



MASSACHUSETTS

Medicare | HMO Blue<sup>®</sup>

## Benefits Overview 2009

Drug Copayments

\$15–\$30–\$50



Medicare HMO Blue is a Medicare Advantage plan from Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

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

# Covered Services for Medicare HMO Blue Members

|   | Your Cost  |
|---|--|
| <b>Primary Care Physician</b>   |  |
| Office visits . . . . .   | \$10 per visit                                   |
| <b>Specialty Care (when medically necessary)</b>  |  |
| Office visits (when referred by your PCP) . . . . .   | \$20 per visit                                   |
| Diagnostic tests and X-rays . . . . .   | No charge  |
| Outpatient surgery . . . . .  | \$50 per visit                                   |
| Outpatient dialysis treatment . . . . .   | No charge  |
| Outpatient radiation therapy . . . . .  | No charge  |
| Cardiac rehabilitation services . . . . .   | \$15 per visit                                   |
| Physical, occupational, and speech therapy . . . . .  | \$15 per visit                                   |
| <b>Preventive Care</b>  |  |
| Periodic checkups . . . . .   | \$10 per PCP visit                               |
| Routine GYN exam—once every calendar year . . . . .   | \$10 per PCP visit<br>\$20 per specialist visit  |
| Screening mammograms—one every 12 months . . . . .  | No charge  |
| Eye exams—one routine exam every 12 months . . . . .  | \$20 per visit                                   |
| Eyewear, including contacts—one pair every 24 months (copays may apply) . . . . .   | All costs after \$100                            |
| Hearing tests—one exam every 12 months . . . . .  | No charge  |
| Hearing aids, fittings, evaluations, batteries, and repairs—every 36 months . . . . .   | All costs after \$400                            |
| <b>Health Promotion Programs</b>  |  |
| Eligible health club membership and exercise classes—each calendar year . . . . .   | All costs after \$150                            |
| Eligible weight loss programs—each calendar year . . . . .  | All costs after \$150                            |
| <b>Inpatient Hospital Services</b>  |  |
| Unlimited days for medically necessary hospitalization in a semi-private room . . . . .<br>including a rehabilitation hospital <sup>1</sup> | \$100 per day<br>(\$500 annual maximum)          |
| Physician services . . . . .  | No charge  |
| Intensive care services . . . . .   | No charge  |
| Diagnostic tests and X-rays . . . . .   | No charge  |
| Drugs provided by hospital during stay . . . . .  | No charge  |
| Physical, occupational, and speech therapy . . . . .  | No charge  |
| <b>Skilled Nursing Facility Care (when medically necessary)</b>   |  |
| Up to 100 days per benefit period <sup>1</sup> (no prior hospital stay required) . . . . .  | \$10 per day—Days 1–20<br>(\$200 annual maximum) |
| <b>Emergency Care</b>   |  |
| For emergencies worldwide:  |  |
| Hospital emergency room (fee waived if admitted within 24 hours) . . . . .  | \$50 per visit                                   |

<sup>1</sup> 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.

## Benefits at a Glance: A Condensed Benefits Overview from Medicare HMO Blue

### Urgently Needed Care<sup>2</sup>

### Your Cost

For urgently needed care inside or outside of the plan service area

|                       |  |
|-----------------------|--|
| Doctor's office ..... | \$10 per primary care visit<br>\$20 per specialty care visit |
|-----------------------|--|

### Mental Health and Substance Abuse (when medically necessary)

Inpatient care for mental health and substance abuse

|   |   |
|---|---|
| In an acute hospital. ....                              | \$100 per day<br>(\$500 annual maximum) |
| In a psychiatric hospital (lifetime limits apply). .... | \$100 per day<br>(\$500 annual maximum) |

Outpatient care

|   |   |
|---|---|
| For mental health and substance abuse—per calendar year. .... | \$20 per visit (1–10)<br>\$30 per visit (11+) |
|---|---|

### Other Health Services (when medically necessary)

|  |           |
|--|-----------|
| Home health services (non-custodial).....    | No charge |
| Durable medical equipment. ....              | No charge |
| Prosthetic devices and ostomy supplies ..... | No charge |

### Dental Services (beyond emergency medical treatment)

|   |                |
|---|----------------|
| One cleaning and one oral exam every six months,<br>including one set of bitewing X-rays every six months ..... | \$20 per visit |
|---|----------------|

### Podiatry Services

|                                     |   |
|-------------------------------------|---|
| Medically necessary foot care ..... | \$10 per PCP visit<br>\$20 per specialist visit |
|-------------------------------------|---|

### Chiropractic Services

|  |                |
|--|----------------|
| Medically necessary spinal manipulation to correct subluxation. .... | \$20 per visit |
|--|----------------|

### Prescription Drug Benefit<sup>3,4</sup>

|  |                               |                 |
|--|-------------------------------|-----------------|
| At a participating retail pharmacy<br>(up to a 30-day supply) <sup>5</sup> | for generic drugs .....       | \$15 copayment  |
|  | for preferred drugs .....     | \$30 copayment  |
|  | for non-preferred drugs ..... | \$50 copayment  |
| Through a participating mail service<br>pharmacy (up to a 90-day supply)   | for generic drugs .....       | \$30 copayment  |
|  | for preferred drugs .....     | \$60 copayment  |
|  | for non-preferred drugs ..... | \$100 copayment |

- Urgently Needed Care is available in the U.S. when you are temporarily outside the plan's service area or in the service area when network providers are not available.
- Copayments apply until you have spent \$4,350 out-of-pocket for your prescription drug costs; thereafter you will pay \$2.40 for generics or drugs treated like generics, \$6.00 for all other drugs, or 5% of the prescription cost, whichever is greater.
- Generic benzodiazepine and barbiturate medications covered by the plan are ineligible for catastrophic benefits under Medicare prescription drug plan rules. Therefore, costs for these medications will not accumulate as out-of-pocket costs which normally help you qualify for catastrophic coverage. The good news is that rather than pay the full cost of these medications during your coverage gap, where applicable, you will receive medications at the lesser of the drug cost or the plan's generic copayments described in the Initial Coverage section.
- 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.

# For More Information

Current members please call 1-800-200-4255 (TTY: 1-800 522-1254)

Monday – Friday, 8:00 a.m. to 8:00 p.m. ET

Prospective members please call your employer

Visit [www.bluecrossma.com/medicare](http://www.bluecrossma.com/medicare)

Or contact your Benefit Administrator

Most people with Medicare may apply, including those who qualify on the basis of a disability. Members must be eligible for Medicare Part A and continue to pay the Part B premium. Enrolled members must use Medicare HMO Blue plan providers for routine care.

Medicare Advantage contracts between the federal government and managed care organizations are valid for one year. The benefits, premiums, copayments, and service areas offered by Medicare HMO Blue are subject to change on January 1 each year.

These pages summarize benefits under your Medicare HMO Blue plan. For a complete list of the benefits and conditions of your plan, consult the Evidence of Coverage. Should any questions arise concerning benefits, the Evidence of Coverage will govern.



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