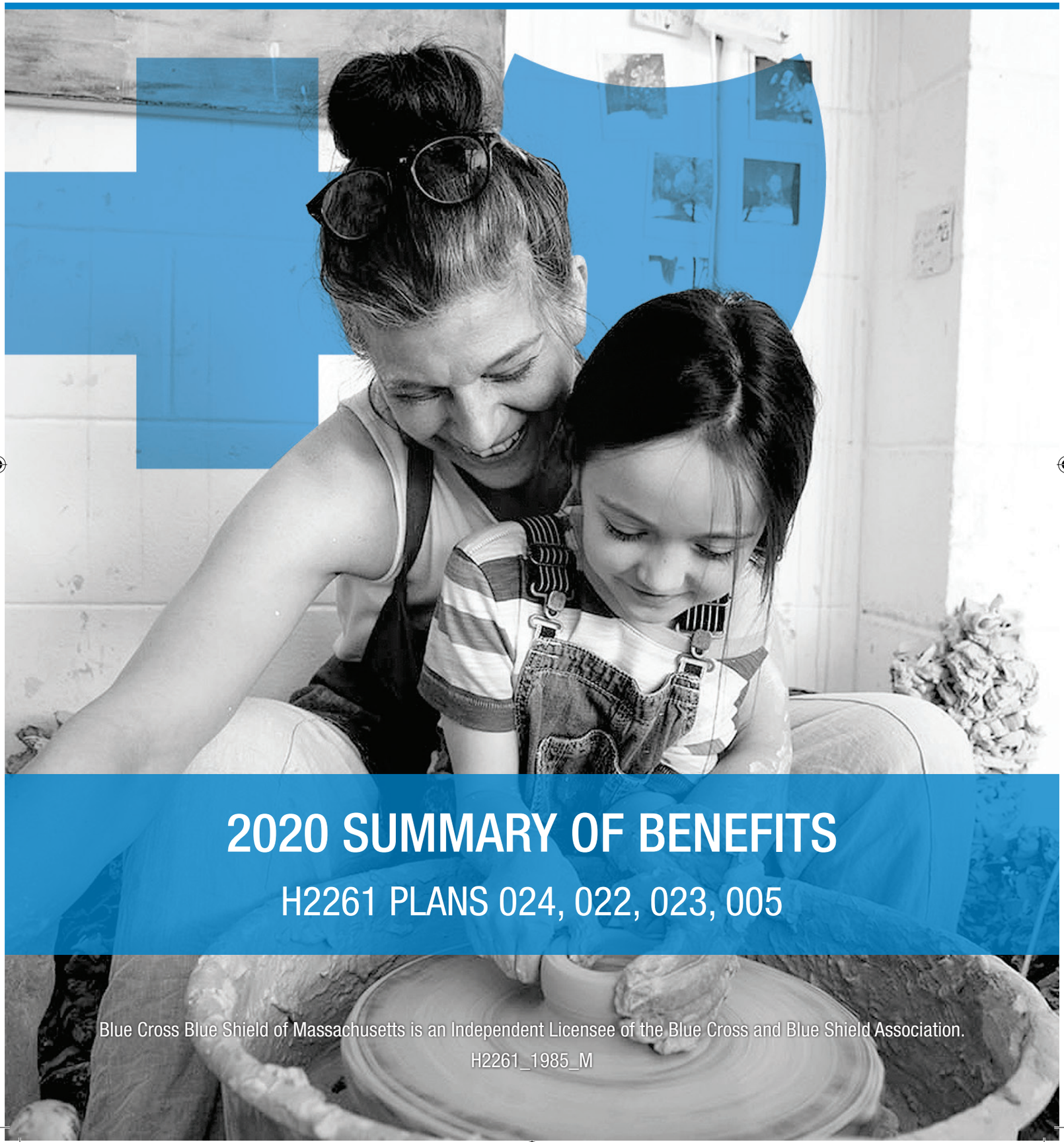
MASSACHUSETTS

Medicare HMO Blue℠ SaverRx (HMO)
Medicare HMO Blue℠ ValueRx (HMO)
Medicare HMO Blue℠ FlexRx (HMO-POS)
Medicare HMO Blue℠ PlusRx (HMO)



2020 SUMMARY OF BENEFITS

H2261 PLANS 024, 022, 023, 005

H2261_1985_M

This information is not a complete description of benefits. Call 1-800-200-4255 (TTY: 711) for more information.

To get a complete list of services we cover, call our Member Service department and ask for the “Evidence of Coverage.” You can also access the “Evidence of Coverage” online at our website, www.bluecrossma.com/medicare-options.

This booklet gives you a summary of drug and health services covered by Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), Medicare HMO Blue FlexRx (HMO-POS) and Medicare HMO Blue PlusRx (HMO) and what you pay.

SUMMARY OF BENEFITS

January 1, 2020 - December 31, 2020

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), Medicare HMO Blue FlexRx (HMO-POS) and Medicare HMO Blue PlusRx (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), Medicare HMO Blue FlexRx (HMO-POS) and Medicare HMO Blue PlusRx (HMO)** cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **http://www.medicare.gov**.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **http://www.medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Sections in this booklet

- Things to Know About **Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), Medicare HMO Blue FlexRx (HMO-POS) and Medicare HMO Blue PlusRx (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call member services at the number shown in the next section.

THINGS TO KNOW ABOUT

Medicare HMO Blue SaverRx (HMO)

Medicare HMO Blue ValueRx (HMO)

Medicare HMO Blue FlexRx (HMO-POS)

Medicare HMO Blue PlusRx (HMO)

Contact Information and Hours of Operation	
Members	
October 1 - March 31 **1-800-200-4255 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 7 days a week	April 1 - September 30 **1-800-200-4255 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 5 days a week, Monday - Friday
If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.	
Non-Members	
October 1 - March 31 **1-800-678-2265 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 7 days a week	April 1 - September 30 **1-800-678-2265 (TTY: 711)** 8:00 a.m. to 8:00 p.m., 5 days a week, Monday - Friday
Our website: www.bluecrossma.com/medicare-options	

Who can join?

To join Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), Medicare HMO Blue FlexRx (HMO-POS) and Medicare HMO Blue PlusRx (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You must continue to pay your Medicare Part B premium.

Our service area includes the following counties in Massachusetts: Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Medicare HMO Blue SaverRx (HMO), Medicare HMO Blue ValueRx (HMO), and Medicare HMO Blue PlusRx (HMO) have a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered.

Medicare HMO Blue FlexRx (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

As a member of our Medicare HMO Blue plans, you must choose a network Primary Care Physician (PCP). Your PCP will provide most of your care and will coordinate or help you arrange the rest of the covered services you get as a member of our plan. In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." Referrals from your PCP are not required for emergency care or urgently needed services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider directory at our website (www.bluecrossma.com/findadoctor).

You can see our plan's pharmacy directory at our website (www.bluecrossma.com/medicare-options).

Or, call us and we will send you a copy of the provider and pharmacy directories. The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.bluecrossma.com/medicare-options.
- Or, call us and we will send you a copy of the formulary. The formulary may change at any time. You will receive notice when necessary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS:

January 1, 2020 - December 31, 2020

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Monthly Plan Premium	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$0 per month** Worcester County: **$0 per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$36 per month** Worcester County: **$56 per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$266 per month** Worcester County: **$266 per month**	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk counties: **$96 per month** Worcester County: **$106 per month**
	You must continue to pay your Medicare Part B premium.			
Deductibles				
Medical:	These plans do not have a medical deductible.			
Prescription Drugs:	$320 per year for Tiers 3, 4, 5	$320 per year for Tiers 3, 4, 5	$200 per year for Tiers 3, 4, 5	$260 per year for Tiers 3, 4, 5
Maximum Out-of-Pocket Responsibility (does not include costs related to prescription drugs)	Your yearly limit(s) in this plan: $6,700 for services you receive from in-network providers.	Your yearly limit(s) in this plan: $4,900 for services you receive from in-network providers.	Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers.	Your yearly limit(s) in this plan: $3,900 for services you receive from in-network providers. $9,900 for services you receive from out-of-network providers.
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your Medicare Part B premium, your plan premium, and any cost-sharing for your Part D prescription drugs.			

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay.			
	$350 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Per admission benefit.	$275 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Per admission benefit.	$150 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Per admission benefit.	**In-network:** $200 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond **Out-of-Network:** 20% of the cost per stay
	Authorization rules may apply			
Outpatient Hospital Coverage	$280/visit	$250/visit	$150/visit	**In-network:** $200/visit **Out-of-Network:** 20% of the total cost
	Authorization rules may apply			
Ambulatory Surgery Center	$280/visit	$250/visit	$150/visit	**In-network:** $200/visit **Out-of-Network:** 20% of the total cost
	Authorization rules may apply			
Doctor's Office Visits				
Primary Care Physician:	$15 copay	$15 copay	$5 copay	**In-network:** $15 copay Out-of-network: $65 copay
Specialist:	$45 copay	$40 copay	$35 copay	**In-network:** $35 copay **Out-of-network:** $65 copay
	Authorization rules may apply. Referral from your doctor may be required.			

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Preventive Care	You pay nothing	You pay nothing	You pay nothing	**In-network:** You pay nothing **Out-of-network:** $65 copay or 20% of the cost, depending on the service
	Our plans cover many preventive services, including:			
	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)* • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling		• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Lung cancer screening (low dose computed tomography (LDCT)) • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Flu shots, pneumococcal shots, Hepatitis B shots (limitations may apply) • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Authorization rules may apply	

*If any other medical condition including polyp or other tissue is found and removed during the procedure this would be considered minimally invasive surgery. Refer to the Outpatient Surgery category for appropriate member cost-share.

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Preventive Care (continued)	You pay $0 for a supplemental annual physical exam. Includes a detailed medical/family history and a head to toe assessment with hands-on examination of all body systems to assess overall general health.	You pay $0 for a supplemental annual physical exam. Includes a detailed medical/family history and a head to toe assessment with hands-on examination of all body systems to assess overall general health.	You pay $0 for a supplemental annual physical exam. Includes a detailed medical/family history and a head to toe assessment with hands-on examination of all body systems to assess overall general health.	You pay $0 in-network and $65 out-of-network for a supplemental annual physical exam. Includes a detailed medical/family history and a head to toe assessment with hands-on examination of all body systems to assess overall general health.
Emergency Care	$90 copay	$90 copay	$75 copay	$90 copay
	Your copay is waived if you are admitted to the hospital within 24 hours or held overnight for observation.			
Urgently Needed Services	$15-$45 copay per visit	$15–$40 copay per visit	$5–$35 copay per visit	In network: $15–$35 copay per visit Out-of-network: $65 copay per visit
Diagnostic Services/Labs/Imaging				
Diagnostic radiology (such as MRIs, CT scans):	$275 copay per day per category	$250 copay per day per category	$150 copay per day per category	In network: $200 copay per day per category Out-of-network: 40% of the cost
	Authorization rules may apply			
Diagnostic tests and procedures	$10 copay per day	$10 copay per day	$0 copay per day	In network: $10 copay per day Out-of-network: 20% of the cost
	Authorization rules may apply			

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Lab services:	$10 copay per day	$10 copay per day	$0 copay per day	In network: $10 copay per day Out-of-network: 20% of the cost
	Authorization rules may apply			
Outpatient x-rays:	$10 copay per day	$10 copay per day	$10 copay per day	In network: $10 copay per day Out-of-network: 20% of the cost
	Authorization rules may apply			
Therapeutic radiology services:	$60 copay per visit	You pay nothing	You pay nothing	In network: You pay nothing Out-of-network: 20% of the cost
Hearing Services				
Routine Exam— up to one per year:	$15-$45 copay	$15–$40 copay	$5–$35 copay	In network: $15–$35 copay Out-of-network: $45 copay
Non Routine Exam:	$15-$45 copay	$15–$40 copay	$5–$35 copay	In network: $15–$35 copay Out-of-network: $65 copay
Hearing Aids:	Our plan pays up to $400 every 36 months for hearing aids	Our plan pays up to $400 every 36 months for hearing aids	Our plan pays up to $400 every 36 months for hearing aids	Our plan pays up to $400 every 36 months for hearing aids
Dental Services				
Limited Medicare-covered dental services:	$45 copay	$40 copay	$35 copay	In network: $35 copay Out-of-network: $65 copay or 20%

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Routine dental services: Single copay for visit that includes: Cleaning (for up to 1 every six months); prophylaxis only - does not include periodontal cleaning Dental x-ray(s)* (for up to 1 every six months) Oral exam (for up to 1 every six months)	$60 copay	$40 copay	$35 copay	**In network:** $35 copay **Out-of-network:** $45 copay

*Dental x-ray(s) coverage is limited to one set of bitewings every 6 months.

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Vision Services				
Medicare-Covered Eye Exam:	$15-$45 copay	$15-$40 copay	$5-$35 copay	**In-network:** $15-$35 copay **Out-of-Network:** $65 copay
Eyewear after cataract surgery: (for Medicare-covered standard eyewear)	$0 copay	$0 copay	$0 copay	**In and Out-of-Network:** $0 copay
Routine eye exam: (up to 1 per year)	$15 copay	$15 copay	$35 copay	**In-network:** $15 copay **Out-of-Network:** Not covered
Eyewear: (For covered eyewear, you pay any balance in excess of the $150 limit.)	Our plan pays up to $150 once every 24 months for prescription eyewear	Our plan pays up to $150 once every 24 months for prescription eyewear	Our plan pays up to $150 once every 24 months for prescription eyewear	**In and Out-of-Network:** Our plan pays up to $150 once every 24 months for prescription eyewear
Mental Health Services				
Inpatient Visit:	$300 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	$275 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	$150 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond	**In-network:** $200 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond **Out-of-Network:** 20% of the cost per stay
	Authorization rules may apply			

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Outpatient group therapy visit:	$40 copay	$40 copay	$35 copay	In-network: $35 copay Out-of-Network: 20% of the cost
	Authorization rules may apply			
Outpatient individual therapy visit:	$40 copay	$40 copay	$35 copay	In-network: $35 copay Out-of-Network: 20% of the cost
	Authorization rules may apply			
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100	Our plan covers up to 100 days in a SNF. You pay nothing per day for days 1 through 20 $160 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100	Our plan covers up to 100 days in a SNF. $20 copay per day for days 1 through 20 $100 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100	Our plan covers up to 100 days in a SNF. In-network: You pay nothing per day for days 1 through 20 $140 copay per day for days 21 through 44 You pay nothing per day for days 45 through 100 Out-of-Network: 20% of the cost per stay
	Authorization rules may apply			
Physical Therapy	$40 copay	$20 copay	$15 copay	In-network: $15 copay Out-of-Network: 20% of the cost
	Authorization rules may apply. Referral from your doctor may be required			
Ambulance	$250 copay per trip	$100 copay per trip	$100 copay per trip	In-network: $100 copay per trip Out-of-Network: $100 copay per trip
	Your copay is waived if you are admitted to the hospital within 24 hours or held overnight for observation. Authorization rules may apply.			

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Transportation (Including chair vans)	Not covered	Not covered	Not covered	Not covered
Medicare Part B Drugs (Including Chemotherapy)	20% coinsurance	15% coinsurance	10% coinsurance	In and Out-of-network: 10% coinsurance
	Authorization rules may apply. Select Part B drugs are subject to step therapy restrictions.			
Foot Care (Podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15-$45 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15–$40 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $5–$35 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $15–$35 copay Out-of-Network: $65 copay
	Referral from your doctor may be required			
Diabetes Supplies and Services*				
Diabetes monitoring supplies:	You pay nothing	You pay nothing	You pay nothing	In-network: You pay nothing Out-of-Network: 20% of the cost
Diabetes self-management training:	You pay nothing	You pay nothing	You pay nothing	In-network: You pay nothing Out-of-Network: 20% of the cost
Therapeutic shoes or inserts:	You pay nothing	You pay nothing	You pay nothing	In-network: You pay nothing Out-of-Network: 20% of the cost

*There is no coinsurance or copayment for the Johnson and Johnson® (One Touch®) blood glucose test strips and blood glucose monitors purchased at participating retail and mail-order pharmacies; otherwise you pay all costs. Test strips and blood glucose monitors are also available at DME suppliers with no coinsurance or copayment. There is no coinsurance or copayment for members eligible for covered therapeutic molded shoes and inserts, diabetes self-management training preventive benefit, or fasting plasma glucose tests.

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Durable Medical Equipment (wheelchairs, oxygen, etc.)	20% of the cost	20% of the cost	10% of the cost	In-network: 10% of the cost Out-of-Network: 20% of the cost
	Authorization rules may apply			
Prosthetic Devices (braces, artificial limbs, etc.)				
Prosthetic devices:	20% of the cost	20% of the cost	10% of the cost	In-network: 10% of the cost Out-of-Network: 20% of the cost
Related medical supplies:	20% of the cost	20% of the cost	10% of the cost	In-network: 10% of the cost Out-of-Network: 20% of the cost
Wellness Programs (See back of this booklet for more details)				
Fitness:	$250 per calendar year	$150 per calendar year	$150 per calendar year	$150 per calendar year
Weight Loss:	$150 per calendar year	$150 per calendar year	$150 per calendar year	$150 per calendar year

WELLNESS PROGRAMS

Medicare HMO Blue SaverRx (HMO)
Medicare HMO Blue ValueRx (HMO)
Medicare HMO Blue FlexRx (HMO-POS)
Medicare HMO Blue PlusRx (HMO)

Take control of your health with our Fitness and Weight Loss Benefits

What is the Fitness Benefit?

Enroll in a qualified health club or fitness facility and receive up to $150 ($250 for HMO Blue SaverRx) per calendar year toward your club membership fees and exercise classes.

What programs qualify?

- Health clubs with a variety of cardiovascular and strength-training exercise equipment, e.g., traditional health clubs, YMCAs, YWCAs, and community fitness centers
- Fitness classes at participating Councils on Aging (COA) facilities; fitness studios with instructor-led groups such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/ spinning and other exercise classes.
- Programs that DO NOT qualify: Martial arts centers; gymnastics facilities; country clubs; tennis, aerobic, or pool-only facilities; social clubs; and sports teams/ leagues. You cannot receive the Fitness Benefit for personal training, lessons, coaching, exercise equipment, or clothing.

What is the Weight Loss Benefit?

Enroll in a qualified weight loss program and receive up to $150 per calendar year toward your program fees. Employer group benefits may vary.

What kinds of programs qualify?

- Traditional Weight Watchers meetings, Weight Watchers Online and At Work program, and hospital-based and other non-hospital based weight loss programs that combine healthy eating, exercise, and coaching sessions.

Programs that DO NOT qualify: Individual nutrition counseling sessions, pre-packaged meals, books, videos, scales, or other items and supplies.

PRESCRIPTION DRUG BENEFITS

	Medicare HMO Blue SaverRx (HMO)	Medicare HMO Blue ValueRx (HMO)	Medicare HMO Blue PlusRx (HMO)	Medicare HMO Blue FlexRx (HMO-POS)
Deductible	$320 per year for Tiers 3, 4, 5	$320 per year for Tiers 3, 4, 5	$200 per year for Tiers 3, 4, 5	$260 per year for Tiers 3, 4, 5
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,020 Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.			

Tier 1 = Preferred Generic Tier 2 = Generic Tier 3 = Preferred Brand

Tier 4 = Non-Preferred Brand Tier 5 = Specialty Tier

Note: Cost-sharing may differ relative to the pharmacy's status as preferred or standard, mail-order, Long Term Care (LTC) or home infusion, and 30 days or 90 days supply.

	Medicare HMO Blue SaverRx (HMO)			Medicare HMO Blue ValueRx (HMO)			Medicare HMO Blue PlusRx (HMO)			Medicare HMO Blue FlexRx (HMO-POS)		
Preferred Retail Cost Sharing												
Drug Tier	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred Generic)	$2 copay	$4 copay	$6 copay	$2 copay	$4 copay	$6 copay	$1 copay	$2 copay	$3 copay	$1 copay	$2 copay	$3 copay
Tier 2 (Generic)	$8 copay	$16 copay	$24 copay	$6 copay	$12 copay	$18 copay	$5 copay	$10 copay	$15 copay	$5 copay	$10 copay	$15 copay
Tier 3 (Preferred Brand)	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay
Tier 4 (Non-Preferred Brand)	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
Tier 5 (Specialty Tier)	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost
Standard Retail Cost-Sharing												
Drug Tier	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred Generic)	$8 copay	$16 copay	$24 copay	$8 copay	$16 copay	$24 copay	$6 copay	$12 copay	$18 copay	$6 copay	$12 copay	$18 copay
Tier 2 (Generic)	$16 copay	$32 copay	$48 copay	$12 copay	$24 copay	$36 copay	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost
Mail Order Cost-Sharing												
Drug Tier	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred Generic)	$2 copay	$2 copay	$2 copay	$2 copay	$2 copay	$2 copay	$1 copay	$1 copay	$1 copay	$1 copay	$1 copay	$1 copay
Tier 2 (Generic)	$8 copay	$16 copay	$16 copay	$6 copay	$12 copay	$12 copay	$5 copay	$10 copay	$10 copay	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$42 copay	$84 copay	$84 copay	$42 copay	$84 copay	$84 copay	$42 copay	$84 copay	$84 copay	$42 copay	$84 copay	$84 copay
Tier 4 (Non-Preferred Brand)	$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay	$95 copay	$190 copay	$190 copay
Tier 5 (Specialty Tier)	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	26% of the cost	25% of the cost	25% of the cost	25% of the cost	26% of the cost	26% of the cost	26% of the cost
If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.												
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020 After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.											
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: • 5% of the cost, or • $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copayment for all other drugs.											

MASSACHUSETTS

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative.

Contact Us: 1-800-678-2265 (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.

Understanding the Benefits	
☐	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit bluecrossma.com/medicare or call **1-800-678-2265** (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.
☐	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
☐	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
Understanding Important Rules	
☐	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
☐	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021
☐	For our HMO Plans: Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
☐	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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Contact Information and Hours of Operation	
Members	
October 1 - March 31 **1-800-200-4255** (TTY: **711**) 8:00 a.m. to 8:00 p.m., 7 days a week	April 1 - September 30 **1-800-200-4255** (TTY: **711**) 8:00 a.m. to 8:00 p.m., 5 days a week, Monday - Friday
If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.	
Non-Members	
October 1 - March 31 **1-800-678-2265** (TTY: **711**) 8:00 a.m. to 8:00 p.m., 7 days a week	April 1 - September 30 **1-800-678-2265** (TTY: **711**) 8:00 a.m. to 8:00 p.m., 5 days a week, Monday - Friday
Our website: www.bluecrossma.com/medicare-options	

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, or sex. 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, or sex, 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, 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 www.hhs.gov.

TRANSLATION RESOURCES

Proficiency of Language Assistance Services

English: ATTENTION: If you 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: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરા 1-800-200-4255 (TTY: 711)

FOR MORE INFORMATION OR HELP WITH ENROLLMENT

bluecrossma.com/Medicare | Medicare Plan Sales: 1-800-678-2265 (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.

Blue Cross Blue Shield of Massachusetts is an HMO and PPO Plan with an Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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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**).

MASSACHUSETTS

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