



2021 BENEFITS OVERVIEW

DRUG COPAYMENTS

\$10 – \$40 – \$80

COVERED SERVICES FOR MEDICARE PPO BLUE (PPO) MEMBERS

The information below provides a summary of the drug and health services covered under this plan. The information is not a complete description of benefits. For more information, please contact your benefit administrator.

Plan Specifics	In Network	Out of Network
Calendar-Year Deductible	\$0	\$0
Out-of-Pocket Maximum	\$3,400 in-network or \$5,100 for combined in- and out-of-network medical services each calendar year—this is the maximum out-of-pocket amounts you pay each year for Medicare-covered services.	
Covered Services	Your Cost for In-Network Services	Your Cost for Out-of-Network Services
Doctor's Office or Telehealth Visits	\$25 per office or telehealth visit	\$45 per visit (telehealth visits not covered)
Inpatient Hospital Care Hospital care for illness or chronic disease for as many days as medically necessary (includes hospital care in a rehabilitation hospital)	\$150 per day—days 1–5 \$0 per day—after day 5	20% of the cost
Emergency Care¹ Hospital emergency room visits	\$75 per visit, waived if admitted within 24 hours	\$75 per visit, waived if admitted within 24 hours
Urgently Needed Care¹ Doctor's office or telehealth visit (telehealth visits not covered with an out-of-network provider)	\$25 per office or telehealth visit	\$45 per visit (telehealth visits not covered) \$75 per office visit for urgently needed care outside the United States
Skilled Nursing Facility (SNF) Care Medically necessary care up to 100 days per benefit period ²	\$20 per day—days 1–20 \$100 per day—days 21–44 \$0 per day—days 45–100/per benefit period	20% of the cost
Mental Health and Substance Use Outpatient mental health and substance use care when medically necessary	\$25 per office or telehealth visit through a network provider	20% of the cost (telehealth not covered)
Inpatient care for mental health and substance use	\$150 per day—days 1–5 \$0 per day—after day 5	20% of the cost

1. Emergency and Urgently Needed Care are available worldwide.

2. A benefit period begins with the first day of a Medicare-covered inpatient hospital stay and ends with the close of a period of 60 consecutive days during which you were not an inpatient of a hospital or a skilled nursing facility.

Covered Services	Your Cost for In-Network Services	Your Cost for Out-of-Network Services
Annual Physical Exam	\$0	\$45 copay
Medicare-Covered Preventive Care and Screening Tests	\$0	\$0
Mammography screening every 12 months	\$0	20% of the cost
Routine gynecological exam once every 24 months	\$0	20% of the cost
Prostate cancer screening exam once per year	\$0	20% of the cost
Routine Dental Services Preventive routine dental care limited to one initial and periodic oral exam, one cleaning, (prophylaxis only — does not include periodontal cleaning) and one set of bitewing X-rays twice in a calendar year	\$0 per visit	\$45 per visit
Hearing Services Routine diagnostic hearing exam once every 12 months	\$0 per visit with a TruHearing provider	\$45 per visit
Hearing aids: Up to two TruHearing [®] -branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit.	\$699 or \$999 copay per aid	No coverage
Vision Care Routine refractive eye exam once every 12 months	\$0 per visit with an EyeMed [®] vision provider	\$45 per visit
Eyewear once every 24 months up to a \$200 maximum	All costs over \$200	All costs over \$200
Other Medicare-Covered Health Services Home health services (non-custodial)	\$0	20% of the cost
Durable medical equipment	10% of the cost (no cost for diabetes equipment and supplies*)	20% of the cost (no cost for diabetes equipment and supplies*)

*Coverage for diabetic test strips and blood glucose monitors is limited to OneTouch[®] products when purchased at participating retail and mail order pharmacies, otherwise you pay all costs. For additional information, contact Member Service or refer to your Evidence of Coverage.

COVERED SERVICES FOR MEDICARE PPO BLUE (PPO) MEMBERS

Covered Services	Your Cost for In-Network Services	Your Cost for Out-of-Network Services
Prosthetic devices and ostomy supplies	10% of the cost	20% of the cost
Outpatient diagnostic test and X-rays	\$10 for cost of lab tests; \$150 per day for CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery); \$10 for X-rays and other diagnostic tests	20% of the cost of lab tests, X-rays and other diagnostic tests 40% of the cost of CT scans, MRIs, PET scans, and nuclear cardiac imaging tests
Outpatient radiation therapy	\$0	20% of the cost
Outpatient surgery	\$150 per visit	20% of the cost
Physical, occupational, and speech therapy	\$15 per visit	20% of the cost
Podiatry Services Medicare-covered services	\$25 per visit	\$45 per visit
Chiropractic Services Manual manipulation of the spine to correct subluxation	\$20 per visit	\$45 per visit
Health and Wellness Programs Disease-specific health and wellness education	\$0	\$0
Smoking cessation counseling	\$0	\$45 per visit
Health Promotion Programs Eligible health club membership or exercise classes (up to \$150 maximum each calendar year)	You pay any balance in excess of the \$150 limit.	You pay any balance in excess of the \$150 limit.
Eligible weight-loss program (up to \$150 maximum each calendar year)	You pay any balance in excess of the \$150 limit.	You pay any balance in excess of the \$150 limit.

Covered Services	Your Cost for In-Network Services	Your Cost for Out-of-Network Services
Prescription Drug Coverage^{3, 4} At a participating retail pharmacy (up to a 30-day supply) ⁴	\$10 for generic drugs \$40 for preferred drugs \$80 for non-preferred drugs	Available under special circumstances: \$10 for generic drugs \$40 for preferred drugs \$80 for non-preferred drugs
Through a participating mail service pharmacy (up to a 90-day supply)	\$20 for generic drugs \$80 for preferred drugs \$160 for non-preferred drugs	Available under special circumstances: \$20 for generic drugs \$80 for preferred drugs \$160 for non-preferred drugs

- After your total yearly drug costs reach \$4,130, you will receive a discount on drugs and generally pay no more than 25% for the plan's costs for brand drugs and 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$6,550. Thereafter, you pay the greater of 5% of the cost of the drug or \$3.70 for generics or drugs treated like generics, and \$9.20 for all other drugs. Cost sharing adjustments will be applied automatically at the point of sale for qualified members.
- Prescription drugs may be available at retail pharmacies up to a 90-day supply. If available, calculate the copayment charge for each 30-day supply. Refer to the Evidence of Coverage for more details.

Member Eligibility

To enroll in the plan, retirees must be entitled to Medicare Part A and enrolled in Medicare Part B. In addition, retirees must permanently reside in the plan service area. Blue Cross Blue Shield of Massachusetts' plan service area includes all 50 states, excluding U.S. territories. Network providers may not be available in some states or in portions of a state within the plan service area; in such cases network cost sharing typically applies.

To locate a participating network provider:

- Call the Member Service phone line during regular business hours, or
- Call **1-800-810-Blue (2583)** to find a Blue Medicare Advantage PPO provider, or
- Visit the **Doctor & Hospital Finder** at member.bluecrossma.com/fad to find a Blue Medicare Advantage PPO provider.



FOR MORE INFORMATION OR HELP WITH ENROLLMENT

Member Service: 1-800-200-4255 (TTY: 711)

April 1 through September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday

October 1 through March 31, 8:00 a.m. to 8:00 p.m. ET, seven days a week

bluecrossma.com/medicare

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract.
Enrollment in Blue Cross and Blue Shield depends upon contract renewal.

This information is not a complete description of benefits.

Call **1-800-200-4255** (TTY: **711**) for more information.

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.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).



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