City of Newton Benefit Comparison Chart for Medicare Eligible Retirees*

Rates per Member per Month – 1/1/2024 – 12/31/2024				
Coverage	BCBS Medex 2 with PDP	BCBS Medicare PPO Blue Freedom Rx		Tufts Medicare Preferred HMO
Network	Any provider that accepts Medicare	BCBS Medicare PPO (National)		Preferred HMO (Massachusetts only)
20% Contribution/Month	$72.53	$74.80		$78.40
25% Contribution/Month	$90.66	$93.50		$98.00
30% Contribution/Month	$108.80	$112.20		$117.60
Inpatient Services		**In Network Services**	**Out of Network**	
Hospital	100% Coverage	$0 copay	$0 copay	100% Coverage after $300 Deductible per Calendar Year
Skilled Nursing	Covered in Full for 100 Days in a benefit period	No cost	No cost	Covered in Full for 100 Days in a benefit period
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.	190 lifetime days; then, 60 days (30 days in alcohol unit) per calendar year	190 lifetime days; then, 60 days (30 days in alcohol unit) per calendar year	Covered in Full in a Network Psychiatric Hospital. 190 Day Lifetime Limit.
Outpatient Services				
PCP Office Visits	Covered in full	$0 copay	$0 copay	$10 copay, $0 for annual physical
Specialist Office Visits	Covered in full	$0 copay	$0 copay	$15 copay
Emergency Room	Covered in full	$0 copay	$0 copay	$50 copay
Outpatient Services/Surgery	Covered in full	$0 copay	$0 copay	$50 per day
Outpatient Rehab Services	Covered in full	$0 copay	$0 copay	$15 copay
Prescriptions Co-Pay 30 Day	Tier 1: $10 / Tier 2: $20 / Tier 3: $35	Tier 1: $5 / Tier 2: $10 / Tier 3: $25		Tier 1: $10 / Tier 2: $25 / Tier 3: $50
Prescriptions Co-Pay 90 Day	Mail Order Tier 1: $20 / Tier 2: $40 / Tier 3: $70	Mail Order Tier 1: $10 / Tier 2: $20 / Tier 3: $50		Mail Order Tier 1: $20 / Tier 2: $50 / Tier 3: $100
Prescriptions Co-Pay Maximum	After copays of $1,500 per plan year, copays reduce to $0	After copays of $8,000 you pay nothing for brand name and generic drugs		After copays of $8,000 you pay nothing for brand name and generic drugs
Routine Dental Services	Not Covered	$0 Copay	$45 per visit	Not Covered
Hearing Aids	Not Covered	Truhearing Provider $699 or $999 copay per aid	No coverage	Up to $500 Allowed for Purchase or Repair every 3 years
Routine Eye Exam	Not Covered	$0 copay with Eyemed Provider	$45 per visit	$15 copay
Eyewear	Not Covered	Once every 24 months up to $200 Maximum		$150 Toward eyeglasses or contacts each year in network, or $90 out-of-network
Ambulance	100% for Medicare approved ambulance service	$0 copay	$0 copay	$50 per day
Chiropractor	Covered in full	$0 per visit	$0 per visit	$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	1-800-200-4255		1-800-701-9000

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