MA Bay Health Care Trust RETIREE BENEFIT COMPARISON 2024 Greater Lowell

Plan features	BCBS Medex II w/pdp (Blue Medicare Rx)	Tufts Medicare Preferred Supplement w/PDP	Tufts Medicare Preferred HMO Prime
Effective Date	**1-Jan-24**	**1-Jan-24**	**1-Jan-24**
Monthly Premium Rates (Full premium)	**$389.90**	**$465.00**	**$397.00**
includes MA Bay admin fee			
RETIREE-SURVIVOR PAYS PER PLAN/PER MO.	**$77.98**	**$93.00**	**$79.40**
Coverage Area			
Not Available In These Massachusetts Counties	Available in all counties	Available in all counties	Available in all counties except Dukes,Franklin, Nantucket and Berkshire
Available in all fifty states	Yes	YES	No
Calendar Year Deductible	None	None	$300 Acute inpatient hospital deductible per calendar year
Out-of-Pocket Maximum	Rx $8,000 OOP max, your prescription drugs co-pay is reduced in accordance with the plan.	Rx $8,000 OOP max, your prescription drugs co-pay is reduced in accordance with the plan.	Rx $8,000 OOP max, your prescription drugs co-pay is reduced in accordance with the plan.
Lifetime Maximum, if applicable	None	None	None
Services Provided In A Physician's Office Primary Care Physician Office Visit	No copay when medically necessary; routine exams not covered	$10 copay; $0 copay for annual routine physical	$10 copay; $0 copay for annual routine physical
Specialist Office Visit	No copay	$10 copay	$15 copay
Services provided in a Retail Clinic Outpatient visit	If covered by Medicare, balance will be covered	$10 copay	$15 copay
Services Provided In A Hospital Setting Emergency Room	No copay	$50 copay	$50 per visit for Medicare-covered ER visits
Waived if Admitted		Yes	Yes if admitted within 24 hours
Per Admission, Hospital	No copay	No copay	No copay after yearly deductible
Copay Limits			
Diagnostic X-Ray and Lab Service	No copay	No copay	No copay
Rehabilitation Hospital	No copay for facilities participating in Medicare	No copay for facilities participating in Medicare	No copay for facilities participating in Medicare
Duration Limits	Up to 100 days per benefit period	Up to 90 days covered for each benefit period	Up to 90 days covered for each benefit period
Skilled Nursing Facility (100 days)	No copay for facilities participating in Medicare	No copay at Medicare-certified skilled Nursing facility	No copay at Medicare-certified skilled Nursing facility
Duration Limits	Up to 100 days per benefit period; plan pays $10 daily for days 101-365	100 days covered for each benefit period	100 days covered for each benefit period after 3 day inpatient hospital stay.

Outpatient surgery	No copay	No copay	$50 copay per day
Ambulance Services	No copay	No copay	$50 copay for Medicare-covered ambulance benefits
Physical Therapy, Occupational Therapy & Chiropractic Treatment			
Physical Therapy	No copay for Medicare approved charges	$10 copay per visit	$15 copay for ea. Medicare-covered visit.
Annual Visit Limits	No	No	No
Occupational Therapy	No copay	$10 copay	$15 copay for ea. Medicare-covered visit.
Annual Visit Limits	No	No	No
Chiropractic Benefit	Yes	Yes	Yes
Copays and Annual Maximums	No copay for manual manipulation of the spine to correct a subluxation that can be shown by x-ray.	$10 copay	$15 copay for ea. Medicare-covered visit.
Mental Health Services In-patient treatment	No copay	No copay	No copay
Duration Limits	90 days per benefit period (plus 365 Medex lifetime benefit days)	Up to 190 days in a **Psychiatric Hospital in a lifetime	Up to 190 days in a Psychiatric Hospital in a lifetime
Out-patient treatment	No copay	$10 copay	$15 copay for ea. Medicare-covered visit.
Annual Visit Limits	None	None	None
Pharmacy Services Retail Copay			
Tier 1	$10	$10	$10
Tier 2	$25	$20	$25
Tier 3	$45	$35	$50
Mail-Order Copay (90 day supply) Tier 1	$20	$20	$20
Tier 2	$50	$40	$50
Tier 3	$90	$70	$100
Separate Pharmacy Deductibles	None	None	None
Vision Care Vision Exam Coverage	Not covered	Covered, $150 allowance glasses or contacts (but not both) each year.	Covered, $150 allowance glasses or contacts each year at EyeMed provider. $90 per year allowance at all other providers.
Frequency		One every 24 months	One per year
Copay		$10 copay	$15 copay
Hearing Testing & Services Hearing Exams	Not covered	Covered	Covered - $15 copay
Frequency		one per calendar year	one per calendar year
Copay		$10 copay	$15 copay
Hearing Aids			

Benefit	Not covered	Covered	Covered
Limits		covered up to $1,700 once every 2 years; covers purchase & repairs.	Up to $500 every three years towards purchase or repair. Other Discounts available through Hearing
Ambulance Service Copay	No copay	No copay	$50 copay for Medicare covered ambulance benefits per day.
Annual Fitness & Wellness Benefit	Not covered	$150 per year toward fitness club membership, instructional fitness classes and/or nutritional counseling	$150 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture and/or wellness programs such as
Weight Management Program	Not covered	$150 per year towards program fees for weight loss program such as WeightWatchers, Jenny Craig, Idiet, or a hospital based weight loss program.	$150 per year towards program fees for weight loss program such as WeightWatchers, Jenny Craig, Idiet, or a hospital based weight loss program.

**Additional days may be covered under Massachusetts Law after 190 day Medicare lifetime maximum is exhausted. Inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital

Under Tufts Medicare Preferred HMO,your Primary Care Physician (PCP) will provide most of your care and will arrange the rest of the covered services you receive as a plan member. In most cases, you must get a referral from your PDP before you see any other health care provider, except in emergency or urgent care situations or for out of area renal dialysis.

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions or conflicts arise, the certificate(s) & riders will govern.