 copayment for each office visit to other providers. For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay 45% of the cost.

	2020 (this year)	2021 (next year)
Partial hospitalization	**In-Network and Out-of-Network:** You pay a $55 copayment for each visit for Medicare-covered partial hospitalization services that are not directly provided by a physician.	**In-Network:** You pay a $55 copayment for each visit for Medicare-covered partial hospitalization services that are not directly provided by a physician. **Out-of-Network:** You pay 45% of the cost for partial hospitalization services that are not directly provided by a physician.
Physician/Practitioner services, including doctor's office visits	**In-Network and Out-of-Network:** You pay a $25 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to other providers. For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a $300 copayment for the surgical visit.	**In-Network:** You pay a $10 copayment for each office visit or telehealth visit to your POC, or other primary care provider, or a $45 copayment for each office visit or telehealth visit to other providers. Member cost sharing does not differ from in-person visits for covered telehealth services. You pay nothing for Medicare covered physician specialist services performed in the home. For Medicare-covered outpatient surgery performed in a hospital you pay a $325 copayment for the surgical visit. For Medicare-covered outpatient surgery performed in an

	2020 (this year)	2021 (next year)
		ambulatory surgical center, you pay $275 copayment for the surgical visit. **Out-of-Network:** You pay a $25 copayment for each office visit to a primary care provider, or a $55 copayment for each office visit to other providers. You pay 45% of the cost for Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center. Telehealth services are not covered. You pay all charges.
Podiatry services	**In-Network and Out-of-Network:** You pay a $25 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to other providers for Medicare-covered services. For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a $300 copayment for the surgical visit.	**In-Network:** You pay a $10 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to other providers for Medicare-covered services. For Medicare-covered outpatient surgery performed in a hospital you pay a $325 copayment for the surgical visit. For Medicare-covered outpatient surgery performed in an

	2020 (this year)	2021 (next year)
		ambulatory surgical center, you pay $275 copayment for the surgical visit. **Out-of-Network:** You pay a $25 copayment for each office visit to a primary care provider, or a $55 copayment for each office visit to other providers. For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center you pay 45% of the cost.
Pulmonary rehabilitation services	**In-Network and Out-of-Network:** You pay a $30 copayment for each visit for Medicare-covered pulmonary rehabilitation services.	**In-Network:** You pay a $30 copayment for each visit for Medicare-covered pulmonary rehabilitation services. **Out-of-Network:** You pay 45% of the cost for Medicare-covered pulmonary rehabilitation services.
Services to treat kidney disease	**In-Network and Out-of-Network:** There is no coinsurance or copayment for Medicare-covered kidney disease education services. You pay 20% of the cost for Medicare-covered outpatient dialysis services	**In-Network:** There is no coinsurance or copayment for Medicare-covered kidney disease education services. You pay 20% of the cost for Medicare-covered outpatient dialysis services to treat kidney disease and conditions.

	2020 (this year)	2021 (next year)
	to treat kidney disease and conditions.	**Out-of-Network:** You pay 45% of the cost for Medicare-covered kidney disease education services. You pay 20% of the cost for Medicare-covered outpatient dialysis services to treat kidney disease and conditions.
Supervised Exercise Therapy (SET)	**In-Network and Out-of-Network:** You pay a $30 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.	**In-Network:** You pay a $30 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease. **Out-of-Network:** You pay 45% of the cost for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.

	2020 (this year)	2021 (next year)
Urgently needed services	**In-Network and Out-of-Network:** You pay a $25 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to other providers for urgently needed services.	**In-Network:** You pay a $10 copayment for each office visit or telehealth visit to your POC, or other primary care provider, or a $45 copayment for each office visit or telehealth visit to other providers for urgently needed services. You pay nothing for covered urgently needed services performed in the home by a network provider. **Out-of-Network:** You pay a $55 copayment for each visit to providers for urgently needed services. Telehealth services are not covered. You pay all charges.

	2020 (this year)	2021 (next year)
Vision – Medicare-covered	**In-Network and Out-of-Network:** You pay a $25 copayment for each office visit to your POC, or other primary care provider, or a $45 copayment for each office visit to other providers. For covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a $300 copayment for the surgical visit.	**In-Network:** You pay a $10 copayment for each office visit to your POC, or a $45 copayment for each office visit to other providers. For Medicare-covered outpatient surgery performed in a hospital you pay a $325 copayment for the surgical visit. For Medicare-covered outpatient surgery performed in an ambulatory surgical center, you pay $275 copayment for the surgical visit. **Out-of-Network:** You pay a $25 copayment for each office visit to a primary care provider. You pay a $55 copayment for each office visit to other providers. You pay 45% of the cost for Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center.

	2020 (this year)	2021 (next year)
Vision- Routine exams and Eyewear • Routine refractive eye exams once every 12 months. • Prescription eyewear once every 24 months up to a $200 maximum, including: – Eyeglasses: Single vision, bifocal, trifocal, or progressive spectacle lenses, and/or frames (includes fittings and dispensing fees); *or* Contact lenses (including contact lens evaluation, fittings and dispensing fees)	**In-Network and Out-of-Network:** Not covered.	**In-Network:** You pay nothing for a covered routine eye exam with EyeMed vision providers. For covered eyewear, you pay any balance in excess of the $200 every 24 months limit. **Out-of-Network:** For a covered routine eye exam, you pay a $45 copayment. For covered eyewear, you pay any balance in excess of the $200 every 24 months limit. The $200 eyewear allowance every 24 months is combined between in-network and out-of-network.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

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

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

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You and your provider can ask the plan to make an exception for you and cover the drug. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List.

If we approve your formulary exception request your coverage will continue for the duration of the approval and as long as your provider continues to prescribe it for you**.**

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.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does 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 Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* which is located on our website at www.bluecrossma.com/medicare-options. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 – Preferred Brand, Tier 4 - Non-Preferred Brand, and Tier 5 Specialty Tier drugs until you have reached the yearly deductible	The deductible is $405. During this stage, you pay the plan's cost-sharing amount for drugs on: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $4 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $16 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. You pay the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.	The deductible is $405. During this stage, you pay the plan's cost-sharing amount for drugs on: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $2 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $16 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 6: Select Care:** *Standard cost-sharing:* You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. You pay the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost-Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

	2020 (this year)	2021 (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 6, Section 5 of your *Evidence of Coverage*. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $4 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $16 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 3: Preferred Brand** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4: Non-Preferred Brand:** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $95 per prescription. **Tier 5: Specialty Tier:** *Standard cost-sharing:* You pay 25% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $2 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $16 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 3: Preferred Brand** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4: Non-Preferred Brand:** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $95 per prescription. **Tier 5: Specialty Tier:** *Standard cost-sharing:* You pay 25% of the total cost.

	2020 (this year)	2021 (next year)
	Preferred cost-sharing: You pay 25% of the total cost.	*Preferred cost-sharing:* You pay 25% of the total cost. **Tier 6: Select Care Tier:** *Standard cost-sharing:* You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription
	Once your total drugs costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drugs costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Medicare PPO Blue SaverRx

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Medicare PPO Blue SaverRx plan.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, 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 www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Blue Cross Blue Shield of Massachusetts offers other Medicare health plans *and* Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Medicare PPO Blue SaverRx.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Medicare PPO Blue SaverRx.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Administrative Changes

We have made a change to the requirement for choosing a Physician of Choice (POC).

Description	2020 (this year)	2021 (next year)
When you become a member of Medicare PPO Blue, you **must** choose a network provider to be your Physician of Choice (POC) from a select group of our plan's network providers. These network providers are primary care providers (internal medicine, family practice and pediatric physicians and nurse practitioners, and physician assistants). (The *Provider Directory* for the plan lists our plan's providers of choice.) Your POC is a network provider who meets state requirements and is trained to give you basic medical care.	POC selection is not required.	POC selection is required.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2021.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In *Massachusetts*, the SHIP is called SHINE (Serving the Health Information Needs of Everyone).

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHINE 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 SHINE at 1-800-243-4636.

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% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** *Massachusetts* has a program called *Prescription Advantage* that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **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 through the Massachusetts HIV Drug Assistance Program HDAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Massachusetts HIV Drug Assistance Program (HDAP) at 1-800-228-2714. Or write to Community Research Initiative of New England/HDAP, The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129.

SECTION 7 Questions?

Section 7.1 – Getting Help from *Medicare PPO Blue SaverRx*

Questions? We're here to help. Please call Member Services at 1-800-200-4255. (TTY only, call 711). We are available for phone calls 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Medicare PPO Blue SaverRx. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.bluecrossma.com/medicare-options. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at http://bluecrossma.com/medicare-options. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* 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 (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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