

MEDEX[®] 2

City of Boston

This Medex plan provides benefits for:

- Medicare Part A and B Deductibles and Coinsurances
- OBRA Benefits

This Medex plan does not provide benefits for:

- Prescription Drugs

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



COVERAGE AND BENEFITS



CLAIMS AND BALANCES

Sign in

Download the app, or create an account at bluecrossma.org.



QUESTIONS? CALL 1-888-714-0189. (TTY) 711.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.

Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**



This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

YOUR MEDICAL BENEFITS

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and lab tests, anesthesia, drugs and medications, and intensive care services	<ul style="list-style-type: none"> • Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance 	After a \$50 calendar-quarter copayment: <ul style="list-style-type: none"> • Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up[†]
Physician or other professional provider services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Skilled nursing facility—participating with Medicare*	<ul style="list-style-type: none"> • Full coverage for days 1–20 • Coverage for days 21–100 after daily Part A coinsurance 	<ul style="list-style-type: none"> • Full coverage of Medicare daily coinsurance for days 21–100 • \$10 daily for days 101–365
Skilled nursing facility—not participating with Medicare*	No benefits	\$8 daily for 365 days per benefit period
Outpatient Care		
Emergency services	80% of approved charges after annual Part B deductible	After a \$50 copayment per visit (waived if admitted or for observation stay), full coverage of Medicare deductible and coinsurance
Office visits, podiatrists' services	80% of approved charges after annual Part B deductible	After a \$15 copayment per visit, full coverage of Medicare deductible and coinsurance
Surgery, radiation therapy, X-ray and lab tests, durable medical equipment, and cardiac rehabilitation services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after annual Part B deductible for all diabetics	Full coverage of Medicare deductible and coinsurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form)	No benefits	Full coverage based on the allowed charge
Chiropractor services	80% of approved charges after annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	After a \$15 copayment per visit, full coverage of Medicare deductible and coinsurance for Medicare-approved charges only
Short-term rehabilitation – physical therapy, speech-pathology, and occupational therapy services approved by Medicare	80% of approved charges after annual Part B deductible	After a \$15 copayment per visit, full coverage of Medicare deductible and coinsurance

	Medicare Provides	Medex Provides
Mental Health and Substance Use Treatment		
Biologically based mental conditions**		
Inpatient admissions in a general or mental hospital	<ul style="list-style-type: none"> • Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance • Coverage for mental hospital admissions is limited to a 190 day lifetime maximum 	After a \$50 calendar-quarter copayment:*** <ul style="list-style-type: none"> • Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Outpatient visits	80% of approved charges after annual Part B deductible	After a \$15 copayment per visit: <ul style="list-style-type: none"> • When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	<ul style="list-style-type: none"> • Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance 	After a \$50 calendar-quarter copayment: <ul style="list-style-type: none"> • Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to a 190 day lifetime maximum	<ul style="list-style-type: none"> • Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)†
Outpatient visits	80% of approved charges after annual Part B deductible	After a \$15 copayment per visit: <ul style="list-style-type: none"> • When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

† The additional days are a combination of days in a general or mental hospital.

* A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

*** The calendar-quarter copayment does not apply to inpatient admissions in a mental hospital.

Preventive Services Approved by Medicare and Medex

Medicare provides coverage for certain preventive services at no cost to members. For certain services covered by Medex, you pay a \$15 copayment per visit. For the current list of covered preventive services, refer to your Medicare & You handbook or go to **medicare.gov**. Some preventive covered services are highlighted below.

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| <ul style="list-style-type: none">• One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)• One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)• One routine colonoscopy every two years for a high-risk member (Full coverage for tests)• Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)• Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test) | <ul style="list-style-type: none">• One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)• One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)• One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)• One routine Pap smear test per calendar year (Full coverage for test) |
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Important Information

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| <ul style="list-style-type: none">• The Medicare deductible and coinsurance amounts are subject to change January 1 of each year.• Benefits are available immediately upon your effective date. | <ul style="list-style-type: none">• Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary. |
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Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-888-714-0189 to learn about discounts, savings, resources, and special programs available to you, like the one listed below.

Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs or equipment (see your plan description for details)	\$150 per calendar year
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Limitations and Exclusions. These pages summarize your health care plan. Your plan description and riders define the full terms and conditions. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.
Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/العربية:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: 711).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: 711).

Japanese/日本語: お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowolgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dée' nóomba biká'ígíjij' béésh bee hodíílnih (TTY: 711).



MASSACHUSETTS

Blue MedicareRxSM (PDP)

2025 SUMMARY OF BENEFITS

2025 Summary of Benefits

Blue MedicareRx (PDP)

Employer Group Medicare
Prescription Drug Plan with
Supplemental Coverage:
\$10 / \$25 / \$45

Option 35



Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

S2893_2414_GRP_M

BLUE MEDICARERX (PDP)

(a Medicare Prescription Drug Plan (PDP) offered by ANTHEM INSURANCE CO., BCBSMA, BCBSRI, & BCBSVT with a Medicare contract)

SUMMARY OF BENEFITS

January 1, 2025 - December 31, 2025

Thank you for your interest in Blue MedicareRx. Blue MedicareRx includes standard Medicare Part D benefits supplemented with coverage provided by your former employer/union health plan. Blue MedicareRx is referred to throughout this Summary of Benefits as “plan” or “this plan.”

This Summary of Benefits tells you some features of our plan. It doesn’t list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call us and ask for the “Evidence of Coverage.”

FOR MORE INFORMATION

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Blue MedicareRx Phone Numbers and Website

Please call Blue MedicareRx for more information about our plan.

Current members should call toll-free **1-888-543-4917**. (TTY/TDD **711**).

Prospective Members, please contact your benefits administrator.

Visit us at our Document Portal:
rxmedicareplans.memberdoc.com.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at **<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

This document is available in other formats such as Braille and large print. For additional information, call us at **1-888-543-4917**, 24 hours a day, 7 days a week. TTY/TDD users should call **711**.

WHO CAN JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B, are a US citizen or are lawfully present in the United States and live in the service area which includes the United States and its territories.

If you are enrolled in a MA coordinated care (HMO or PPO) plan or a MA private fee-for-service (MA PFFS) plan that includes Medicare prescription drugs, you may not enroll in a prescription drug plan (PDP) unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service (PFFS) plan that does not provide Medicare prescription drug coverage or a MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP. Please contact your local benefits administrator for more information.

WHICH DRUGS ARE COVERED?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our Document Portal at: **rxmedicareplans.memberdoc.com**. Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of 3 “tiers”. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, your out-of-pocket prescription costs to date and what stage of the benefit you have reached. Later in this document we discuss the benefit stages in your Medicare prescription drug coverage that occur: Initial Coverage and Catastrophic Coverage. For more information about formulary tiers and stages of the benefit, please see the plan's formulary and the Evidence of Coverage on our Document Portal at: **rxmedicareplans.memberdoc.com**, or contact Customer Care at the number listed above.

WHICH PHARMACIES CAN I USE?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's pharmacy directory on our Document Portal at: **rxmedicareplans.memberdoc.com**. Or, call us and we will send you a copy of the pharmacy directory.

ADDITIONAL BENEFIT INFORMATION FOR BLUE MEDICARE RX

Important message about what you pay for vaccines

Our plan covers most Part D vaccines at no cost to you. Call Customer Care 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.

SUMMARY OF BENEFITS

January 1, 2025 – December 31, 2025

PRESCRIPTION DRUG BENEFITS

The benefits described below are offered by Blue MedicareRx, a standard Medicare Part D plan supplemented with benefits provided by your former employer. As an enhanced benefit, your former employer limits your maximum out-of-pocket prescription costs to \$1,500 per calendar year for covered medications.

Initial Coverage		You pay the following until your total yearly drug costs reach \$2,000 ¹ :	
Standard Retail Cost-Sharing		One-month supply	Three-month supply ²
Tier 1	Generic	\$10	\$30
Tier 2	Preferred Brand	\$25	\$75
Tier 3	Non-Preferred Drug	\$45	\$135
		Specialty drugs are limited to a one-month supply per fill.	
Mail Order Cost-Sharing		One-month supply	Three-month supply
Tier 1	Generic	\$10	\$20
Tier 2	Preferred Brand	\$25	\$50
Tier 3	Non-Preferred Drug	\$45	\$115
		Specialty drugs are limited to a one-month supply per fill.	

Catastrophic Coverage
During this payment stage, you pay nothing for your Part D covered drugs.

- 1. All covered drugs are on the Blue MedicareRx group formulary/drug list.
- 2. Available at retail pharmacies that have agreed to allow members to fill 90-day supplies of their prescriptions.

GENERAL INFORMATION

In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.

Certain prescription drugs will have maximum quantity limits.

Your provider must get prior authorization from Blue MedicareRx for certain prescription drugs.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances as long as the pharmacy is located within

the United States and its territories. For examples of what would qualify as special circumstances, refer to the Evidence of Coverage (EOC). Your copayment and/or coinsurance at out-of-network pharmacies is the same as at network pharmacies and depends on whether you purchase a Generic, Brand, or Non-Preferred drug. When using an out of network pharmacy, you may be responsible for any cost differential between the amount charged and the allowed charge.

Medicare considers drugs which cost more than \$950 for a one month supply to be specialty drugs.

Blue MedicareRx:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (Braille, large print, audio CD, data CD, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need these services, call the number on the back of your Member ID Card. TTY/TDD users should call 711.

If you believe that Blue MedicareRx has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Blue MedicareRx (PDP)

Grievance Department Coordinator
P.O. Box 30016
Pittsburgh, PA 15222-0330
Phone: 1-866-884-9478
Fax: 1-866-217-3353

You can file a grievance in person, by mail, or fax.
If you need help filing a grievance, Blue MedicareRx
Grievance Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY: 1-800-537-7697

Complaint forms are available at
hhs.gov/ocr/office/file/index.html.

You can file a complaint if you feel that you received inaccurate, misleading, or inappropriate information. Please call Customer Care at the number listed on the back page of this booklet (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.

NOTES



FOR QUESTIONS, OR TO ENROLL:

This information is not a complete description of benefits. Please refer to the contact list below for more information.

Please call Blue MedicareRx for more information about our plan.
Current members should call toll-free 1-888-543-4917. (TTY/TDD 711)
Prospective Members, please contact your benefits administrator.
Visit us at rxmedicareplans.memberdoc.com

Customer Care Hours:

24 hours a day, 7 days a week

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [medicare.gov](https://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.



MASSACHUSETTS

Blue Cross and Blue Shield of Massachusetts, Inc., is an Independent Licensee of the Blue Cross and Blue Shield Association.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans.

The joint enterprise is a Medicare-approved Part D Sponsor.

Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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