



MASSACHUSETTS

Medicare HMO Blue (HMO)

# 2022 BENEFITS OVERVIEW

Drug Copayments

\$10 – \$40 – \$80



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

# COVERED SERVICES FOR MEDICARE HMO BLUE (HMO) 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
Calendar-Year Deductible	\$0
Out-of-Pocket Maximum	\$3,400 calendar-year, out-of-pocket maximum (excludes prescription drug cost sharing)
Covered Services	Your Cost for In Network Services
Doctor's Office or Telehealth Visits	\$15 per primary care provider (PCP) visit \$35 per specialty care visit
<b>Inpatient Hospital Care</b> 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
<b>Emergency Care<sup>1</sup></b> Hospital emergency room visits	\$75 per visit, waived if admitted within 24 hours
<b>Urgently Needed Care<sup>1</sup></b> Doctor's office or telehealth visit	\$15 per PCP visit \$35 per other provider visit \$75 per each office visit for urgently needed services outside the United States (telehealth visits not covered)
<b>Skilled Nursing Facility (SNF) Care</b> Medically necessary care up to 100 days per benefit period <sup>2</sup>	\$20 per day—days 1-20 \$100 per day—days 21-44 \$0 per day—days 45-100
<b>Mental Health and Substance Use</b> Outpatient mental health and substance use care when medically necessary	\$35 per office or telehealth visit
Inpatient care for mental health and substance use	\$150 per day—days 1-5
Annual Physical Exam	\$0

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
<b>Medicare-Covered Preventive Care and Screening Tests</b>	\$0
Mammography screening every 12 months	\$0
Routine gynecological exam once every 24 months	\$0
Prostate cancer screening exam once per year	\$0
<b>Routine Dental Services</b> 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
<b>Hearing Services</b> Routine diagnostic hearing exam once every 12 months with a TruHearing® provider	\$0 You must use a TruHearing provider.
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
<b>Vision Care</b> Routine refractive eye exam once every 12 months with an EyeMed® provider (you must use an EyeMed provider)	\$0 per visit
Eyewear every 24 months up to a \$200 maximum (you must use an EyeMed provider)	All costs over \$200
<b>Other Medicare-Covered Health Services</b> Home health services (non-custodial)	\$0
Durable medical equipment	10% of the cost (no cost for diabetes equipment and supplies*)
Prosthetic devices and ostomy supplies	10% of the cost
Outpatient diagnostic tests and X-rays	\$5 per day for X-rays, \$10 per day for lab tests and other diagnostic 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)
Outpatient radiation therapy	\$0
Outpatient surgery	\$150 per visit
Physical, occupational, and speech therapy	\$15 per visit

\*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. For additional information, contact Member Service or refer to your Evidence of Coverage.

# COVERED SERVICES FOR MEDICARE HMO BLUE (HMO) MEMBERS

Covered Services	Your Cost for In-Network Services
<b>Podiatry Services</b> Medicare-covered services	\$15 per PCP visit \$35 per other provider visit
<b>Chiropractic Services</b> Manual manipulation of the spine to correct subluxation	\$15 per visit
<b>Health and Wellness Programs</b> Disease-specific health and wellness education	\$0
Smoking cessation counseling	\$0
<b>Health Promotion Programs</b> Eligible health club membership, exercise equipment, or exercise classes (up to \$150 maximum each calendar year)	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.
<b>Prescription Drug Coverage<sup>3, 4</sup></b> At a participating retail pharmacy (up to a 30-day supply) <sup>4</sup>	\$10 for generic drugs \$40 for preferred drugs \$80 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

3. After your total yearly drug costs reach \$4,430, you will receive a discount on drugs and generally pay no more than 25% for the plan's costs for brand drugs and 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$7,050. Thereafter, you pay the greater of 5% of the cost of the drug or \$3.95 for generics or drugs treated like generics, and \$9.85 for all other drugs. Cost sharing adjustments will be applied automatically at the point of sale for qualified members.

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 permanently reside in the plan service area and be entitled to Medicare Part A and enrolled in Medicare Part B. The service area for this plan includes: Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester Counties, MA. You must live in one of these areas to join this plan.

To locate a participating network provider, call the Member Service phone line during regular business hours, or visit **Find a Doctor** at [member.bluecrossma.com/fad](https://member.bluecrossma.com/fad).

These pages summarize benefits under the Medicare HMO Blue (HMO) plan. Some services may require prior authorization. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information, contact the plan.



# 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, 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, 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 ភាសាខ្មែរ:** លើសពីការជួយភាសាខ្មែរ, លេខជំនួយប្រែកម្រិតភាសា ខេមបូឌីយ៉ា គឺអាចមានសំណួរអ្នក 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: Εάν 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)



## QUESTIONS?

### 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](https://bluecrossma.com/medicare)

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

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