SUMMARY OF BENEFITS

Medex® 3 Plan 2020

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

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® or Google Play™.

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

<table>
<thead>
<tr>
<th>Inpatient Care</th>
<th>Medicare Provides</th>
<th>Medex Provides</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Outpatient Care</th>
<th>Medicare Provides</th>
<th>Medex Provides</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td>80% of approved charges after annual Part B deductible</td>
<td>Full coverage of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Blood glucose monitors and materials to test for the presence of blood sugar</td>
<td>80% of approved charges after annual Part B deductible for all diabetics</td>
<td>Full coverage of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Urine test strips (Claims must be submitted on a Medex Subscriber Claim form)</td>
<td>No benefits</td>
<td>Covered to the same extent as brand-name prescription drugs</td>
</tr>
<tr>
<td>Chiropractor services</td>
<td>80% of approved charges after annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray</td>
<td>Full coverage of Medicare deductible and coinsurance for Medicare-approved charges only</td>
</tr>
<tr>
<td>Short-term rehabilitation – physical therapy, speech-pathology, and occupational therapy services approved by Medicare</td>
<td>80% of approved charges after annual Part B deductible</td>
<td>Full coverage of Medicare deductible and coinsurance</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Treatment</td>
<td>Medicare Provides</td>
<td>Medex Provides</td>
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<tr>
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<tr>
<td><strong>Biologically based mental conditions</strong> **</td>
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</tr>
</tbody>
</table>
| 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† | • 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 Benefits

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Medex Provides</th>
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</table>
| At a designated retail pharmacy | Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs. | After a $35 calendar-quarter deductible:  
• Full coverage (generic drugs)  
• 80% coverage (brand-name drugs) |
| Through the designated mail-service pharmacy (up to a 90-day supply for each prescription or refill) | No benefits | Full coverage after a:  
• $2 copayment (generic drugs)  
• $15 copayment (brand-name drugs) |

### 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](http://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)

### 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.

### Questions? Call 1-800-262-BLUE (2583). (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: [bluecrossma.com](http://bluecrossma.com).

Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at [bluecrossma.com/myblue](http://bluecrossma.com/myblue).

**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.
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.
Translation Resources
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 Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/العربية: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم ،TTY: 711).

Mon-Khmer, Cambodian/កាលប្រែ: ការជួនដំណឹងថ្មីសម្រាប់សំណាក់ភាសាខ្មែរ ឬអ្នកប្រើប្រាស់ភាសាខ្មែរ គ្រប់គ្រាន់ស្ថានភាពយ័ត្ដិប្រការប្រឹក្សាដ៏មានសមត្ថភាព អាចបានប្រើប្រាស់ប្រុសប្រស្តាន់ដោយមិនចេញចិត្ត (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).


Greek/αλληλικά: 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).