

Bentley University - 2021 Retiree Benefit Options

	BCBS Medex2	Tufts Medicare Preferred - Prime Supplement	Tufts Medicare Preferred - HMO Prime RX
Physician Selection:	Any Physician who accepts Medicare	Any Physician who accepts Medicare	Must see a network provider
Referrals:	Not Required	Not Required	Required
Residence/Counties	Anywhere in the US	Anywhere in the US	Barnstable, Bristol, Essex, Hampden, Hampshire Middlesex, Norfolk, Plymouth, Suffolk, Worcester
SUMMARY OF BENEFITS	YOU PAY	YOU PAY	YOU PAY
Out of pocket maximum	None	None	\$3,400
Inpatient Care	Nothing through a 365 day lifetime maximum after medicare benefit are used up	Nothing after \$300 Ded. through an additional 365 lifetime days after Medicare days are exhausted then all charges (applies to mental health - General Hospital)	\$300 per calendar year (does not apply to inpatient mental health admissions)
Skilled Nursing	Nothing for day 1-100 per benefit period; charges over \$10 per day from day 101-365 per benefit period; then all charges	Nothing for day 1-100 per benefit period; charges over \$10 per day from day 101-365 per benefit period; then all charges	Nothing for day 1-100 per benefit period; charges over \$10 per day from day 101-365 per benefit period; then all charges
Outpatient Office Visit	Nothing	\$15 copay	\$10 copay
Specialist Office Visit	Nothing	\$15 copay	\$15 copay
Substance Abuse Visit	Nothing	\$15 copay	\$15 copay
Routine Annual Physical Exam	Not covered through BCBSMA Medex2 plan, but may be covered under Medicare	Nothing	Nothing
Routine GYN Exam	Nothing: 1 exam every two years (1 routine Pap smear test each year)	\$15 copay (Routine Pelvic Exam/Pap test covered w/ \$0 copay, medically necessary exams carry \$15 copay)	\$15 copay (Routine Pelvic Exam/Pap test covered w/ \$0 copay once every 24 months, medically necessary exams carry \$15 copay)
Routine Eye Exam	Not covered	\$15 copay; \$150 per year toward lenses, frames, or contacts (but not both)	\$15 copay; \$150 per year toward lenses, frames, or contacts (but not both) at an EyeMed provider (or \$90 at a non-network provider)
Outpatient Mental Health	Nothing, 24 visit per year maximum if non-biologically base and not covered by Medicare	Biologically based - \$15 copay Non-Biologically based - \$15 copay	Biologically based - \$15 copay Non-Biologically based - \$15 copay
Chiropractic	Nothing for Medicare approved charges	\$15 copay	\$15 copay
Home Health Care	Nothing	Nothing	Nothing
Hearing Aids	Not covered	Allowance up to \$500 every 3 years	Allowance up to \$500 every 3 years
Durable Medical Equipment	Nothing	Nothing	Nothing
Ambulance	Emergency - Nothing Non Emergency - Part B ded. & coinsurance	\$50 copay per day	\$50 copay per day
Physical, Occup. & Speech Therapy	Nothing	\$15 copay	\$15 copay
Lab & Therapeutic Radiology	Nothing	Nothing	Nothing
MRI, PET, CT	Nothing	Nothing	Nothing
Outpatient Surgery	Nothing	\$50 per day	\$50 per day
Emergency Care	Nothing	\$50 copay	\$50 copay
Annual Wellness Allowances	Not Covered	\$150/year for fitness club membership, instructional fitness classes or nutritional counseling. \$150 reimbursement toward Weight Management programs.	\$150/year for fitness club membership, instructional fitness classes, acupuncture or nutritional counseling. \$150 reimbursement toward Weight Management programs.
PRESCRIPTION DRUGS:	No Deductible	No Deductible (no annual limit)	No Deductible (no annual limit)
Retail (30 day supply)	\$10/\$25/\$45	\$10/\$25/\$50	\$10/\$25/\$50
Mail Order (90 day supply)	\$20/\$50/\$90	\$20/\$50/\$110	\$20/\$50/\$100
Payments greater than \$6,550 you pay the greater of:	Generic: \$3.70 copay Brand: \$9.20 copay	Generic: \$3.70 copay Brand: \$9.20 copay	Generic: \$3.70 copay Brand: \$9.20 copay