City of Waltham Benefit Comparison
Chart of Medicare Plans

Effective 7/1/21- 6/30/22	BLUE CROSS BLUE SHIELD OF MASSACHUSETTS	
BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
	Your Responsibility	**Your Responsibility**
Deductible - Medical	No deductible	$50 per member per Calendar Year for Extendend Benefits $100 per family per calendar year for Extendend Benefits (Does not apply to approved prolonged illness conditions, private duty nursing, services with a copayment and prescription drug benefits)
Calendar Year Coinsurance Maximum	None	None
Lifetime Benefit Maximum	None	None
INPATIENT		
General Hospital, *Mental Hospital, Substance Abuse Facility* (semi-private room and board and special services)	No cost 90 days per benefit period (plus 365 Medex lifetime benefit days)	No cost

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BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
	Your Responsibility	**Your Responsibility**
Physician Services, Surgical Charges, Anesthesia and Consultations.	No cost	No cost

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BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
	Your Responsibility	**Your Responsibility**
Skilled Nursing Facility	No cost up to 100 days per benefit period, then amount in excess of $16 per day from day 101 thru day 365	No cost
Non - Medicare Skilled Nursing Facility	Amount in excess of $16 per day from day 1 to day 365 in the benefit period.	
Rehabilitation Hospital	No cost	No cost
OUTPATIENT		
Emergency Room Visits for Emergency or Accident Care	No cost	No cost
Outpatient Surgery	No cost	No cost
Radiation and Chemotherapy	No cost	No cost
Diagnostic X-ray and Lab	No cost	No cost

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BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
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Hemodialysis	No cost	No cost
Physical Therapy	No cost	20% Coinsurace
Mental Health & Substance Abuse	No cost	Biologically based mental conditions: No Cost Non-biologically based mental conditions: No Cost
Alcoholism Treatment	No cost	No Cost
Medical Care	No cost	20% coinsurance after deductible
Routine Physical Exams	Not covered (Medicare pays in full one annual wellness exam)	Not Covered. Member pays all Charges
Routine GYN Exam	No cost. 1 exam every 2 Calendar years (1 routine Pap smear test each Calendar year at No Cost)	Not Covered. Member pays all Charges. (Full Coverage for ONE Routine Pap Smear Test each Calendar Year.)

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BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
	Your Responsibility	**Your Responsibility**
Routine Vision	All charges. Not a covered benefit	All Charges. Not a covered benefit
Visiting Nurse Home Health Care	No cost	20% Coinsurance after Deductible
Durable Medical Equipment	No cost	20% Coinsurance after Deductible
Prosthetic Devices	No cost	20% Coinsurance after Deductible
Ambulance (when medically necessary)	No cost	20% Coinsurance after Deductible
Chiropractor Visits	No cost for manual manipulation of the spine to correct a subluxation that can be shown by x-ray. Other Chiropractic Services Not Covered. Member pays all charges.	20% Coinsurance after Deductible

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BENEFIT	**Medex III OBRA**	**Master Medical Carve Out A&B**
	Your Responsibility	**Your Responsibility**
Prescription Drugs	**Retail Pharmacies:** $50 Drug Deductible per Calendar Yr. No Cost for Generic Drugs 20% Coinsurance for Brand Name Drugs **Mail order:** $2 Copayment for Generic 90 Day Supply $15 Copay for Brand Name 90 Day Supply 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	**Retail Pharmacies:** 20% Coinsurance (no cost after $200 Coinsurance/member) (no cost after $400 Coinsurance/family) **Mail order:** $5 Copayment for Generic 90 Day Supply $10 Copayment for Brand Name 90 Day Supply 30-day supply retail pharmacy or 90-day supply mail service or designated retail pharmacy Non-formulary drugs: all charges

These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.