

Comparison of Health Plans for Retirees with Medicare Parts A and B

Benefit Category	BCBS Medex 2 & Blue Medicare Rx	Medicare HMO Blue
Type of Plan	Medicare Supplement Plan	Medicare Advantage HMO Plan
Location	Nationwide	Must reside in Massachusetts
Monthly Premium	Retiree Share: \$140.86/month ----- Surviving Spouse Share: \$234.78/month	Retiree Share: \$189.73/month ----- Surviving Spouse Share: \$316.22/month
INPATIENT CARE		
General Hospital: Semi-Private Room & Board and Special Services	Full coverage of Medicare deductible & coinsurance	\$150 per day: Days 1-5 for illness/chronic disease for as many days as medically necessary
Rehabilitation Hospital	Full coverage of Medicare deductible & coinsurance	\$150 per day: Days 1-5 for illness/chronic disease for as many days as medically necessary
Skilled Nursing Facility	<i>Facility participates with Medicare:</i> Medicare covers days 1-20 Plan covers days 21-100 \$10 daily for days 101-365 ----- <i>Facility does not participate with Medicare:</i> \$8 daily for 365 days per benefit period	\$20 per day: Days 1-20 \$100 per day: Days 21-44 \$0 per day: Days 45-100 *Medically necessary care only for up to 100 days per benefit period
OUTPATIENT CARE		
Medical Office Visits	Full coverage of Medicare deductible & coinsurance	\$15 PCP visit
Consult & Care by Specialists	Full coverage of Medicare deductible & coinsurance	\$35 specialist visit
Annual Routine Physical Exam	Not covered	Covered in full
Diagnostic Lab & X-ray Services	Full coverage of Medicare deductible & coinsurance	\$5 per day: X-rays \$10 per day: lab tests and other diagnostic tests \$150 per day: CT scans, MRIs, PET scans, and nuclear cardiac imaging tests *Imaging costs waived if on the same day as an ER visit or outpatient day surgery
Day Surgery	Full coverage of Medicare deductible & coinsurance	\$150 per visit
Radiation & Chemotherapy	Full coverage of Medicare deductible & coinsurance	Covered in full
Urgent & Emergency Care	Full coverage of Medicare deductible & coinsurance	\$15 PCP visit \$35 other provider visit \$75 outside of US (no telehealth) \$75 ER visit (waived if admitted within 24H)

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Outpatient Mental Health & Substance Abuse	Full coverage of Medicare deductible & coinsurance	\$35 per office or telehealth visit
Routine Vision Care	Not covered	Exam once a year with EyeMed provider covered in full. Eyewear allowance of \$200 every two years.
Hearing Services	Not covered	Exam once a year with TruHearing provider covered in full. Up to two TruHearing Advanced or Premium hearing aids every year, \$699 or \$999 copay per aid.
Preventative Dental	Not covered	Exam, cleaning, and bitewing X-rays twice a year covered in full
Occupational, Physical, and Speech Therapy	Full coverage of Medicare deductible & coinsurance	\$15 per visit
Chiropractic Services	Full coverage of Medicare deductible & coinsurance for Medicare-approved charges only	\$15 per visit
Podiatry Services	Not covered	\$35 per visit
Prescription Drugs	<p>Retail OR Mail Order 30-day supply: \$15: generic \$30: preferred \$50: non-preferred</p> <p>-----</p> <p>Retail 90-day supply: \$45: generic \$90: preferred \$150: non-preferred *No 90-day for speciality drugs</p> <p>-----</p> <p>Mail Order 90-day supply: \$30: generic \$60: preferred \$100: non-preferred *No 90-day for speciality drugs</p>	<p>Retail 30-day supply: \$10: generic \$25: preferred \$45: non-preferred</p> <p>-----</p> <p>Mail Order 100-day supply generic OR 90-day supply other: \$20: generic \$50: preferred \$90: non-preferred</p>
OTHER BENEFITS		
Fitness Benefit	\$150 maximum each calendar year	\$150 maximum each calendar year
Weight Loss Benefit	\$150 maximum each calendar year	\$150 maximum each calendar year