City of Newton Benefit Comparison Chart for Medicare Eligible Retirees*

Rates per Member per Month – 7/1/2023 – 12/31/2023 *The contribution percentage for retirees and spouses will be based on the contribution percentage last paid as an active employee. Rates may change January 1, 2024.*			
Coverage	**Medex 2 with PDP**	**Tufts Medicare Preferred**	**BC/BS Medicare HMO Blue**
Massachusetts Residency	Not Required	Required	Required
20% Contribution/Month	$74.30	$77.20	$79.70
25% Contribution/Month	$92.88	$96.50	$99.62
30% Contribution/Month	$111.46	$115.80	$119.54
Inpatient Services			
Hospital	100% Coverage	100% Coverage after $300 Deductible per Calendar Year	Day 1-5: $150 per day copay Day 6 and beyond $0 copay
Skilled Nursing	Covered in Full for 100 Days in a benefit period	Covered in Full for 100 Days in a benefit period	Days 1-20: $20 copay per day, Days 21-44: $100 copay per day, Days 45-100: $0 copay per day
Mental Health and Substance Abuse Care days	Covered in Full for 190 days Inpatient Lifetime Limit. After Medicare limit is reached, 120 days per benefit year.	Covered in Full in a Network Psychiatric Hospital. 190 Day Lifetime Limit. 90 covered for inpatient stay. After limit, 60 lifetime reserve days allowed	$35 per office visit. Inpatient $150 per day for days 1 - 5 190 day lifetime limit
Outpatient Services			
PCP Office Visits	Covered in full	$10 copay, $0 for annual physical	$15 copay, $0 for annual physical
Specialist Office Visits	Covered in full	$15 copay	$35 copay
Emergency Room	Covered in full	$50 copay	$75 copay
Outpatient Services/Surgery	Covered in full	$50 per day	$150 per visit
Outpatient Rehab Services	Covered in full	$15 copay	$15 copay
Prescriptions Co-Pay 30 Day	Tier 1: $10 / Tier 2: $20 / Tier 3: $35	Tier 1: $10 / Tier 2: $25 / Tier 3: $50	Tier 1: $10 / Tier 2: $25 / Tier 3: $45
Prescriptions Co-Pay 90 Day	Mail Order Tier 1: $20 / Tier 2: $40 / Tier 3: $70	Mail Order Tier 1: $20 / Tier 2: $50 / Tier 3: $100	Mail Order Tier 1: $20 / Tier 2: $50 / Tier 3: $90
Prescriptions Co-Pay Maximum	After copays of $1,500 per plan year, copays reduce to $0	After copays of $7,400 copays are reduced to $4.15 for generic or $10.35 for brand name drugs	After copays of $7,050, copays are reduced to the greater of 5% or $3.95 for generic or $9.85 for brand name drugs
Dental	Not Covered	Not Covered	$0 (Preventive services only every 6 months)
Hearing Aids	Not Covered	Up to $500 Allowed for Purchase or Repair every 3 years	$699 copay per aid for Advanced Aids, $999 copay for Premium. Must use TruHearing.
Routine Eye Exam	Not Covered	$15 copay	$0 copay must use an EyeMed Provider
Eyewear	Not Covered	$150 Toward eyeglasses or contacts each year in network, or $90 out-of-network	Routine exams no copay with EyeMed providers. Covered eyewear $200 every 24 months
Ambulance	100% for Medicare approved ambulance service	$50 per day	$75 copay
Chiropractor	Covered in full	$15 copay	$15 copay
Fitness Benefit	$150 Fitness /$150 Weight Management Reimbursement	$150 Fitness /$150 Weight Management Reimbursement	$150 Fitness /$150 Weight Management Reimbursement
Customer Service	1-800-258-2226	1-800-701-9000	1-800-200-4255

***Note: This is a summary only. Please refer to the carrier's plan description for more detail.**