MASSACHUSETTS

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

Annual Notice of Changes for 2022

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

You are currently enrolled as a member of Medicare HMO 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 2022 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, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. 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, 2021, you will be enrolled in Medicare HMO 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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in *Medicare HMO Blue SaverRx*.

- If you join another plan by **December 7, 2021**, your new coverage will start **on January 1, 2022.** You will automatically be 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 HMO 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 HMO Blue SaverRx*.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for *Medicare HMO 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	2021 (this year)	2022 (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 amount 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.)	$7,550	$7,550
Doctor office visits	Primary care visits: $10 per visit Specialist visits: $0 - $45 per visit	Primary care visits: $10 per visit Specialist visits: $0 - $45 per visit
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.	Per admission: ▪ Days 1-5: $390 copay per day ▪ Days 6 and beyond: $0 copay per day	Per admission: ▪ Days 1-5: $390 copay per day ▪ Days 6 and beyond: $0 copay per day

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $320 for tiers 3, 4, and 5 Copayments during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $8 • Drug Tier 2: $16 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 27% coinsurance • Drug Tier 6: $5 Preferred cost-sharing: • Drug Tier 1: $2 • Drug Tier 2: $8 • Drug Tier 3: $42 • Drug Tier 4: $95 • Drug Tier 5: 27% coinsurance • Drug Tier 6: $0	Deductible: $300 for tiers 3, 4, and 5 Copayments during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $8 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 28% coinsurance Preferred cost-sharing: • Drug Tier 1: $0 • Drug Tier 2: $8 • Drug Tier 3: $42 • Drug Tier 4: $95 • Drug Tier 5: 28% coinsurance

Annual Notice of Changes for 2022
Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (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 5 regarding "Extra Help" from Medicare.

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

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 amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550	$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 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 2022 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 2022 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 *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

	2021 (this year)	2022 (next year)
Dental services – non-Medicare covered preventive routine and comprehensive services	There is no coinsurance or copayment for covered preventive dental services. Preventive Dental Services include: • Periodic or routine oral exams 2 times calendar year • Routine cleaning, and polishing of the teeth (does not include	There is no coinsurance or copayment for covered preventive dental services. There is a $500 calendar year maximum **combined** for covered **preventive** and **comprehensive** dental services. Preventive Dental services include: • Periodic or routine oral exams 3 times per 12 months • Routine cleaning, scaling, and polishing

	2021 (this year)	2022 (next year)
	periodontal cleaning) 2 times per calendar year • Bitewing X-ray(s) up to 2 sets per calendar year	of the teeth 3 times per 12 months • Bitewing X-rays once every 6 months • Single-tooth X-rays as needed • Full mouth X-rays, 7 or more films, or panoramic X-ray with bitewing X-rays once every 60 months
	Comprehensive dental Not covered.	**Comprehensive dental** You pay 50% coinsurance for covered comprehensive dental services. Comprehensive dental services include: Fillings; Root canal treatments; Gum treatments; Prosthetic maintenance; Oral surgery; Crowns; Tooth replacement There is a $500 calendar year maximum **combined** for covered **preventive** and **comprehensive** dental services. Limits apply, please refer to your *Evidence of Coverage* for more information

	2021 (this year)	2022 (next year)
Diabetes self-management training, diabetic services and supplies	Prior authorization not required.	Prior authorization may be required for certain diabetes services and supplies. Your network provider must contact the plan to obtain prior authorization.
Hearing Services – hearing aids	You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models	You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: • First year of follow-up provider visits for fitting and adjustments • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models
Health and wellness education programs **Fitness benefit**	A qualified fitness program is: a full service health club where you use a variety of cardiovascular and strength training equipment for fitness including individual health clubs and fitness centers, YMCAs, YWCAs, Jewish Community Centers; or Council on Aging sites and municipal fitness centers; or, a fitness	A qualified fitness program is: a full service health club where you use a variety of cardiovascular and strength training equipment for fitness including individual health clubs and fitness centers, YMCAs, YWCAs, Jewish Community Centers; or Council on Aging sites and municipal fitness centers; or, a fitness studio

	2021 (this year)	2022 (next year)
	studio where you take instructor-led group classes for cardiovascular and strength training such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning.	where you take instructor-led group classes for cardiovascular and strength training such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning. A qualified fitness program also includes **virtual/online fitness** memberships, subscriptions, programs, or classes that provide cardiovascular and strength training using a digital platform. Also covered is H**ome Fitness Equipment** like stationary bikes, weights, exercise bands, treadmills, fitness machines.
	No reimbursement will be provided for any initiation fees or fees or costs you pay for: personal training sessions; country clubs; social clubs (such as ski, tennis, or hiking clubs); sports camps, leagues, or teams; spas; instructional dance studios; pool-only facilities; ski passes; and martial arts schools.	No reimbursement will be provided for any initiation fees or fees or costs you pay for: personal training sessions; country clubs; social clubs (such as ski, tennis, or hiking clubs); sports camps, leagues, or teams; spas; instructional dance studios; pool-only facilities; ski passes; and martial arts schools. No reimbursement for wearable fitness trackers or Home Fitness Equipment that are considered “Recreational Equipment” or “Sports Equipment”. Examples include - kayaks, inline

	2021 (this year)	2022 (next year)
		skates, bicycles, ice skates, trampolines, fitness clothing, and sneakers.
Meals Program -	There is no coinsurance or copayment for Meals 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.	There is no coinsurance or copayment for Meals Post-Hospitalization or Post- Outpatient same day surgery. After a discharge from an inpatient stay at a hospital or outpatient day surgery, 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.

	2021 (this year)	2022 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $275 copayment for each category of test for each service date.	For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $310 copayment for each category of test for each service date.
Outpatient mental health care	You pay a $40 copayment each office visit or telehealth visit for Medicare-covered outpatient mental health services.	You pay a $30 copayment each office visit or telehealth visit for Medicare-covered outpatient mental health services.
Outpatient substance use services	You pay a $40 copayment for each visit for Medicare covered outpatient substance use services.	You pay a $30 copayment for each visit for Medicare covered outpatient substance use services.
Outpatient surgery including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $10 copayment for each office visit to your PCP, 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 each visit. For Medicare-covered outpatient surgery performed in an	You pay a $10 copayment for each office visit to your PCP, or a $45 copayment for each office visit to a specialist. You pay nothing and no referral is required for Medicare-covered outpatient surgery by a specialist when performed in the home furnished by a network provider. For Medicare-covered outpatient surgery performed in a hospital you pay a $325 copayment for each visit. For Medicare-covered outpatient surgery performed in an ambulatory surgical center you pay a

	2021 (this year)	2022 (next year)
	ambulatory surgical center you pay a $280 copayment for each visit	$280 copayment for each visit
Over-the-counter allowance (OTC) A calendar year allowance to be used toward the purchase of select over-the-counter health and wellness items. Examples of OTC items include: first aid, cough, cold, allergy, pain relievers, antacids, vitamins/minerals and more. CVS will manage the OTC benefit. See the OTC catalog for a list of eligible items. Purchase OTC items by mail, phone, or in participating CVS retail stores. You can find the catalog, participating locations, and order online 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 am to 8 pm ET.	Not covered	Our plan pays up to $150 per calendar year toward select over-the-counter health & wellness products.
Physician/Practitioner services, including doctor's office visits	You pay a $10 copayment for each office visit or telehealth visit to your PCP, or a $45 copayment for each office visit or telehealth visit to a specialist. You pay nothing for Medicare covered physician specialist services performed in the home.	You pay a $10 copayment for each office visit or telehealth visit to your PCP, or a $45 copayment for each office visit or telehealth visit to a specialist. You pay nothing and no referral is required for Medicare covered specialist services performed in the home.

	2021 (this year)	2022 (next year)
Special Supplemental Benefits for the Chronically Ill Members that are identified with 5 or more designated chronic conditions who participate in a BCBSMA approved case management program will have reduced cost sharing for Telehealth Specialist visits. The chronic conditions are: o Cancer, cardiovascular disorders, chronic heart failure, dementia, diabetes, end-stage liver disease, end-stage renal disease (ESRD), chronic lung disorders, stroke, chronic kidney disease, other depression, other cerebral vascular disease, and/or other vascular disease.	Not covered	There is no coinsurance or copayment for eligible members for telehealth specialist visits.

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.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

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	2021 (this year)	2022 (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 $320. During this stage, you pay the plan's cost-sharing amount for drugs on: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $8 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 $8 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.	The deductible is $300. During this stage, you pay the plan's cost-sharing amount for drugs on: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $8 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*.

	2021 (this year)	2022 (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 $8 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 $8 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 27% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic:** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $8 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 28% of the total cost.

	2021 (this year)	2022 (next year)
	Preferred cost-sharing: You pay 27% of the total cost. **Tier 6: Select Care:** *Standard cost-sharing:* You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription.	*Preferred cost-sharing:* You pay 28% of the total cost.
	Once your total drugs costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Once your total drugs costs have reached $4,430, 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 HMO 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 HMO 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 2022 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 the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 HMO 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 HMO 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 6.1 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 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, 2022.

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, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 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 5 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 4 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 6 Questions?

Section 6.1 – Getting Help from *Medicare HMO 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 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for *Medicare HMO 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 www.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 6.2 – 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 2022*

You can read the *Medicare & You 2022* 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.

MASSACHUSETTS

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