COMPARISON OF SELECTED BENEFITS UNDER MEDICARE PLANS OFFERED BY THE CITY OF BOSTON - benefits in effect as of July 1, 2011

This is a comparison of selected benefits under each of the City's Medicare plans. It does not represent complete plan benefits. Each plan's benefits are subject to certain definitions, limitations, conditions and exclusions as outlined in the respective plan documents. Should any questions arise concerning benefits, plan documents will govern.

For all plans except the Master Medical Medicare A&B Carveout plan, benefits are only available for medically necessary care provided or authorized by the member's plan primary care physicians. As a member of Tufts Medicare Complement and Managed Blue For Seniors, you will be fully responsible for the Medicare deductible and coinsurance for services which are not provided or authorized by your plan primary care physician. As a member of Medicare HMO Blue, or Tufts Medicare Preferred, you will receive no coverage from either the plans or from Medicare for care that is not provided or authorized by your plan doctor, except for emergency care and urgently needed out-of-area care.

COVERED SERVICES	MEDICARE HMO BLUE	TUFTS MEDICARE PREFERRED HMO	MANAGED BLUE FOR SENIORS	TUFTS MEDICARE COMPLEMENT	HARVARD PILGRIM MEDICARE ENHANCE	MASTER MEDICAL MEDICARE A&B CARVEOUT
Premium Effective 7/1/11	$34.92 per month	$24.20 per month	$37.53 per month	$41.80 per month	$37.50 per month	$111.88 per month
Office Visits	$15 PCP Visits $30 Specialist Visits $ 0 for annual physical	$10 PCP Visits $15 Specialist Visits $ 0 for annual physical	$10 copayment per visit	$10 copayment per visit $ 0 for annual physical	$15 copayment per visit $ 0 for annual physical	After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges
Prescription Drugs Purchased At Participating Pharmacies	Up to a 30-day supply: $10 generic $25 preferred brand name $45 non-preferred brand name	Up to a 30 day supply: $10 generic $25 brand name $50 non-preferred	Up to a 60-day supply: 25% copayment for generic formulary; 50% copayment for brand name formulary; 75% copayment for non-formulary.	Up to a 30-day supply: $5 generic $10 preferred brand $25 non-preferred	Up to a 30-day supply: $10 generic (Tier 1) $20 select brand (Tier 2) $35 non-select brand (Tier 3)	You pay 20% coinsurance. When the 20% coinsurance reaches $200 in a calendar year, you are then covered in full for the rest of that calendar year.
Prescription Drugs Purchased by Mail Order	Up to a 90-day supply: $20 generic $50 preferred brand name $90 non-preferred brand name	Up to a 90 day supply: $20 generic $50 brand name $100 non-preferred (co-pays less for 30 or 60 day supply)	Up to a 90-day supply: $5 for generic formulary $30 for brand name formulary $50 for non-formulary	Up to a 90-day supply: $10 generic $20 preferred brand $75 non-preferred brand	Up to a 90 day supply: $20 generic (Tier 1) $40 select brand (Tier 2) $105 non-select brand (Tier 3)	Up to a 90-day supply: $5 generic $10 brand name
Inpatient Care in an Acute Care Hospital	Members pay $150 per day up to a maximum of $750 per year.	Covered in full after one time annual deductible of $300.	Covered in full	Covered in full	Covered in full	Covered in full
Inpatient Care in Skilled Nursing Facility Care (SNF)	Members pay $50 per day for covered services up to a total of $1,000 each calendar year	Covered in full for up to 100 days per benefit period[1]	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.	Covered in full for 100 days per benefit period[1]	Covered in full for up to 100 days per benefit period[1]	Covered in full. You must have been hospitalized three or more days in a row and transferred to the SNF within 30 days of the hospital discharge

[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.

	MEDICARE HMO BLUE	TUFTS MEDICARE PREFERRED	MANAGED BLUE FOR SENIORS	TUFTS MEDICARE COMPLEMENT	HARVARD PILGRIM MEDICARE ENHANCE	MASTER MEDICAL MEDICARE A&B CARVEOUT
Emergency Care at a Hospital Emergency Room	$50 copayment, waived if admitted.	$50 copayment, waived if admitted.	$50 copayment, waived if admitted.	$50 copayment, waived if admitted.	$50 copayment, waived if admitted to hospital.	Covered in full for hospital charges; After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges for provider services.
Ambulance Services	$100 copayment, 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 co-pay per day.	$40 copayment for medically necessary transport. Full coverage for emergency transport. .	Medicare approved ambulance services covered at 100%	Medicare approved ambulance services covered at 100%	20% coinsurance for medically necessary transport. Full coverage for transporting inpatient between hospital and Skilled Nursing Facility and back.
Dental Care	After you pay a $25 copayment 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.	No coverage for routine dental care.	No coverage for routine dental care.	No coverage for routine dental care.	No coverage for routine dental care.
Chiropractic Services	$30 copayment per visit including spinal manipulation services furnished by a Chiropractor.	Covered for Medicare approved services with a $15 copay.	$10 copayment per visit including spinal manipulation services furnished by a Chiropractor.	Covered for Medicare approved services with a $10 copay.	Covered for Medicare approved services with a $15 copay.	You pay 20% coinsurance.
Eyeglasses	Up to $150 once every 24 months for eyewear including fittings and evaluations.	Once every calendar year, covered for up to $150 for eyeglasses.	Discounts from participating providers	Discounts from participating providers	One pair of eyeglasses or contact lenses after each cataract surgery.	Discounts from participating providers
Hearing Aids	Up to $400 every 36 months.	Covered up to $500 for the purchase or repair of hearing aids every three years	Not covered	Not covered	Not covered	Not covered