MASSACHUSETTS

Medicare PPO Blue (PPO)

2021 BENEFITS OVERVIEW

DRUG COPAYMENTS
$5 – $10 – $25

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 Care[1] Hospital emergency room visits	$75 per visit, waived if admitted within 24 hours	$75 per visit, waived if admitted within 24 hours
Urgently Needed Care[1] 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	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
Inpatient care for mental health and substance use	$150 per day—days 1-5 $0 per day—after day 5	20% of the cost
Annual Physical Exam	$0	$45 copay

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
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 every 24 months up to a $200 maximum	All costs over $200	All costs over $200 (this allowance is combined in an out-of-network)
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. No coverage for other test strips. 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]	$5 for generic drugs $10 for preferred drugs $25 for non-preferred drugs	Available under special circumstances: $5 for generic drugs $10 for preferred drugs $25 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: $10 for generic drugs $20 for preferred drugs $50 for non-preferred drugs

3. Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach $6,550; thereafter, you will pay $3.70 for generics or drugs treated like generics, $9.20 for all other drugs.
4. 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 **www.bcbs.com** to find a Blue Medicare Advantage PPO provider.

NONDISCRIMINATION NOTICE

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, contact the Medicare Advantage Appeals and Grievance Manager.

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 Medicare Advantage Appeals and Grievance Manager by mail at P.O. Box 55007, Boston, MA 02205; phone at **1-800-200-4255** (TTY: **711**) from April 1 through September 30, 8:00 a.m. to 8:00 p.m., Monday through Friday, or October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week; fax at **617-246-8506**; or email at **MedicareAdvantageRXAppeals@bcbsma.com**. You can file a grievance in person, by mail, fax, email, or you can call **1-800-200-4255** (TTY: **711**).

If you need help filing a grievance, the Medicare Advantage Appeals and Grievance Manager 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**.

TRANSLATION RESOURCES

Proficiency of Language Assistance Services

English: ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call **1-800-200-4255** (TTY: **711**).

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

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

Chinese/繁體中文: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-200-4255** (TTY: **711**).

French Creole/Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-200-4255** (TTY: **711**).

Vietnamese/Tiếng Việt: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-200-4255** (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-200-4255** (телетайп: **711**).

Arabic/العربية:
ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-200-4255**
(هاتف الصم والبكم: **711**).

Mon-Khmer, Cambodian ខ្មែរ: [illegible] **1-800-200-4255** (TTY: **711**).

French/Français: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-200-4255** (ATS: **711**).

Italian/Italiano: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-200-4255** (TTY: **711**).

Korean/한국어: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-200-4255** (TTY: **711**) 번으로 전화해 주십시오.

Greek/ελληνικά: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-200-4255** (TTY: **711**).

Polish/Polski: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-200-4255** (TTY: **711**).

Hindi हिंदी : ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-200-4255** (TTY: **711** पर कॉल करें)

Gujarati/ગુજરાતી : સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-200-4255** (TTY: **711**)

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.

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