Mass General Brigham Advantage Secure (HMO-POS) offered by *Mass General Brigham Health Plan*

Annual Notice of Changes for 2025

You are currently enrolled as a member of Mass General Brigham Advantage Secure (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 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 **MassGeneralBrighamAdvantage.org**. You may also call Customer 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 coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

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

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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, 2024, you will stay in Mass General Brigham Advantage Secure (HMO-POS).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Mass General Brigham Advantage Secure (HMO-POS).
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Service number at (855)833-3668 for additional information. (TTY users should call 711.) Hours are October 1 through March 31, seven days a week from 8:00 am – 8:00 pm EST and April 1 through September 30, Monday through Friday 8:00 am – 8:00 pm EST. This call is free.
- This document is also available in braille and large print. Please contact Customer Service at the number above for more information.
- **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 Mass General Brigham Advantage Secure (HMO-POS)

- Mass General Brigham Health Plan is an HMO-POS/PPO organization with a Medicare contract. Enrollment in Mass General Brigham Health Plan depends on contract renewal.
- When this document says "we," "us," or "our," it means Mass General Brigham Health Plan. When it says "plan" or "our plan," it means Mass General Brigham Advantage Secure (HMO-POS).

H6847_1141PDT_M

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *Mass General Brigham Advantage Secure (HMO-POS)* in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$52	$52
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.)	From network providers: $3,350 From network and out-of-network providers combined: $7,000	From network providers: $3,350 From network and out-of-network providers combined: $7,000
Doctor office visits	**In-Network** Primary care visits: $0 Copay per visit Specialist visits: $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: $45 Copay per visit **Out-of-Network** Primary care visits: $20 Copay per visit Specialist visits: $50 Copay per visit
Inpatient hospital stays	**In-Network** $230 Copay per day for days 1-5.	**In-Network** $250 Copay per day for days 1-5.

Cost	2024 (this year)	2025 (next year)
	$0 Copay per day for days 6-90. **Out-of-Network** 30% Coinsurance per admission	$0 Copay per day for days 6-90. **Out-of-Network** 30% Coinsurance per admission
Part D prescription drug coverage (See Section 1.5 for details.)	**Deductible**: $0 **During the Initial Coverage Stage:** • Drug Tier 1: $0 • Drug Tier 2: $3 • Drug Tier 3: $37 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% You pay $35 per month supply of each covered insulin product on this tier. **Catastrophic Coverage**: • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.	**Deductible**: $0 **During the Initial Coverage Stage**: • Drug Tier 1: $0 • Drug Tier 2: $5 • 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% You pay $35 per month supply of each covered insulin product on this tier. **Catastrophic Coverage**: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$52	$52 There is no change to your premium for 2025

- 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 7 regarding "Extra Help" from Medicare.

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 for 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	2024 (this year)	2025 (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.	$3,350	$3,350 Once you have paid $3,350 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 in-network providers for the rest of the calendar year.

Cost	2024 (this year)	2025 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out of pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$7,000	$7,000 Once you have paid $7,000 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 in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at **MassGeneralBrighamAdvantage.org**. You may also call Customer 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 2025 *Provider Directory* MassGeneralBrighamAdvantage.org 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 2025 *Pharmacy Directory* MassGeneralBrighamAdvantage.org 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 Customer 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.

Cost	2024 (this year)	2025 (next year)
Annual Physical Exam	The covered annual physical exam includes a detailed medical/family history and a thorough head to toe assessment with hands-on examination of all the body systems to assess overall general health along with providing recommendations for preventive screenings, vaccination(s), and counseling about healthy behaviors. This is covered once every 12 months. If you receive services that address a medical condition during the same office visit, additional cost-share may apply. If you have other tests or lab work at your annual physical exam, those services are covered at the standard cost-sharing.	The covered annual physical exam includes a detailed medical/family history and a thorough head to toe assessment with hands-on examination of all the body systems to assess overall general health along with providing recommendations for preventive screenings, vaccination(s), and counseling about healthy behaviors. This is covered once every calendar year. If you receive services that address a medical condition during the same office visit, additional cost-share may apply. If you have other tests or lab work at your annual physical exam, those services are covered at the standard cost-sharing.
Annual Wellness Visit	If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is	If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is

Cost	2024 (this year)	2025 (next year)
	covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	covered once every calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.
Inpatient Hospital Care	**In-Network:** You pay $230 copay each day for days 1-5. You pay a $0 copay each day for days 6 and beyond. **Out-of-Network:** For each admission you pay 30% of the total cost.	**In-Network:** You pay $250 copay each day for days 1-5. You pay a $0 copay each day for days 6 and beyond. **Out-of-Network:** For each admission you pay 30% of the total cost.
Inpatient Services in a Psychiatric Hospital	**In Network:** In a psychiatric unit at a general hospital or in a free-standing psychiatric hospital, you pay a $230 copay each day for days 1-5. You pay a $0 copay for days 6 and beyond. **Out-of-Network:** For each admission you pay 30% of the total cost.	**In Network:** In a psychiatric unit at a general hospital or in a free-standing psychiatric hospital, you pay a $250 copay each day for days 1-5. You pay a $0 copay for days 6 and beyond. **Out-of-Network:** For each admission you pay 30% of the total cost.

Cost	2024 (this year)	2025 (next year)
Medicare-covered Additional Telehealth Services	**In-Network:** You pay a $0 minimum copay for Medicare-covered Additional Telehealth Services. You pay a $40 maximum copay for Medicare-covered Additional Telehealth Services.	**In-Network:** You pay a $0 minimum copay for Medicare-covered Additional Telehealth Services. You pay a $45 maximum copay for Medicare-covered Additional Telehealth Services.
Medicare-covered Dental Services	**In-Network:** You pay a $40 copay for Medicare-covered dental services. **Out-of-Network:** You pay a $50 copay for Medicare-covered dental services.	**In-Network:** You pay a $45 copay for Medicare-covered dental services. **Out-of-Network:** You pay a $50 copay for Medicare-covered dental services.
Medicare-covered Eye Exams	**In-Network:** You pay $40 copay for Medicare-covered eye exam. **Out-of-Network:** You pay $50 copay for Medicare-covered eye exam.	**In-Network:** You pay a $45 copay for Medicare-covered eye exam. **Out-of-Network:** You pay a $50 copay for Medicare-covered eye exam.
Medicare-covered Hearing Exams	**In-Network:** You pay a $40 copay for Medicare-covered hearing exam. **Out-of-Network:** You pay a $50 copay for	**In-Network:** You pay a $45 copay for Medicare-covered hearing exam. **Out-of-Network:** You pay a $50 copay for

Cost	2024 (this year)	2025 (next year)
	Medicare-covered hearing exam.	Medicare-covered hearing exam.
Medicare-covered Other Health Care Professional Services	**In-Network:** You pay a $0 minimum copay for Other Health Care Professional Services. You pay a $40 maximum copay for Other Health Care Professional Services. **Out-of-Network:** You pay a $20 minimum copay for Other Health Care Professional Services. You pay a $50 maximum copay for Other Health Care Professional Services.	**In-Network:** You pay a $0 minimum copay for Other Health Care Professional Services. You pay a $45 maximum copay for Other Health Care Professional Services. **Out-of-Network:** You pay a $20 minimum copay for Other Health Care Professional Services. You pay a $50 maximum copay for Other Health Care Professional Services.
Medicare-covered Physician Specialist Services	**In-Network:** You pay $40 copay for Medicare-covered Physician Specialist Services. **Out-of-Network:** You pay $50 copay for Medicare-covered Physician Specialist Services.	**In-Network:** You pay $45 copay for Medicare-covered Physician Specialist Services. **Out-of-Network:** You pay $50 copay for Medicare-covered Physician Specialist Services.
Wigs for Hair Loss Related to Chemotherapy	Not covered	**In-Network:** There is a $350 allowance Every Year. **Out-of-Network:** There is a $350 allowance Every Year.

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, or moving them to a different cost-sharing tier. **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, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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 Customer Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-

biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Service or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and 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 sent you 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 you haven't received this insert by September 30, 2024, please call Customer Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (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**. 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." Most adult Part D vaccines are covered at no cost to you.	**Preferred Generics:** You pay $0 per prescription. **Generics:** You pay $3 per prescription. Your cost for a one-month mail-order prescription is $3. **Preferred Brand:** You pay $37 per prescription. Your cost for a one-month mail-order prescription is $37. **Non-Preferred Drug:** You pay $100 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once you have paid $5,030 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**Preferred Generics:** You pay $0 per prescription. **Generics:** You pay $5 per prescription. Your cost for a one-month mail-order prescription is $5. **Preferred Brand:** You pay $47 per prescription. Your cost for a one-month mail-order prescription is $47. **Non-Preferred Drug:** You pay $100 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Dental Services	Our plan covers routine and comprehensive dental coverage through Liberty Dental Plan. Their Customer Service phone number is: 888-352-7556. TTY/TDD users should call 1-877-855-8039. Special equipment is required to talk to agents via TTY. Their Customer Service hours are October 1-March 31, 8:00 a.m.-8:00 p.m. seven days a week and April 1-September 30, 8:00 a.m.-8:00 p.m., Monday through Friday.	Our plan covers routine and comprehensive dental coverage through DentaQuest. Their customer service number will be listed on our Supplemental Benefit Card. Members will receive the card by January 1, 2025. Their Customer Service hours are October 1 - March 31 8:00 a.m.-8:00 p.m. EST seven days a week and April 1 - September 30 8:00 a.m. - 8:00 p.m. EST. Monday through Friday. View their provider network as of 10/1/2024 at this link https://www.dentaquest.com/

Description	2024 (this year)	2025 (next year)
	Comprehensive benefits – adjunctive services **In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 20% of the total cost. **Authorization not required for the following services:** Restorative Services Endodontics Periodontics Oral and Maxillofacial Surgery Adjunctive General Services	**Comprehensive benefits – adjunctive services** **In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay a $0 copayment. **Authorization required for the following services:** Restorative Services Endodontics Periodontics Oral and Maxillofacial Surgery Adjunctive General Services
How to ask us to pay you back or to pay a bill you have received	You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 36 months of the date you received the service, item, or drug.	You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service, item, or drug.
Meals Program - Post Hospitalization	Referral is required.	Referral is not required.
Medicare Prescription Payment Plan	Not Applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it

Description	2024 (this year)	2025 (next year)
		can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January - December). To learn more about this payment option, please contact us at 1-855-833-3668 or visit Medicare.gov.
Over-the-counter (OTC) drugs and supplies	Up to $95 per calendar quarter and must be ordered through Convey Health Solutions. Unused balances at the end of each quarter will not be carried over to the next quarter. For 2024, members have access to their OTC benefit through catalog, web, or on-line phone ordering. Convey Health Solutions will mail to each member a catalogue that lists items and costs and process to request and receive OTC items. Orders will be shipped to your home.	Up to $95 per calendar quarter through Convey Health Solutions. Unused balances at the end of each quarter will not be carried over to the next quarter. For 2025, members will be receiving a Flexible Benefit Mastercard® in the mail by January 1, 2025 with information on how to use their benefit card. Eligible OTC items can be purchased in retail stores such as CVS, Walgreens, Rite Aid, Walmart and many others. In addition, members can purchase eligible OTC items from a catalog, web, or on-line phone ordering. If members wish to order through a catalog, members can request one to be mailed to their home.
Part D drugs long-term supply	A long-term supply is up to a 90-day supply.	A long-term supply is up to a 100-day supply.
Transportation to Medical Visits	Not Covered	Your Mass General Brigham Advantage Secure (HMO-POS) has an allowance of $120 per

Description	2024 (this year)	2025 (next year)
		calendar quarter to help cover costs for non-emergent transportation, like taxis, public transportation or rideshare, for medical visits. For 2025, members will receive a Flexible Benefit Mastercard® in the mail by January 1, 2025, with information on how to use their benefit card at point of services.
Wellness Benefit - Prescription Hearing Aids	Hearing aids limited to TruHearing brand only.	Your Mass General Brigham Advantage Secure (HMO-POS) has a combined Wellness Benefit. The Wellness benefit has a yearly allowance of $450 to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids. For 2025, members will receive a Flexible Benefit Mastercard® in the mail by January 1, 2025, with information on how to use their benefit card at point of services.
Wellness Benefit: Fitness	For eligible health club Membership, classes or Home Fitness Equipment, Mass General Brigham Advantage Secure (HMO-POS) will reimburse you up to $300 per calendar year. Any amount above $300 is the responsibility of the member.	Your Mass General Brigham Advantage Secure (HMO-POS) fitness benefit is now a combined Wellness Benefit. The wellness benefit has a yearly allowance of $450 to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids.

Description	2024 (this year)	2025 (next year)
	Please submit your reimbursement request with name and address of fitness facility, months of participation, total amount paid, and frequency and type of payment. There are two ways to submit your fitness and weight loss reimbursement requests: • Complete an online form which can be found on the member portal at: Member.MassGeneralBrighamHealthPlan.org • Complete the reimbursement form which can be found online at MassGeneralBrighamAdvantage.org/forms or by calling our Customer Service department and requesting one. Once completed, the form can be mailed to: Mass General Brigham Health Plan Medicare Advantage, Suite 850 399 Revolution Drive Somerville, MA 02145	You may use your allowance at health clubs, such as YMCA or community fitness centers, who offer cardiovascular or strength training classes or programs as well as for home fitness equipment and fitness trackers purchased from retail sporting goods stores where Mastercard® is accepted. For 2025, members will receive a Flexible Benefit Mastercard® in the mail by January 1, 2025, with information on how to use their benefit card at point of services.
Wellness Benefit: Weight Loss Program	For eligible weight loss programs, Mass General Brigham Advantage Secure (HMO-POS) will reimburse you up to $150 per calendar year. Any amount above $150 is the responsibility of the member.	Your Mass General Brigham Advantage Secure (HMO-POS) weight loss benefit is now a combined Wellness Benefit. The Wellness benefit has a yearly allowance of $450 to use towards fitness, eligible weight loss programs or costs toward

Description	2024 (this year)	2025 (next year)
	Please submit your reimbursement request with name and address of fitness facility, months of participation, total amount paid, and frequency and type of payment. There are two ways to submit your fitness and weight loss reimbursement requests: • Complete an online form which can be found on the member portal at: Member.MassGeneralBrigham HealthPlan.org • Complete the reimbursement form which can be found online at MassGeneralBrighamAdvantage.org/forms or by calling our Customer Service department and requesting one. Once completed, the form can be mailed to: Mass General Brigham Health Plan Medicare Advantage, Suite 850 399 Revolution Drive Somerville, MA 02145	your prescription hearing aids. For eligible weight loss programs, you may use your allowance at hospitals and non-hospital based multi-session weight loss programs led by nutritionists, registered dieticians, or other certified healthcare professionals. For 2025, members will receive a Flexible Benefit Mastercard® in the mail by January 1, 2025 with information on how to use their benefit card at point of services.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Mass General Brigham Advantage Secure (HMO-POS)

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 Mass General Brigham Advantage Secure (HMO-POS).

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 plans for 2025 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 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Mass General Brigham Health Plan offers other Medicare health 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 Mass General Brigham Advantage Secure (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Mass General Brigham Advantage Secure (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service 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 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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.

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. You can learn more about SHINE by visiting their website (www.mass.gov/health-insurance-counseling).

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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a 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.

- **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. To be eligible for the ADAP operating in your State, 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, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call 1-800-228-2714. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-855-833-3668 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Mass General Brigham Advantage Secure (HMO-POS)

Questions? We're here to help. Please call Customer Service at 1-855-833-3668. (TTY only, call 711). We are available for phone calls October 1 through March 31, seven days a week from 8:00 am – 8:00 pm EST and April 1 through September 30, Monday through Friday from 8:00 am –8:00 pm EST. This call is free.

Read your *2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Mass General Brigham Advantage Secure (HMO-POS). 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 **MassGeneralBrighamAdvantage.org.** You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **MassGeneralBrighamAdvantage.org.** 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 2025*

Read the *Medicare & You 2025* 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.