WellSense Added Value (HMO) offered by
Boston Medical Center Health Plan, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of WellSense Added Value (HMO). 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 wellsense.org/medicare. You can also review the separately mailed Evidence of Coverage to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an Evidence of Coverage.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

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

☐ Check the changes in the 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 WellSense Added Value (HMO).
- 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 WellSense Added Value (HMO).

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 Additional Resources

- Please contact our Member Services number at 855-833-8128 for additional information. (TTY users should call 711.) Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). This call is free.
- Member Services also has free language interpreter services available.
- This document may be available in other formats such as braille, large print, or other alternate formats. For additional information call Member Services at 855-833-8128.
- **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 WellSense Added Value (HMO)

- WellSense Added Value (HMO) is an HMO plan with a Medicare Advantage contract. Enrollment in WellSense Added Value (HMO) depends on contract renewal.

- When this document says “we,” “us,” or “our”, it means Boston Medical Center Health Plan, Inc., d/b/a/ WellSense Health Plan. When it says “plan” or “our plan,” it means WellSense Added Value (HMO).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for WellSense Added Value (HMO) in several important areas. **Please note this is only a summary of costs**.

These are 2023 cost-sharing amounts and may change for 2024. WellSense Added Value (HMO) will provide updated rates as soon as they are released.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$31.10	36.00
Deductible	$226	$240
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 2.2 for details.)	$8,300	$8,850
Doctor office visits	Primary care visits: Part B deductible and 20% coinsurance per visit Specialist visits: Part B deductible and 20% coinsurance per visit	Primary care visits: Part B deductible and 20% coinsurance per visit Specialist visits: Part B deductible and 20% coinsurance per visit
Inpatient hospital stays	$560 per day for days 1-4 of an inpatient stay. $0 per day for days 5-90.	$565 per day for days 1-4 of an inpatient stay. $0 per day for days 5-90.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $505 Coinsurance during the Initial Coverage Stage: **All tiers:** You pay 25% of the total cost 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.).	Deductible: $545 Coinsurance during the Initial Coverage Stage: **All tiers:** You pay 25% of total cost Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in WellSense Added Value (HMO) in 2024

If you do nothing by December 7, 2023, we will automatically enroll you in our WellSense Added Value (HMO). This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through WellSense Added Value (HMO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – 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.)	$31.10	$36.00

- 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 2.2 – 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	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as Copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,300	$8,850 Once you have paid $8,850 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at wellsense.org/medicare. You may also call Member Services 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 Services so we may assist.

Section 2.4 – 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	2023 (this year)	2024 (next year)
Inpatient hospital stay, including inpatient rehabilitative stays and stays in a critical access hospital (CAH)	You pay a $560 Copay for days 1-4 of a hospital stay/admission and then $0 Copay for days 5-90.	You pay a $565 Copay for days 1-4 of a hospital stay/admission and then $0 Copay for days 5-90. .
Inpatient psychiatric and substance use services, including detoxification, stays in a licensed general hospital, psychiatric facility, or critical access hospital	You pay a $370 Copay for days 1-5 of a hospital stay/admission and then $0 Copay for days 6-90.	You pay a $385 Copay for days 1-5 of a hospital stay/admission and then $0 Copay for days 6-90.
Inpatient stay in a Skilled Nursing Facility	You pay daily cost-sharing for days 21-100 of $196 in a benefit period.	You pay daily cost-sharing for days 21-100 of $203 in a benefit period.
Emergency Services	You pay $95 per visit. Copay is waived if admitted to the hospital within 24 hours of a visit to the Emergency Department of a hospital.	You pay $100 per visit. Copay is waived if admitted to the hospital within 24 hours of a visit to the Emergency Department of a hospital.

Cost	2023 (this year)	2024 (next year)
Urgently Needed Services	You pay $60 per visit. Copay is waived if admitted to the hospital within 24 hours of a visit to an Urgent Care Center.	You pay $55 per visit. Copay is waived if admitted to the hospital within 24 hours of a visit to an Urgent Care Center.
Over-the-Counter (OTC) Items	Mandatory supplemental benefit of $150 per quarter with no roll-over to the next calendar quarter of any unused amounts.	Mandatory supplemental benefit of $245 per quarter with no roll-over to the next calendar quarter of any unused amounts.
Home Meals Program	Coverage is provided up to a maximum of 14 meals in a member's residence immediately following surgery or inpatient hospitalization. Meals must be requested within 30 days of discharge.	Coverage is provided up to a maximum of 28 meals in a member's residence immediately following inpatient acute care setting. Meals must be requested within 30 days of discharge.
Transportation, Ground Ambulance Services	Prior Authorization is required.	Prior Authorization is required in a situation where non-emergency transportation by ambulance is medically required and it is documented that the member's condition is such that other means of transportation could endanger the person's health.

Cost	2023 (this year)	2024 (next year)
Nurse Line	N/A	Covered
Medicare Part B Drugs, Step Therapy	Not Covered	Covered
Vision Hardware	Covered for non-Medicare covered vision hardware including eyeglasses, contact lenses or hardware upgrades up to a maximum of $200 every calendar year.	Covered for non-Medicare covered vision hardware including eyeglasses, contact lenses or hardware upgrades up to a maximum of $300 every calendar year.
Diabetic Supplies and Services	Prior Authorization is required.	Prior Authorization may be required for Diabetic Supplies and services that cost $500 or more.
Diabetic Therapeutic Shoes/Inserts	Prior Authorization is required.	Prior Authorization is required for Diabetic Therapeutic Shoes/Inserts that cost $500 or more.
Durable Medical Equipment (DME)	Prior Authorization is required.	Prior Authorization is required for DME that costs $500 or more.
Medical Supplies	Prior Authorization is required.	Prior Authorization is required for Medical Supplies that cost $500 or more.

Cost	2023 (this year)	2024 (next year)
Outpatient Mental Health Specialty Services	Prior Authorization is required.	Prior Authorization is required only for Transcranial-Magnetic Stimulation and Applied Behavioral Analysis.
Medicare Part B Chemotherapy/Radiation Drugs	Part B Deductible and 20% Coinsurance.	Radiation drugs are subject to 0% coinsurance and Chemotherapy drugs are subject to 20% coinsurance.
Other Medicare Part B Drugs	Part B Deductible and 20% Coinsurance.	Some Part B drugs, such as vaccines are 0% coinsurance while other drugs such as IUDs may apply 20% coinsurance.
Insulin Drugs	**All Tiers:** You pay 25% of total cost. (Tier 1 is subject to Rx Deductible before the 25% Coinsurance applies)	**Standard Retail** 1 Month Copay : $35 2 Month Copay: $70 3 Month Copay: $105 **Standard Mail Order** 3 Month Copay: $105 **Long-Term Care** 1 Month Copay: $35 **Out-of-Network** 1 Month Copay: $35

Section 2.5 – 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. The "Drug List" includes many – but not all – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete "*Drug List"** by calling Member Services (see the back cover) or visiting our website wellsense.org/medicare.

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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

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

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 may 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 please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $505.	The deductible is $545.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **All tiers:** You pay 25% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **All tiers:** You pay 25% of the total cost.
Stage 2: Initial Coverage Stage (continued)		

Stage	2023 (this year)	2024 (next year)
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage) OR you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage) OR you have paid $8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage 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 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in WellSense Added Value (HMO)

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 WellSense Added Value (HMO).

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 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 2.1 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 6), or call Medicare (see Section 8.2). To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (medicare.gov/plan-

compare), read the Medicare & You 2023 handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2). As a reminder, Boston Medical Center Health Plan, Inc. (WellSense) 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 WellSense Added Value (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from WellSense Added Value (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 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 New Hampshire, the SHIP is called ServiceLink Aging and Disability Resource Center.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. ServiceLink Aging and Disability Resource Center 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 ServiceLink Aging and Disability Resource Center at 866-634-9412. You can learn more about ServiceLink Aging and Disability Resource Center by visiting their website servicelink.nh.gov.

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).
- **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 New Hampshire AIDS Drug Assistance

Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-852-3345, ext. 4502.

SECTION 7 Questions?

Section 7.1 – Getting Help from WellSense Added Value (HMO)

Questions? We're here to help. Please call Member Services at 855-833-8128. (TTY only, call 711.) We are available for phone calls Monday – Friday 8:00 a.m. – 8:00 p.m. (from October 1 to March 31, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.) Calls to this number is free. 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 WellSense Added Value (HMO). 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 wellsense.org/medicare. You can also review the enclosed Evidence of Coverage to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Visit our Website

You can also visit our website at wellsense.org/medicare. 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.