MASSACHUSETTS

SUMMARY OF BENEFITS

MEDEX® 3 PLAN

3-TIER PRESCRIPTION DRUG COVERAGE

City of Beverly

This Medex plan provides benefits for:
- Medicare Part A and B Deductibles and Coinsurances
- Prescription Drugs
- OBRA Benefits

UNLOCK THE POWER OF YOUR PLAN

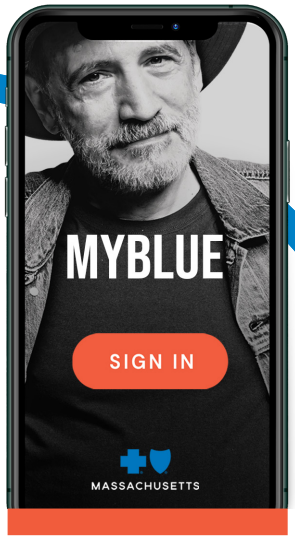
MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

Sign in

Download the app, or create an account at **bluecrossma.com.**



QUESTIONS? CALL 1-800-258-2226 (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)**

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.

YOUR MEDICAL BENEFITS

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
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*	• Full coverage for days 1–20 • Coverage for days 21–100 after daily Part A coinsurance	• Full coverage of Medicare daily coinsurance for days 21–100 • $10 daily for days 101–365
Skilled nursing facility—not participating with Medicare*	No benefits	$8 daily for 365 days per benefit period
Outpatient Care		
Office visits, emergency services, 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	Covered to the same extent as brand-name (Tier 2) prescription drugs
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

	Medicare Provides	Medex Provides
Mental Health and Substance Use Treatment		
Biologically based mental conditions**		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after Part A deductible • Coverage for days 61–90 after daily Part A coinsurance • Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to 190 days per lifetime	• Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • 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)†
Outpatient visits	80% of approved charges after annual Part B deductible	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

† The additional days 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.

	Medicare Provides	Medex Provides
Prescription Drugs		
At a designated retail pharmacy (up to a 30-day supply for each prescription or refill)	Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	Full coverage after a: • $10 copayment for Tier 1 • $20 copayment for Tier 2 • $35 copayment for Tier 3
Through the designated mail order pharmacy (up to a 90-day supply for each prescription or refill)	No benefits	Full coverage after a: • $10 copayment for Tier 1 • $20 copayment for Tier 2 • $35 copayment for Tier 3

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, refer to your Medicare & You handbook or go to **medicare.gov**. Some preventive covered services are highlighted below.

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- 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)
- 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)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- 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)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.
- The Medicare inpatient deductible and coinsurance amounts are subject to change January 1 of each year.
- Benefits are available immediately upon your effective date.
- You are encouraged to use an Express Scripts Pharmacy℠ outside of Massachusetts. These pharmacies will file claims for you as long as you have your ID card with you.

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. administers claims payment only and does not assume financial risk for claims.

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION PHARMACY PROGRAM

Why Do I Pay Different Amounts for Different Medications?

Medications are placed on different tiers based on a variety of factors, including what they are used for, their cost, and whether an equivalent or alternative medication is available. The level or tier that your medication is on determines your cost share.

What Is Cost Share?

When you fill a prescription, the amount you pay to the pharmacy is called your cost share. Your cost share may include your copayment, coinsurance, and deductibles. Generally, you pay the lowest amount of cost share for a Tier 1 medication and the highest amount for a Tier 3 medication. The pharmacy will inform you of your cost share for each prescription.

For more information about your specific prescription benefits, review the information in the chart on the previous page or call the Member Service number on the front of your ID card, Monday through Friday, 8:00 a.m. to 6:00 p.m.

What Is Quality Care Dosing?

Quality Care Dosing is a pharmacy management program whose goal is medication safety and affordability. The Quality Care Dosing program helps to ensure that the quantity and dose of medications you receive complies with U.S. Food and Drug Administration (FDA) recommendations, as well as manufacturer and clinical information.

As part of this program, when you fill a prescription, the dosage is verified electronically in two ways:

- Dose Consolidation—Checks to see whether you're taking two or more pills a day that can be replaced with one pill providing the same daily dosage.
- Recommended Monthly Dosing Level—Checks to see that your monthly dosage is consistent with the manufacturer's and FDA's monthly dosing recommendations and clinical information.

For the most current list of medications subject to Quality Care Dosing, along with associated dosing limits, use our Medication Lookup tool at **bluecrossma.com/medications**.

Why Do Some Medications Require Prior Authorization?

Prior Authorization is another pharmacy management program that has a goal of ensuring safety and affordability. As part of this program, your doctor is required to obtain prior authorization before prescribing specific medications. This process ensures that your doctor has determined that this medication is necessary to treat you, based on specific medical standards.

For the most current list of medications that require Prior Authorization, use our Medication Lookup tool at **bluecrossma.com/medications**.

What Is Step Therapy?

Step therapy is a pharmacy management program that also has a goal of safety and affordability for members. Step therapy is a key part of our prior authorization program that allows us to help your doctor provide you with an appropriate and affordable medication treatment. Before coverage is allowed for certain costly "second-step" medications, we require that you first try an effective, but less expensive "first-step" medication. Some medications may have multiple steps. For the most current list of medications that require Step Therapy, use our Medication Lookup tool at **bluecrossma.com/medications**.

Why Aren't All Medications Covered?

Your prescription pharmacy program provides coverage for over 4,000 prescription medications. Most medications that are not covered and are on our non-covered list have covered alternatives that have been proven to be equally safe and effective. Check with your doctor about appropriate alternatives if you currently take any non-covered medications.

For the most current list of non-covered medications, and to see covered alternatives, use our Medication Lookup tool at **bluecrossma.com/medications**.

Note: Your doctor may request coverage for a non-covered medication if no covered alternative is appropriate for treating your condition. In such cases, ask your doctor to contact Blue Cross Blue Shield of Massachusetts.

What Are the Benefits of Using the Mail Order Pharmacy?

If you take a medication on an ongoing basis, such as one to lower cholesterol or treat high blood pressure, you'll find that our mail order pharmacy:

- Is a fast, convenient way to get your medications
- Can save you money
- Gives you a 90-day supply of your medication for less than you'd pay at a retail pharmacy
- Sends the prescription to your home

Express Scripts® administers our mail order pharmacy. If you're already using another mail service pharmacy, your remaining refills will be transferred automatically to the Express Scripts Pharmacy.

Note: Your prescription pharmacy program limits your prescriptions to a 30-day supply from a designated retail pharmacy for each prescription, unless you are using Express Scripts for a 90-day supply of an approved ongoing medication.

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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**.

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**; 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**.

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PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/عربية:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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