City of Boston - Medicare Plan Comparison Chart (Effective July 1, 2016)

Covered Services	Harvard Pilgrim Medicare Enhance	Tufts Medicare Preferred Supplement/PDP	Managed Blue for Seniors	Tufts Medicare Preferred HMO	Medicare HMO Blue	Master Medical Carve-Out A&B
Monthly Rate	$44.07	$39.39	$40.30	$29.38	$33.15	$140.14
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 in Plan Service area	Reside in Plan Service area	Reside in Plan Service area	Reside anywhere in the United States or one of its territories
Office Visits	$15 copay per visit $0 for annual physical	$10 copay per visit $0 for annual physical	$10 copay per visit	PCP: $10 copay Specialist: $15 copay $0 for annual physical	PCP: $15 Specialist: $35 $0 for annual physical	After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges
Prescription Drugs Purchased at Participating Pharmacies	Copays for up to a 30-day supply: Generic: $10 Select brand: $20 Non-select brand: $35	Copays for up to a 30-day supply: Tier 1: $5 Tier 2: $10 Tier 3: $25	Coinsurance for up to a 60-day supply: Generic: 25% Brand name: 50% Non-formulary: 75%	Copays for up to a 30-day supply: Tier 1: $10 Tier 2: $25 Tier 3: $50	Copays for up to a 30-day supply: Generic: $10 Preferred: $25 Non-preferred: $45	You pay 20% co-insurance. When the 20% co-insurance reaches $200 in a calendar year, you are then covered in full for allowed charges for the rest of that calendar year.
Prescription Drugs Purchased by Mail Order	Copays for up to a 90-day supply: Generic: $20 Select brand: $40 Non-select brand: $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: Generic: $5 Brand name: $30 Non-formulary: $50	Copays for up to a 90-day* supply: Tier 1:$20 Tier 2: $50 Tier 3: $100 *Copays are less for a 30 or 60 day supply	Copays for up to a 90-day supply: Generic: $20 Preferred: $50 Non-preferred: $90	Copays for up to a 90-day supply: Generic: $5 Brand name: $10
Inpatient Care in an Acute Care Hospital	Covered in full	Covered in full	Covered in full	Covered in full after one time annual deductible of $300	Member pays $150 per day for days 1 – 5 (up to $750 per admission), then covered in full	Covered in full
Inpatient Care in Skilled Nursing Facility Care (SNF)	Covered in full for up to 100 days per benefit period[1]	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.	Covered in full for up to 100 days per benefit period[1]	Member pays $40 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. You must have been hospitalized three or more days in a row and transferred to the SNF within 30 days of the hospital discharge.

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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	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	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.	Medicare approved ambulance services covered with a $50 copay per day	$100 copay, waived if admitted within 24 hours of trip. Covered in full for trips between hospital and Skilled Nursing Facility.	Covered in full for transporting inpatient between hospital and SNF. After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges for provider services.
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 $10 copay	$10 copay per visit including spinal manipulation services furnished by a Chiropractor	Covered for Medicare approved services with a $15 copay	$20 copay per visit including spinal manipulation services furnished by a Chiropractor	After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges for provider services.
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.	Discounts from participating providers	$150 allowance per year towards eyewear or contact lenses, but not both at contracting Eyemed providers.	Up to $150 once every 24 months for eyewear including fittings and evaluations	Discounts from participating 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	Covered up to $500 for the purchase or repair of hearing aids every three years at contracting providers.	Covered up to $400 every 36 months	Not Covered

[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.