SUMMARY OF BENEFITS

Medex® 2 Plan 2018

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

This Medex plan does not provide benefits for:
• Prescription Drugs

MIT

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>
<tbody>
<tr>
<td>Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services</td>
<td>• Coverage for days 1–60 per benefit period after Part A deductible&lt;br&gt;• Coverage for days 61–90 after daily Part A coinsurance&lt;br&gt;• Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance</td>
<td>• Full coverage of Medicare deductible and coinsurance&lt;br&gt;• Full coverage of lifetime reserve day coinsurance&lt;br&gt;• Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†</td>
</tr>
<tr>
<td>Physician or other professional provider 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>Skilled nursing facility—participating with Medicare*</td>
<td>• Full coverage for days 1–20&lt;br&gt;• Coverage for days 21–100 after daily Part A coinsurance</td>
<td>• Full coverage of Medicare daily coinsurance for days 21–100&lt;br&gt;$10 daily for days 101–365</td>
</tr>
<tr>
<td>Skilled nursing facility—not participating with Medicare*</td>
<td>No benefits</td>
<td>$8 daily for 365 days per benefit period</td>
</tr>
</tbody>
</table>

<p>| Outpatient Care                                                               |                                                                                 |                                                                                  |
|------------------------------------------------------------------------------|                                                                                 |                                                                                  |
| 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 | 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                                                                      | Full coverage based on the allowed charge                                       |
| 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&lt;br&gt;• 20% of the approved charges for services not covered by Medicare |
| 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                           |</p>
<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biologically based mental conditions</strong>**</td>
</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 |

<table>
<thead>
<tr>
<th>Non-biologically based mental conditions</th>
</tr>
</thead>
</table>
| 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 per benefit period 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.
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, please refer to your Medicare & You handbook or go to www.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

- The Medicare inpatient deductible and coinsurance amounts are subject to change January 1 of each year.
- Benefits are available immediately upon your effective date.
- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.

Questions? Call 1-800-932-8323. (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: www.bluecrossma.com.

Interested in receiving information from us via e-mail? Go to www.bluecrossma.com/email to sign up.

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. is the administrator of the benefits described in this Summary of Benefits. Blue Cross Blue Shield administers claim payments only and does not assume financial risk for claims.
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).


Mon-Khmer, Cambodian/ភាសាខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ បានប្រឈមជំនួយភាសាជាច្រើន គឺអាចរកបានសំណួរអ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្បៅបេើ្រ័ណ្ណ សរាគា េ្លៃួនរ្រស់អ្នក (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).


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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए निश्चित 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 ભાષાની સહાયતા સેવાઓ વિના મૂલભણ છે. તમારા આઇડી કાર્ડ પર આપિયા નંબર પર મેબર સર્વીસ ને કોલ કરો (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）。


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


Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k’ehjí yánílt’i’go saad bee yát’i’ éí t’áájítį́k’e bee niká’a’doowólgo éí ná’ahoot’i’. Díí bee anítahíí ninaaltsoos bine’deé’ nóomba biká’ígííį’ béésh bee hodiílnih (TTY: 711).