HARVARD
Human Resources

2023 MEDICAL PLAN COMPARISON CHART FOR RETIREES AND SPOUSES/DOMESTIC PARTNERS AGE 65 OR OVER

(FOR RETIRED HUCTW AND LOCAL 26 RETIRED ON/AFTER 7/5/2011)

You must be enrolled in Medicare Parts A & B. The benefits described include coverage through Medicare.
Be sure to check the service area of the medical insurance provider you are interested in to ensure you are eligible to participate.

MEDICAL PLAN COVERAGE	BCBS MEDEX 1-800-882-1093 • www.bcbsma.com	HPHC/ MEDICARE ENHANCE 1-877-679-5667 • www.harvardpilgrim.org	TUFTS HEALTH PLAN MEDICARE PREFERRED HMO 1-800-246-2400 • www.tuftshealthplan.com
Service Area	You can see any physician who accepts Medicare.	You can see any physician who accepts Medicare.	You must live in the Tufts Medicare Preferred HMO service area, and select a Primary Care Physician (PCP) from the network. Contact Tufts for the complete service area and a list of PCPs
Annual Deductible	$250 deductible per calendar year	None	None
Out-of-Pocket Maximum (for medical only, does not apply to prescription benefit)	$1,000 out-of-pocket maximum per calendar year	None	$3,400 out-of-pocket maximum per calendar year
HOSPITAL INPATIENT CARE			
Semi-private room and hospital services and supplies when medically necessary.	Coverage coordinated with Medicare benefits; please refer to the BCBS Medex Summary of Benefits for details.	Covered at 100% per benefit period.	Covered in full after one $200 deductible per year.
OUT-OF-HOSPITAL CARE			
Physician's Services	Deductible then 20% coinsurance	$15 copayment per visit.	$10 copayment per visit for primary care physician; $15 copayment for specialist.
Diagnostic, Lab, and X-ray Tests	Deductible then 20% coinsurance	Covered in full.	Covered in full.
PREVENTIVE HEALTH CARE			
Routine Physical Exams	Coverage coordinated with Medicare benefits.	$15 copayment.	Covered in full.
Routine Hearing Exams	Coverage coordinated with Medicare benefits.	$15 copayment.	$15 copayment.
Immunizations	Coverage coordinated with Medicare benefits.	Covered in full.	Covered in full.
Routine Pap Smears and Mammograms (test only, not related services)	Coverage coordinated with Medicare benefits.	Covered in full.	Covered in full.

This chart compares the major coverage provisions. In the event of any inconsistency, Harvard's formal contracts will govern. For additional information, call the medical care provider directly.

2023 MEDICAL PLAN COMPARISON CHART FOR RETIREES AND SPOUSES/DOMESTIC PARTNERS AGE 65 OR OVER (CONT.)

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PRESCRIPTION DRUGS - MEDICARE PART D, ADMINISTERED THROUGH EXPRESS SCRIPTS MEDICARE			
Administered through Express Scripts Medicare for all medical plans. Retail: May purchase up to a 90 day supply at retail, copayments apply for each 30 day supply	At a participating pharmacy for 30-day supply: $7 copayment for generic $25 copayment for preferred brand $50 copayment for non-preferred brand	At a participating pharmacy for 30-day supply: $10 copayment for generic $20 copayment for preferred brand $35 copayment for non-preferred brand	At a participating pharmacy for 30-day supply: $10 copayment for generic drugs $25 copayment for preferred brand $50 copayment for non-preferred brand
Copayment for up to a 90-day supply through Express Scripts Medicare Home Delivery (saves over retail cost). Call 866-544-2895 for information on mail order. (International retirees call 877-787-8684.)	Through Express Scripts Medicare home delivery for 90-day supply: $14 copayment for generic $50 copayment for preferred brand $100 copayment for non-preferred brand	Through Express Scripts Medicare home delivery for 90-day supply: $20 copayment for generic $40 copayment for preferred brand $105 copayment for non-preferred brand	Through Express Scripts Medicare home delivery for 90-day supply: $20 copayment for generic $50 copayment for preferred brand $100 copayment for non-preferred brand
Prescription Out-of-Pocket Maximum	$1,250 out-of-pocket maximum per calendar year	None	None
EMERGENCY SERVICES			
Hospital Emergency Room (ER) and outside of HMO Service Area. Note: Whenever possible, notify your plan of any medical emergency within 48 hours.	Deductible then 20% coinsurance	$50 copayment (waived if hospitalized).	$50 copayment (waived if hospitalized).
HARVARD UNIVERSITY HEALTH SERVICES (HUHS)			
HUHS	HUHS available to participants. Member will be billed for services not covered in full by Medicare and BC/BS Medex.	HUHS available to participants.	HUHS not available to participants.
MENTAL HEALTH SERVICES			
Outpatient Care Office Visits	Deductible then 20% coinsurance	Biologically based: $15 copayment for each individual/group therapy visit. Unlimited visits. Other: $15 copayment after Medicare coverage is exhausted, up to 24 visits.	$15 copayment per visit. Unlimited visits.
Psychiatric Hospital	Deductible then 20% coinsurance	Biologically based covered at 100%. Same benefits as acute inpatient hospital care. Other: covered at 100% up to 60 days per calendar year.	Covered in full up to Medicare's lifetime limit of 190 days.

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AMBULANCE SERVICE			
Ambulance Service	Deductible then 20% coinsurance if Medicare determines services are medically necessary.	Covered in full for Medicare-covered ambulance services.	Covered in full for Medicare-covered ambulance services.
HOME HEALTH CARE			
Medically Necessary Home Health Services	Deductible then 20% coinsurance. You pay all charges for home services not covered by Medicare.	Covered in full when medically necessary.	Covered in full when medically necessary.
SKILLED NURSING CARE FACILITY			
Semi-private room and necessary services in a Medicare-approved nursing facility	Deductible then 20% coinsurance	Covered in full up to 100 days per benefit period.	Covered in full up to 100 days per benefit period.
DURABLE MEDICAL EQUIPMENT			
Prosthetic Devices	Deductible then 20% coinsurance	Covered in full when medically necessary.	Covered in full when medically necessary.
VISION CARE			
Annual Eye Exams for Glasses	Coverage coordinated with Medicare for certain conditions only.	$15 copayment	$15 copayment
Eyeglasses	Coverage coordinated with Medicare for certain conditions only.	Up to $200 towards eyewear every 24 months.	Coverage for eyewear up to $150 per member at Eyemed provider; up to $90 at any other eyewear provider per calendar year.
ADDITIONAL BENEFITS			
Additional Benefits	Naturally Healthy Rewards Program offers discounts on acupuncture, massage therapy and nutritional counseling.	Hearing aids – up to $500 per calendar year.	Hearing aids – $500 towards purchase or repair every 3 years and discounts through Hearing Care Solutions.

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