



## 2007 Health Care Comparison Chart for Retirees and Spouses Age 65 or Over

**Harvard University Benefits Services Group**

**617-496-4001**

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 health insurance provider you are interested in to ensure you are eligible to participate.

Health Care Coverage	Medex 3 1-800-814-4371 www.bcbsma.com	HPHC First Seniority Freedom 1-800-421-3550 www.harvardpilgrim.org	Tufts Health Plan Medicare Preferred HMO 1-800-246-2400 www.tuftshealthplan.com	Managed Blue for Seniors 1-800-325-2583 www.bcbsma.com	Tufts Medicare Complement 1-800-462-0224/617-466-1000 www.tuftshealthplan.com
<b>Coverage Availability</b>	Open to all eligible for Harvard post-retirement health coverage.	Open to all eligible for Harvard post-retirement health coverage.	Open to all eligible for Harvard post-retirement health coverage.	Closed group (available only to those currently enrolled).	Closed group (available only to those currently enrolled).
<b>Hospital Inpatient Care</b> Semi-private room and necessary hospital services and supplies when medically necessary	Coverage coordinated with Medicare benefits; please refer to the Medex 3 Member Handbook for Details.	Covered in full.	Covered in full after one \$200 deductible per year.	Covered in full; 365 lifetime maximum days after Medicare benefits are exhausted.	Covered in full.
<b>Out-of-Hospital Care</b> Physician's Services	Covered in full for non-routine medical care.	Covered in full after \$15 co-pay per visit.	Covered in full after \$10 co-pay per visit for primary care doctor and \$15 co-pay for specialist.	Covered in full after \$10 co-pay per visit.	Covered in full after \$10 co-pay per visit.
Diagnostic, Lab, and X-ray Tests	Covered in full.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
<b>Preventive Health Care</b> Routine Physical Exams	No benefits for routine or preventive care.	Covered in full after \$15 co-pay.	Covered in full after \$10 co-pay.	Covered in full after \$10 co-pay.	Covered in full after \$10 co-pay.
Routine Hearing Exams	No benefits for routine or preventive care.	Covered in full after \$15 co-pay.	Covered in full after \$15 co-pay.	Not covered.	Covered in full after \$10 co-pay.
Immunizations	Only if covered by Medicare.	Covered in full.	Covered in full.	Covered in full.	Covered in full.
Routine Pap Smears and Mammograms (test only, not related services)	One each calendar year.	Covered in full.	Covered in full.	One each calendar year.	One each calendar year.
<b>Prescription Drugs</b> 30-day Retail	After \$35 per calendar quarter deductible, no cost for generic drugs at Express Scripts (ESI) network pharmacy (this network includes most major chains – CVS, Brooks, Walgreen's, Stop & Shop, Wal-Mart). Member pays a \$35 per calendar quarter deductible and 20% co-insurance for brand name drugs at Express Scripts network pharmacy.	Member pays \$10 for generic, \$20 select brand, and \$35 non-select brand at HPHC participating pharmacy per 30-day supply.	Member pays \$10 for generic drugs, \$25 for preferred brand and \$50 for non-preferred brand for a 30-day supply at pharmacy.	Member pays 25% for generic, 50% for brand name, and 75% for non-formulary drugs at Express Scripts ESI network pharmacy for a 60-day supply.	Member pays \$8 for generic, \$20 for preferred brand and \$35 for non-preferred brand name drugs for up to a 30-day supply.
90-day Mail Orders	No calendar quarter deductible for the 90-day supply. \$2 copay for each generic drug, \$15 copay for each brand name drug.	Covered after \$20 co-pay for generic, \$40 select brand and \$105 non-select brand per 90-day supply through mail service pharmacy.	Covered after \$20 co-pay for generic drugs, \$50 co-pay preferred brand and \$100 co-pay for non-preferred brand for a 90-day supply for mail-away.	Mail order: with a 90-day supply, member pays \$5 for generic, \$30 for brand name, and \$50 for non-formulary drugs.	
<b>Emergency Services</b> Hospital Emergency Room (ER) and outside of HMO Service Area. Note: Whenever possible, notify your plan of any medical emergency within 48 hours.	Covered in full for allowed charges.	Covered in full after \$50 co-pay (waived if hospitalized). Must call HPHC within 48 hours.	Covered in full after \$50 co-pay (waived if hospitalized).	Covered in full after \$50 co-pay (waived if hospitalized).	Covered in full after \$50 co-pay (waived if hospitalized).
<b>Harvard University Health Services (HUHS)</b>	HUHS available to participants. Member will be billed for services not covered in full by Medicare and Medex 3.	Not available to participants.	Not available to participants.	Not available to participants.	Not available to participants.
<b>Service Area</b>	You can see any physician who accepts Medicare.	You can see any physician who accepts Medicare. (Harvard Vanguard physicians do not currently accept this coverage).	You must live in the Tufts Medicare Preferred HMO service area, and select a PCP from the network (contact Tufts for the complete service area and a list of PCPs).		

Note: Red-Shaded columns describe closed options which are only available to those currently enrolled.

They are included on this chart for comparison purposes.

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

Plan Name	<b>Medex 3</b> 1-800-814-4371 www.bcbsma.com	<b>HPHC</b> <b>First Seniority Freedom</b> 1-800-421-3550 www.harvardpilgrim.org	<b>Tufts Health Plan</b> <b>Medicare Preferred HMO</b> 1-800-246-2400 www.tuftshealthplan.com	<b>Managed Blue</b> <b>for Seniors</b> 1-800-325-2583 www.bcbsma.com	<b>Tufts Medicare</b> <b>Complement</b> 1-800-462-0224/617-466-1000 www.tuftshealthplan.com
<b>Mental Health Services</b> Outpatient Care Office Visits	When covered by Medicare, the Part B deductible and co-insurance are covered with no visit limit.  When not covered by Medicare, up to 24 visits per calendar year.	Covered on a calendar year basis up to 20 visits. Co-payments: visits 1–8, \$15/visit; visits over 8, \$25/individual session. After the 20th visit, member pays 50% of the full charge per visit.  \$5 for each group therapy visit (1-20); 50% of the cost for each group therapy visit(s) 21 and beyond.	Covered in full after \$15 co-pay per visit. Unlimited visits.	24 visits per year covered at \$10 per visit.	TMS covers the Medicare B annual deductible and co-insurance up to Medicare maximum benefit payment limit.
Psychiatric Hospital	Covered in full after Part A deductible, co-insurance and Medicare coverage to 120 days per benefit period (at least 60 days per calendar year).	Covered in full up to 90 days per benefit period; lifetime limit of 190 days.	Covered in full up to Medicare’s lifetime limit of 190 days. Then 60 days per calendar year are covered in full.	Covered in full up to Medicare’s lifetime limit of 190 days. Then 60 days per calendar year are covered in full.	Covered in full up to Medicare’s lifetime limit of 190 days. Then 60 days per calendar year covered in full, and up to 30 days per calendar year in a substance abuse treatment facility.
<b>Ambulance Service</b>	Covered in full if Medicare determines services are medically necessary.	Covered in full when medically necessary.	Covered in full for emergencies.	\$40 per one-way transport (waived if transport for emergency care).	Covered in full if medically necessary.
<b>Home Health Care</b> Medically Necessary Home Health Services	Covered in full for Medicare-authorized services. You pay all charges for home health care services not covered by Medicare.	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full for Medicare-authorized services. You pay all charges for home health care services not covered by Medicare.	Medicare pays 100% unlimited part-time skilled home health services (except nutrition counseling, physician home visits and inhalation therapy) if provided by a home health agency participating with Medicare. TMC will pay charges for nutrition counseling, physician home visits and inhalation therapy when medically necessary.
<b>Skilled Nursing Care Facility</b> Semi-private room and necessary services in a Medicare-approved nursing facility	Full coverage up to 100 days per benefit period if admitted within 30 days of hospital discharge; then \$10 coverage daily from 101st – 365th day per benefit period.	100 days per benefit period covered in full.	100 days per benefit period covered in full.	100 days per benefit period covered in full.	100 days per benefit period covered in full.
<b>Durable Medical Equipment</b> Prosthetic Devices	Covered in full.	Covered in full when medically necessary.	Covered in full when medically necessary.	Covered in full if approved by Medicare with \$10 co-pay each.	Covered in full with plan approval.
<b>Vision Care</b> Eye Exams for Glasses  Eyeglasses	Not covered.  Not covered.	\$15 co-pay.  1 pair of glasses after each cataract surgery; \$200 towards eyewear every 24 months.	\$15 co-pay (1 routine exam per calendar year).  One free pair of eyeglasses (frames and lenses) per calendar year, or \$69 allowance toward purchase each year.	\$10 co-pay (1 routine exam per calendar year).  Not covered except after cataract surgery.	\$10 co-pay (1 routine exam per calendar year).  Coverage only if glasses or contacts replace the natural lens of the eye. TMC will cover the Medicare B deductible and 20% co-insurance only for lenses covered by Medicare. Discounts on eyeglasses available at participating optometrists and ophthalmologists.
<b>Additional Benefits</b>	Naturally Healthy Rewards Program offers discounts on acupuncture, massage therapy and nutritional counseling.	Hearing aids – up to \$500 every 12 months towards purchase or repair. Dental – 1 cleaning and exam per year, covered in full.	Hearing aids – \$500 towards purchase or repair every 3 years.		

<b>Supplemental Life Insurance Cost</b>	
Age	Monthly Cost per \$1,000 of Insurance
55-59	\$ 0.171
60-64	\$ 0.218
65-69	\$ 0.398
70	\$ 0.880