



MASSACHUSETTS

## SUMMARY OF BENEFITS



# Medex<sup>®</sup> 2 Plan 2019

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

## Town of Canton

**Download the MyBlue Member App**—Get instant and secure access to your personal health care information any time you need it. A simple tap connects you to your claims history, your ID card, financial accounts, even your doctor. Download the app from the App Store<sup>®</sup> or Google Play<sup>™</sup>.



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.

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

# Your Medical Benefits

	Medicare Provides	Medex Provides
<b>Inpatient Care</b>		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	<ul style="list-style-type: none"> <li>• Coverage for days 1–60 per benefit period after Part A deductible</li> <li>• Coverage for days 61–90 after daily Part A coinsurance</li> <li>• Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>• Full coverage of Medicare deductible and coinsurance</li> <li>• Full coverage of lifetime reserve day coinsurance</li> <li>• Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up<sup>†</sup></li> </ul>
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"> <li>• Full coverage for days 1–20</li> <li>• Coverage for days 21–100 after daily Part A coinsurance</li> </ul>	<ul style="list-style-type: none"> <li>• Full coverage of Medicare daily coinsurance for days 21–100</li> <li>• \$10 daily for days 101–365</li> </ul>
Skilled nursing facility—not participating with Medicare*	No benefits	\$8 daily for 365 days per benefit period
<b>Outpatient Care</b>		
Office visits, accident treatment, sudden and serious medical emergency treatment, surgery, radiation therapy, X-ray and lab tests, podiatrists' services, 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	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	Full coverage of Medicare deductible and coinsurance

# Your Medical Benefits

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

<sup>†</sup> The additional days per benefit period 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.

## Preventive Services Approved by Medicare and Medex

Medicare provides coverage for certain preventive services at no cost to members. For the current list of covered preventive services, please refer to your Medicare & You handbook or go to [www.medicare.gov](http://www.medicare.gov). Some preventive covered services are highlighted below.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)</li><li>• One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)</li><li>• One routine colonoscopy every two years for a high-risk member (Full coverage for tests)</li><li>• 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)</li><li>• 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)</li></ul> | <ul style="list-style-type: none"><li>• One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)</li><li>• One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)</li><li>• 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)</li><li>• One routine Pap smear test per calendar year (Full coverage for test)</li></ul> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Important Information

- |                                                                                                                                                                                                                                  |                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• The Medicare inpatient deductible and coinsurance amounts are subject to change January 1 of each year.</li><li>• Benefits are available immediately upon your effective date.</li></ul> | <ul style="list-style-type: none"><li>• Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.</li></ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|

## Questions? Call 1-800-782-3675. (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)**

For more information about Blue Cross Blue Shield of Massachusetts, log on to: [www.bluecrossma.com](http://www.bluecrossma.com).

Interested in receiving information from us via e-mail? Go to [www.bluecrossma.com/email](http://www.bluecrossma.com/email) to sign up.

**Limitations and Exclusions.** These pages summarize the benefits of 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. is the administrator of the benefits described in this Summary of Benefits. Blue Cross Blue Shield administers claim payments only and does not assume financial risk for claims.



**Blue MedicareRxSM (PDP)**  
**Employer Group Medicare Prescription Drug Plan with supplemental coverage**  
**\$15 / \$30 / \$50**

## Summary of Benefits

January 1, 2019 – December 31, 2019

### 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.

<b>Initial Coverage</b>		<i>You pay the following until your total yearly drug costs reach \$3,820<sup>1</sup>:</i>	
<b>Standard Retail Cost-Sharing</b>		<b>One-month supply</b>	<b>Three-month supply<sup>2</sup></b>
<b>Tier 1</b>	<b>Generic</b>	<b>\$15</b>	<b>\$45</b>
<b>Tier 2</b>	<b>Preferred Brand</b>	<b>\$30</b>	<b>\$90</b>
<b>Tier 3</b>	<b>Non-Preferred Drug</b>	<b>\$50</b>	<b>\$150</b>
<i>Specialty drugs are limited to a one-month supply per fill.</i>			
<b>Mail Order Cost-Sharing</b>		<b>One-month supply</b>	<b>Three-month supply</b>
<b>Tier 1</b>	<b>Generic</b>	<b>\$15</b>	<b>\$30</b>
<b>Tier 2</b>	<b>Preferred Brand</b>	<b>\$30</b>	<b>\$60</b>
<b>Tier 3</b>	<b>Non-Preferred Drug</b>	<b>\$50</b>	<b>\$100</b>
<i>Specialty drugs are limited to a one-month supply per fill.</i>			
<b>Coverage Gap</b>			
After your total yearly drug costs reach \$3,820, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance as outlined above.			
Your copayments and/or coinsurance will not change until you qualify for Catastrophic Coverage.			
<b>Catastrophic Coverage</b>		<i>After your yearly out-of-pocket drug costs reach \$5,100, you pay:</i>	
<b>Generic (including brand drugs treated as generic)</b>		<b>\$3.40</b>	
<b>All other Drugs</b>		<b>\$8.50</b>	

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.



MASSACHUSETTS

# 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, 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 [civilrightscoordinator@bcbsma.com](mailto:civilrightscoordinator@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](http://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](http://hhs.gov).