MASSACHUSETTS

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

Annual Notice of Changes for 2023

<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. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review 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*.

- **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.

- Review the changes to Medical care costs (doctor, hospital)
- Review the changes to our drug coverage, including authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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, 2022, you will stay in Medicare HMO Blue SaverRx.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Medicare HMO Blue SaverRx.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

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 document 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*.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for *Medicare HMO Blue SaverRx* in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher 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	$5,600
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	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	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	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	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 You pay a $35 copayment for Select Insulins. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by "SI" used to refer to Select Insulins in the Drug List. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (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.

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

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	2022 (this year)	2023 (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	$5,600 Once you have paid $5,600 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 and Pharmacy Networks

Updated directories are located on our website at www.bluecrossma.com/findadoctor and https://medicare.bluecrossma.com/member-resources/pharmacy-benefits/medical-advantage-pharmacy-network. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

	2022 (this year)	2023 (next year)
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 studio where you take instructor-led group classes for cardiovascular and	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 where you take instructor-led group classes for cardiovascular and

	2022 (this year)	2023 (next year)
	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 **Home 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 for wearable fitness trackers or Home Fitness Equipment that are considered "Recreational Equipment" or "Sports Equipment". Examples include - kayaks, inline skates, bicycles, ice skates, trampolines, fitness clothing, and sneakers.	strength training such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning. A qualified fitness program also includes pool-only facilities. This includes but is not limited to: • Membership and other fees to facilities with pools • Water aerobic and other classes at facilities with pools • Aqua therapy at facilities with pools 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 **Home 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

	2022 (this year)	2023 (next year)
		dance studios; 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 skates, bicycles, ice skates, trampolines, fitness clothing, and sneakers.
Health and wellness education programs (cont'd) Learn to Live is an online program to help with mental health issues like anxiety, insomnia, depression and substance abuse and improve overall emotional health. Learn to Live is a coach-supported, digital program based on the principles of cognitive behavioral therapy. To get more information on the Learn to Live program you can go to our website (www.bluecrossma.com/medicare-options). You can access Learn to Live through your MyBlue online account.	Learn to Live program was not covered in 2022	There is no coinsurance or copayment to access to the online Learn to Live program.
Cardiac Rehabilitation Services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive	You pay a $45 copayment for each visit for Medicare-covered cardiac rehabilitation services.	You pay a $40 copayment for each visit for Medicare-covered cardiac rehabilitation services.

	2022 (this year)	2023 (next year)
cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.		
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a $30 copayment for each visit for Medicare-covered pulmonary rehabilitation services.	You pay a $20 copayment for each visit for Medicare-covered pulmonary rehabilitation services.
Supervised Exercise Therapy (SET)	You pay a $30 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.	You pay a $20 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay a $40 copayment for each visit for Medicare-covered outpatient rehabilitation services. (The Medicare benefit limit for outpatient physical therapy, occupational therapy, and speech language therapy does not apply to your benefits under our plan.) *Before you receive physical, occupational, and/or speech language therapy services, your network provider must*	You pay a $40 copayment each office visit or telehealth visit for Medicare-covered outpatient rehabilitation services. (The Medicare benefit limit for outpatient physical therapy, occupational therapy, and speech language therapy does not apply to your benefits under our plan.) *Before you receive physical, occupational, and/or speech language*

	2022 (this year)	2023 (next year)
	first obtain prior authorization.	*therapy services, your network provider must first obtain prior authorization.*
Over-the-counter allowance (OTC) A quarterly 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. Note: Any unused allowance does not roll over to the next benefit period. You cannot exceed your quarterly benefit amount.	Our plan pays up to $150 per calendar year toward select over-the-counter health & wellness products.	Our plan pays up to $65 per quarter toward select over-the-counter health & wellness products. The unused quarterly allowance will not be carried over from quarter to quarter.

	2022 (this year)	2023 (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.	There is no coinsurance or copayment for eligible members for telehealth specialist visits.	Not covered

Section 1.5 – 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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a

product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

We have made changes to the list of insulin drugs that will be covered as Select Insulins at a lower cost-sharing. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by "SI" used to refer to Select Insulins in the Drug List. If you have questions about the Drug List, you can also call Member Service (Phone numbers for Member Service are printed on the back cover of this booklet). This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

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."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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 Drug, and Tier 5 Specialty Tier drugs 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.	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. There is no deductible for Medicare HMO Blue SaverRx for Select Insulins. You pay a $35 copayment for a one-month supply of Select Insulins.

Changes to Your Cost-Sharing in the Initial Coverage Stage

	2022 (this year)	2023 (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 filled 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. *Preferred cost-sharing:* You pay 28% of the total cost.	Your cost for a one-month supply filled 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 Drug:** *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. *Preferred cost-sharing:* You pay 28% of the total cost.

	2022 (this year)	2023 (next year)
	Once your total drugs costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	You pay a $35 copayment for Select Insulins. Once your total drugs costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage). Medicare HMO Blue SaverRx offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be a $35 copayment for a one-month supply.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - 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.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – 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.

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 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *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, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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 so.
    - – *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

Providing quality care and service is always one of our top priorities, that is why we're changing the company that administers your prescription benefits, on our behalf, starting January 1, 2023. While this change will help us deliver greater benefits in the long run, it may affect one or more of your current prescriptions. We are here to help if you have any questions or need support, and you can contact Member Service directly using the methods outlined in Section 7.1 of this booklet. If you are impacted by the change, we will reach out to you with more details. However, there are a few things you can proactively do to make sure you ensure you receive the prescriptions you need starting in 2023.

If you use mail-order service to receive your prescriptions, beginning January 1, 2023, you'll have a new mail service pharmacy called the CVS Caremark Mail Service Pharmacy. You can create a MyBlue account at http://www.bluecrossma.org. Once signed in, click on My Medications, and then Pharmacy Benefits Manager. With a few additional clicks, you'll come to your prescription dashboard. Follow the prompts there for ordering a refill. You can also call CVS Caremark Mail Service Pharmacy directly at 1-877-817-0493 or via TTY at 711.

Also, you should review the updated formulary to see if your prescriptions changed tiers or are no longer on the formulary. Your drugs may also require prior authorization, step therapy, and/or quantity limits. You find the updated 2023 formulary at www.bluecrossma.com/medicare-options. If your prescription is no longer on the formulary, or on a higher tier this year, you can work with your doctor on alternatives, or ask for an exception via the process outlined in the *Evidence of Coverage*.

Finally, our pharmacy network will change in 2023. You can go to www.bluecrossma.com/medicare-options to review the 2023 Pharmacy Directory to confirm that your pharmacy is still in the network, and whether it is a Preferred pharmacy or a Standard pharmacy.

Again, we will reach out to you if you are impacted by any of the changes outlined above. For answers to frequently asked questions and a list of covered medications for 2023, go to **bcbsma.info/pharmacyupdate**.

Description	2022 (this year)	2023 (next year)
Ordering Prescriptions via Mail-order	Call Express Scripts at 1-800-820-9729 (TTY: 1-800-716-3231)	You can create a MyBlue account at http://www.bluecrossma.org. Once signed in, click on My Medications, and then Pharmacy Benefits Manager. With a few additional clicks, you'll come to your prescription dashboard. Follow the prompts there for ordering a refill. You can also call CVS Caremark Mail Service Pharmacy directly at 877-817-0493 or via TTY at 711.

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, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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. 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; 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.

- **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 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 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. You can file a complaint if you feel that you received inaccurate, misleading or inappropriate information. Please call Member Service at 1-800-200-4255 (TTY users call: 711). If your complaint involves a broker or agent, be sure to include the name of the broker/agent when filing your complaint.

Read your 2023 *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 2023. For details, look in the 2023 *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 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.