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	BC/BS MEDEX w/medex rx	**BC/BS Managed Blue for Seniors w/rx**	**BC/BS MEDICARE HMO BLUE w/rx**	**HNE MEDICARE SECURE ADVANTAGE PLAN w/rx**
retiree pays	*177.12 monthly*	*169.87 monthly*	*199.24 monthly*	*156.00 monthly*
city pays	*177.12 monthly*	*169.87 monthly*	*199.24 monthly*	*156.00 monthly*
Deductible coinsurance max/lifetime benefit max	none - full coverage after medicare	none	Deductible $0 Out of pocket maximum $3,400 (exclude rx coverage)	Deductible $0 out of pocket maximum $3,400
INPATIENT CARE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up	Semiprivate room and board $0 Physician care $0 Surgical services $0 RX $0	Hospital care for illness or chronic disease for as many days as medically necessary (includes hospital care in a rehabilitation hospital) $150 per day—days 1-5	hospital $300 per admission (max 3 copayments)
Physician or other professional provider services	Full coverage of Medicare deductible and coinsurance	$0	Doctor's Office or Telehealth Visits $15 per primary care provider (PCP) visit $35 per specialty care visit	$15 co-pay
Skilled nursing facility—participating with Medicare	Full coverage of Medicare daily coinsurance for days 21–100 • $10 daily for days 101–365	$0/100 days per benefit period	Medically necessary care up to 100 days per benefit period2 $20 per day—days 1-20 $100 per day—days 21-44 $0 per day—days 45-100	Days 1–5: $0 | Days 6–50: $75 | Days 51–100: $0 Copay per day
Skilled nursing facility—not participating with Medicare	$8 daily for 365 days per benefit period	n/a	n/a	n/a
OUTPATIENT CARE	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**

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office visits, emergency services, surgery, radiation, therapy, x-ray, lab test, podiatrist, durable medical equipment, cardiac rehabilitation	Full coverage of Medicare deductible and coinsurance	Routine office visits $10 per visit Allergy care and testing $10 per visit Cardiac rehabilitation services $10 per visit Immunizations and injections Nothing Diagnostic tests Nothing X-rays and lab tests Nothing Limited oral surgery $10 per visit durable medical equipment $10 per item emergency visit $50	$15 per primary care provider (PCP) visit $35 per specialty care visit Hospital emergency room visits $75 per visit, waived if admitted within 24 hours Outpatient diagnostic tests and X-rays $5 per day for X-rays, $10 per day for lab tests and other diagnostic tests; $150 per day for CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery) Outpatient radiation therapy $0 Durable medical equipment 10% of the cost (no cost for diabetes equipment and supplies*)	office visit $15 urgent care $15 emergency room $65 rehabilitation $15 lab work/xrays $0 durable medical equipment $0 high cost imaging $50
blood glucose monitors and materials to test for the presence of blood sugar	Full coverage of Medicare deductible and coinsurance	no cost	no cost	no cost
chiropractor services	Full coverage of Medicare deductible and coinsurance for Medicare-approved charges only	$10 per visit	$15 per visit	$15
short term rehabilitation, physical therapy, speech pathology, occupational therapy approved by medicare	Full coverage of Medicare deductible and coinsurance	Rehabilitation hospital (365 days in a lifetime, after Medicare days end) $0	$15 per visit	$15

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vision services	not covered	$10 one exam per calendar year	Routine refractive eye exam once every 12 months with an EyeMed®´ provider (you must use an EyeMed provider) $0 per visit Eyewear every 24 months up to a $200 maximum (you must use an EyeMed provider) All costs over $200	Preventive Vision Exam–EyeMed $0 Vision Eyewear Allowance–EyeMed $100 every two years
hearing services	not covered	not covered	Routine diagnostic hearing exam once every 12 months with a TruHearing®´´ provider $0 You must use a TruHearing provider. Hearing aids: Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids. You must see a TruHearing provider to use this benefit. $699 or $999 copay per a	Preventive Hearing Exam3 $15 Hearing Aid Benefit–TruHearing® 4 $699 copay per aid for Advanced Aids $999 copay per aid for Premium Aids
dental services	not covered	not covered	Preventive routine dental care limited to one initial and periodic oral exam, one cleaning, (prophylaxis only — does not include periodontal cleaning) and one set of bitewing X-rays twice in a calendar year - $0 per visit	$250 per year
MENTAL HEALTH AND SUBSTANCE USE TREATMENT	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
biologically based mental conditions				

Inpatient admissions in a general or mental hospital	Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up	Inpatient admissions in a network general or mental hospital $0	n/a	n/a
Outpatient visits	• When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum	• Outpatient visits (No limit) $10	n/a	n/a
non-biologically based mental conditions				
Inpatient admissions in a general hospital	Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up†	Inpatient admissions in a network general hospital $0	$150 per day - days 1 - 5	n/a

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Inpatient admissions in a mental hospital/general hospital	Full coverage of Medicare deductible and coinsurance • Full coverage of lifetime reserve day coinsurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)†	Inpatient admissions in a network mental hospital or substance use facility (after Medicare days end, up to 60 days per calendar year) $0	$150 per day - days 1 - 5	$300 co pay per admission/inpatient behavioral health 190 day lifetime
Outpatient visits	When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year	Outpatient visits covered by Medicare and up to 24 visits per calendar year when not covered by Medicare $10 per visit	$35 per office or telehealth visit	$15

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ADDITIONAL SERVICES	• One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests) • One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests) • One routine colonoscopy every two years for a high-risk member (Full coverage for tests) • Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests) • Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test) • One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment) • One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam	Medicare-approved yearly gynecological exams $10 per visit Medicare-approved ambulance service when medically necessary per one-way transport (copayment waived for emergency transport) $40 copayment Skilled nursing facility (100 days per benefit period) Nothing Rehabilitation hospital (365 days in a lifetime, after Medicare days end) Nothing Medicare-approved home health care as requested by a Managed Blue for Seniors physician Nothing Medicare-approved outpatient physical, speech/language pathology, and occupational therapy $10 per visit Medicare-approved durable medical equipment $10 per item	Home health services (non-custodial) $0 Durable medical equipment 10% of the cost (no cost for diabetes equipment and supplies*) Prosthetic devices and ostomy supplies 10% of the cost Outpatient diagnostic tests and X-rays $5 per day for X-rays, $10 per day for lab tests and other diagnostic tests; $150 per day for CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery) Outpatient radiation therapy $0 Mammography screening every 12 months $0 Routine gynecological exam once every 24 months $0 Prostate cancer screening exam once per year $0	Fitness Center/Weight Watchers®/ Acupuncture/Activity Tracker 3 $150 per year Over-the-Counter (OTC) Items Allowance6 $40 per quarter Mom's Meals Home Meal Delivery Up to 2 meals/day for 14 days post-discharge from inpatient hospital or SNF stay
FITNESS REIMBURSEMENT	$150 PER YEAR	$150 PER YEAR	$150 per year	$150 per year
PRESCRIPTION DRUGS - included with all plans	**YOU PAY 30 DAYS SUPPLY**	**YOU PAY 30 DAYS SUPPLY**	**YOU PAY 30 DAY SUPPLY**	**YOU PAY 30 DAY SUPPLY**
Generic	$10	$10	$10	$20
Preferred Brand	$20	$20	$25	$25

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Non-Preferred Brand	$35	$35	$45	$45
Mail Order one-month supply	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Generic	$10	$10	$10	$20
Preferred Brand	$20	$20	$25	$25
Non-Preferred Brand	$35	$35	$45	$45
Mail order three -month supply	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Generic	$20	$20	$20	$20
Preferred Brand	$40	$40	$50	$50
Non-Preferred Brand	$70	$70	$90	$135