MASSACHUSETTS

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

Annual Notice of Changes for 2024

<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 ValueRx. Next year, there will be changes to the plan's costs and benefits. ***Please see page 2 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 Service 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 2024 "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 2024* 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, 2023, you will stay in Medicare PPO Blue ValueRx.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Medicare PPO Blue ValueRx.
- 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 Service 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 call is free.
- 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 ValueRx*

- 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 PPO Blue ValueRx.

OMB Approval 0938-1051 (Expires: August 31, 2026)

Annual Notice of Changes for 2024
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Medicare PPO Blue ValueRx in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$75	$72
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: $4,900 From network and out-of-network providers combined: $4,900	From network providers: $4,900 From network and out-of-network providers combined: $4,900
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $0 - $40 copay per visit **Out-of-Network:** Primary care visits: $20 copay per visit Specialist visits: $50 copay per visit	**In-Network:** Primary care visits: $0 copay per visit Specialist visits: $0 - $40 copay per visit **Out-of-Network:** Primary care visits: $20 copay per visit Specialist visits: $50 copay per visit

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network:** Per admission ▪ Days 1-5: $325 copay per day ▪ Days 6 and beyond: $0 copay per day **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: $325 copay per day ▪ Days 6 and beyond: $0 copay per day **Out-of-Network:** Per admission ▪ Days 1-5: $350 copay per day ▪ Days 6 and beyond: $0 copay per day

Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copays during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $8 • Drug Tier 2: $12 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 28% coinsurance You pay $35 per month supply of each covered insulin product on this tier. Preferred cost-sharing: • Drug Tier 1: $0 • Drug Tier 2: $6 • Drug Tier 3: $42 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 28% coinsurance You pay $35 per month supply of each covered insulin product on this tier.	Deductible: $0 Copays during the Initial Coverage Stage: Standard cost-sharing: • Drug Tier 1: $8 • Drug Tier 2: $12 • Drug Tier 3: $47 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay $35 per month supply of each covered insulin product on this tier. Preferred cost-sharing: • Drug Tier 1: $0 • Drug Tier 2: $6 • Drug Tier 3: $42 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage:

Cost	2023 (this year)	2024 (next year)
	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	• During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$75	$72

- 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

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2023 (this year)	2024 (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 plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,900	$4,900 Once you have paid $4,900 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.
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. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$4,900	$4,900 Once you have paid $4,900 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 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 Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 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 2024 *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 Service 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.

	2023 (this year)	2024 (next year)
Combined Dental, Vision and Hearing Allowance Our plan offers a prepaid debit card (Flex Card) with a combined annual limit to help reduce your out-of-pocket expenses for dental, vision, and hearing services. This includes: • Out-of-pocket costs associated with comprehensive dental benefits (including fillings, extractions, and dentures) • Supplemental vision services (including glasses, frames, contacts, and routine eye exams) • One hearing aid per ear, per year (batteries included) Any unused benefit dollars will expire at the end of the year. This benefit is not a replacement for your other dental, vision, and/or hearing benefits and is designed to help offset certain expenses and will not cover cosmetic procedures or expenses.	Not covered.	A $700 allowance will be loaded to your Flex Card and can be used to help reduce your out-of-pocket expenses for dental, vision, and hearing services. Any unused benefit dollars will expire at the end of the year. This benefit is not a replacement for dental, vision, or hearing benefits and is designed to help offset out-of-pocket expenses and will not cover cosmetic procedures or expenses. This allowance is shared among Dental, Vision, and Hearing out-of-pocket expenses.

	2023 (this year)	2024 (next year)
The Flex Card is only for your personal use, cannot be sold or transferred, and has no cash value. This allowance and any amounts paid out-of-pocket for this benefit do not count toward your maximum out-of-pocket amount. For more information please call 1-800-971-6798 (TTY 711), or visit MAFlexCard.com		
Health and wellness education programs **Fitness benefit** **Weight loss program benefit**	Fitness benefit to use toward costs you pay to participate in a qualified fitness program. For eligible health club membership or classes or Home Fitness Equipment, you pay any balance in excess of the $150 limit. Weight loss program benefit to use toward a qualified weight loss program. For eligible weight loss programs, you pay any balance in excess of the $150 limit.	Fitness benefit (offered via Flex Card) to use toward costs you pay to participate in a qualified fitness program. For eligible health club membership or classes or Home Fitness Equipment, you pay any balance in excess of the $250 limit. Your $250 fitness benefit allowance will be loaded onto your Flex Card. For more information about using this benefit please visit MAFlexCard.com or call 1-800-971-6798 (TTY 711). Weight loss program benefit (offered via Flex Card) to use toward a qualified weight loss program.

	2023 (this year)	2024 (next year)
		For eligible weight loss programs, you pay any balance in excess of the $250 limit. Your $250 weight loss program benefit allowance will be loaded onto your Flex Card. For more information about using this benefit please visit MAFlexCard.com or call 1-800-971-6798 (TTY 711).
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network:** For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $250 copayment for each category of test for each service date. **Out-of-Network:** 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:** For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $250 copayment for each service date **Out-of-Network:** For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a $325 copayment for each service date.
Outpatient Hospital services	**In-Network:** For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a $250 copayment for each visit.	**In-Network:** For Medicare-covered outpatient surgery you pay a: • $200 copayment for surgical visit in a hospital

	2023 (this year)	2024 (next year)
		• $250 copayment for surgical visit in an ambulatory surgical center.
Pulmonary rehabilitation services	**In-Network:** You pay a $20 copayment for each visit for Medicare-covered pulmonary rehabilitation services.	**In-Network:** You pay a $15 copayment for each visit for Medicare-covered pulmonary rehabilitation services.
Supervised Exercise Therapy (SET)	**In-Network:** You pay a $20 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.	**In-Network:** You pay a $15 copayment for each visit for Medicare-covered supervised exercise therapy services for peripheral artery disease.

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", which could include removing or adding drugs, changing 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, or if your drug has been moved to a different cost-sharing tier.**

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 Service for more information.

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 Service 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	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-Sharing in the Initial Coverage Stage

	2023 (this year)	2024 (next year)
Stage 2: 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*. Most adult Part D vaccines are covered at no cost to you. 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 $0 per prescription. **Tier 2: Generic:** *Standard cost-sharing:* You pay $12 per prescription. *Preferred cost-sharing:* You pay $6 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.	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 $12 per prescription. *Preferred cost-sharing:* You pay $6 per prescription. **Tier 3: Preferred Brand**: *Standard cost-sharing:* You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay $42 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4: Non-Preferred Drug:** *Standard cost-sharing:* You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay $95 per

	2023 (this year)	2024 (next year)
	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 PPO Blue ValueRx 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	prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5: Specialty Tier:** *Standard cost-sharing:* You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost-sharing:* You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. Once your total drugs costs have reached $5,030, 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**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Fitness and Weight loss Program Benefit Administration	To obtain reimbursement for eligible fitness and weight loss program benefit expenses, you must submit a fitness benefit claim and/or weight loss program claim, as applicable. Use our convenient online reimbursement tool through your MyBlue account or mail in a completed claim form. Call Member Service to request the applicable claim form or print directly from our website. Send the completed claim form to Member Service.	Members will have the fitness and weight loss program benefit allowance loaded onto their Flex Card instead of submitting for reimbursement. For more information about using this benefit please visit MAFlexCard.com or call 1-800-971-6798 (TTY 711).

Description	2023 (this year)	2024 (next year)
Administration of Incentives for Annual Wellness Visit, Health Risk Assessment, and Initial Health Assessment	Incentives are offered via gift card for members who have completed health risk assessments and an initial health assessment.	Incentives for completing an initial health assessment, annual wellness visit, and/or health risk assessments will be loaded onto your Flex Card. For more information and to receive your rewards visit **MAFlexCard.com**. To find out where you can use your rewards visit **MAFlexCard.com** or call **1-800-971-6798** (TTY **711**).
Enhanced Disease Management Administration	Members who qualify can receive enhanced disease management administered through Square Knot	Members who qualify can receive enhanced disease management administered through Square Knot and/or Hinge Health.
Administration of Benefits Due to the Public Health Emergency	The flexibilities to see an out-of-network provider at the in-network cost-share will continue through the end of 2023 to ensure that you have enough time to make changes.	After 12/31/2023 if you see an out-of-network provider you will either be charged the out-of-network cost share, or you may be financially responsible for services because the provider is out-of-network.

Description	2023 (this year)	2024 (next year)
Selecting a Provider of Choice (POC)	When you become a member of Medicare PPO Blue, you **must** choose a network provider to be your POC from a select group of our plan's network providers.	When you become a member of Medicare PPO Blue, you **must** choose a network provider to be your POC from a select group of our plan's network providers, otherwise we may automatically select a POC based on who you are already seeing regularly.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Medicare PPO Blue ValueRx

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 ValueRx plan.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2024 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 2024* 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 PPO Blue ValueRx.
- 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 ValueRx.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Service 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 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, 2024.

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, 2024, 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, 2024.

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 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 ValueRx

Questions? We're here to help. Please call Member Service 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 2024 *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 2024. For details, look in the 2024 *Evidence of Coverage* for Medicare PPO Blue ValueRx. 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 Service 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

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 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document 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.