

City of Boston - Medicare Plan Comparison Chart (Effective July 1, 2020)

| | Medicare Supplements | | | | Medicare Advantage | |
|--|--|---|--|---|--|--|
| Covered Services | Harvard Pilgrim Enhance with Aetna SilverScript PDP | Tufts Medicare Preferred Supplement/PDP | BCBSMA Medex 2 with Blue Medicare RX PDP | BCBSMA Managed Blue for Seniors | BCBSMA Medicare HMO Blue | Tufts Medicare Preferred HMO |
| Monthly Rate | \$44.98 | \$47.38 | \$47.92 | \$55.44 | \$47.90 | \$41.25 |
| Residence Eligibility | Reside anywhere in the United States or one of its territories | Reside anywhere in the United States or one of its territories | Reside anywhere in the United States or one of its territories | Reside in Plan Service area | Reside in Plan Service area | Reside in Plan Service area |
| Office Visits | \$15 copay per visit \$0 for annual physical | \$15 copay per visit \$0 for annual physical | \$15 copay per visit \$0 for annual physical | \$15 copay per visit \$15 copay for annual physical | PCP: \$15 Specialist: \$35 \$0 for annual physical | PCP: \$15 copay Specialist: \$15 copay \$0 for annual physical |
| Prescription Drugs Purchased at Participating Pharmacies | Copays for up to a 30-day supply: Tier 1: \$10 Tier 2: \$20 Tier 3: \$35 | Copays for up to a 30-day supply: Tier 1: \$5 Tier 2: \$10 Tier 3: \$25 | Copays for up to a 30-day supply: Tier 1: \$10 Tier 2: \$20 Tier 3: \$35 | Coinsurance for up to a 60-day supply: Tier 1: 25% Tier 2: 50% Tier 3: 75% | Copays for up to a 30-day supply: Tier 1: \$10 Tier 2: \$25 Tier 3: \$45 | Copays for up to a 30-day supply: Tier 1: \$10 Tier 2: \$25 Tier 3: \$50 |
| Prescription Drugs Purchased by Mail Order | Copays for up to a 90-day supply: Tier 1: \$20 Tier 2: \$40 Tier 3: \$105 | Copays for up to a 90-day supply: Tier 1: \$10 Tier 2: \$20 Tier 3: \$75 | Copays for up to a 90-day supply: Tier 1: \$20 Tier 2: \$40 Tier 3: \$70 | Copays for up to a 90-day supply: Tier 1: \$5 Tier 2: \$30 Tier 3: \$50 | Copays for up to a 90-day supply: Tier 1: \$20 Tier 2: \$50 Tier 3: \$90 | Copays for up to a 90-day supply: Tier 1: \$20 Tier 2: \$50 Tier 3: \$100 |
| Inpatient Care in an Acute Care Hospital | Covered in full After \$50 copay per admission, max of 1 copay per person per quarter (Copay does not apply to behavioral health) | Covered in full after \$50 copay per admission, max of \$200 per person per year (Copay does not apply to behavioral health) | Covered in full After \$50 copay per admission, max of 1 copay per person per quarter | Covered in full after \$50 copay per admission, max of 1 copay per person per quarter (Copay does not apply to behavioral health) | Member pays \$150 per day for days 1 – 5 (up to \$750 per admission), then covered in full | Covered in full after one time annual deductible of \$300 |
| Inpatient Care in Skilled Nursing Facility Care (SNF) | Covered in full for 100 days per benefit period ¹ after 3-day inpatient hospital stay | Covered in full for 100 days per benefit period ¹ after 3-day inpatient hospital stay | Covered in full for 100 days per benefit period ¹ after 3-day inpatient hospital stay | Covered in full for up to 100 days per benefit period ¹ . You must have been hospitalized three or more days in a row and transferred to the SNF within 30 days of the hospital discharge. | Member pays \$20 per day for days 1 – 20; \$100 per day for days 21 – 44; \$0 per day for days 45 – 100. Coverage for up to 100 days per benefit period ¹ | Covered in full for up to 100 days per benefit period ¹ |

| | Medicare Supplements | | | | Medicare Advantage | |
|--|--|---|--|---|---|--|
| <i>Covered Services</i> | Harvard Pilgrim Enhance with Aetna Silverscript PDP | Tufts Medicare Preferred Supplement/PDP | BCBSMA Medex 2 with Blue Medicare RX PDP | BCBSMA Managed Blue for Seniors | BCBSMA Medicare HMO Blue | Tufts Medicare Preferred HMO |
| Emergency Care at a Hospital Emergency Room | \$50 copay, waived if admitted to hospital | \$50 copay, waived if admitted to hospital | \$50 copay, waived if admitted to hospital | \$50 copay, waived if admitted to hospital | \$75 copay, waived if admitted to hospital | \$50 copay, waived if admitted to hospital |
| Ambulance Services | Medicare approved ambulance services covered at 100% | Medicare approved ambulance services covered at 100% | Medicare approved ambulance services covered at 100%. | Full coverage for emergency transport. \$40 copay for non-emergency transport. | \$100 copay, waived if admitted within 24 hours of trip. Covered in full for trips between hospital and Skilled Nursing Facility. | Medicare approved ambulance services covered with a \$50 copay per day |
| Dental Care | No coverage for routine dental care | No coverage for routine dental care | No coverage for routine dental care | No coverage for routine dental care | After you pay a \$35 copay per visit, you are covered every six months for: 1 cleaning; 1 oral exam, including one set of bitewing X-rays | No coverage for routine dental care |
| Chiropractic Services | Covered for Medicare-approved services with a \$15 copay | Covered for Medicare approved services with a \$15 copay | Covered for Medicare-approved services with a \$15 copay | \$15 copay per visit including spinal manipulation services furnished by a Chiropractor | \$20 copay per visit including spinal manipulation services furnished by a Chiropractor | Covered for Medicare approved services with a \$15 copay |
| Eyeglasses | One pair of eyeglasses or contact lenses after each cataract surgery | \$150 per year towards eyewear or contact lenses, but not both. This benefit is a reimbursement from the plan with receipt of purchase. | Not Covered | Discounts from participating providers | Up to \$150 once every 24 months for eyewear including fittings and evaluations | \$150 allowance per year towards eyewear or contact lenses, but not both at contracting EyeMed providers. |
| Hearing Aids | Not Covered | Members reimbursed for first \$500 (covered in full); then for 80% of next \$1,500, up to a total of \$1,700 every 2 years from any provider. | Not Covered | Not Covered | Covered up to \$400 every 36 months | Covered up to \$500 for the purchase or repair of hearing aids every three years at contracting providers. |

¹ Benefit Period: The time period defined by Medicare to determine when coverage in a hospital or Skilled Nursing Facility starts and ends. A benefit period starts on the first day a beneficiary receives care in a hospital or Skilled Nursing Facility and ends when the beneficiary has not received care in a hospital or Skilled Nursing Facility for 60 days in a row.