

2026 MEDICARE SUPPLEMENTAL PLAN OFFERINGS INCL. PART D

	HARVARD PILGRIM MEDICARE ENHANCE W/ AETNA RX	BLUE CROSS BLUE SHIELD MANAGED BLUE FOR SENIORS W/ BLUE MEDICARE RX	BLUE CROSS BLUE SHIELD MEDEX II W/ BLUE MEDICARE RX CLOSED TO NEW ENROLLEES (1% Contribution Rate)	TUFTS MEDICARE PREFERRED HMO (Medicare Advantage Plan)	BLUE CROSS BLUE SHIELD MEDICARE PPO BLUE FREEDOM Rx (Medicare Advantage Plan)
Full Cost Rates	\$504.11	\$505.76	\$528.66	\$438.00	\$530.25
Retiree Contribution Rates					
10% Monthly Contribution	\$50.41	\$50.58	\$5.29	\$43.80	\$53.03
15% Monthly Contribution (Retire after 10/1/09)	\$75.62	\$75.86		\$65.70	\$79.54
Plan Information					
Website	harvardpilgrim.org aetnaretireplans.com	bcbsma.com bmedicareRx.com	bcbsma.com bmedicareRx.com	thmp.org	bcbsma.com
Telephone Number	HPHC:1-888-333-4742 Aetna:1-833-272-9886	Medical:1-800-325-2583 Rx: 1-888-543-4917	Medical: 1-800-258-2226 Rx: 1-888-543-4917	1-800-936-1902	1-800-200-4255
Annual Deductible	None	None	None	None	None
Coverage Area	Nationwide Network as long as seeing a Medicare provider; Emergency coverage worldwide	MA HMO Network Only - Care in MA Only	Nationwide Network as long as seeing a Medicare provider, no out of network benefits	MA Network only. Excludes Dukes, Berkshire	In Network and Out of Network - Nationwide Coverage
Annual Out of Pocket Maximum	Medical: None Prescription: \$2,100	Medical: None Prescription: \$2,100	Medical: None Prescription: \$2,100	Medical: \$3,400 out of pocket max excluding plan premiums and prescription drug copays Prescription: \$2,100	Medical: \$3,400 in-network or \$5,100 for combined in- and out-of-network medical services Prescription \$2,100
Inpatient Care In hospital, semiprivate room and board, surgical and special services	100% coverage	100% coverage	100% coverage	100% coverage after \$300 deductible (per calendar year)	In Network/Out of Network- \$0
Outpatient Surgery	100% coverage	100% coverage	100% Coverage	\$50 per day	In Network/Out of Network- \$0
Outpatient Care					
Office Visits, Specialist Consultations, Routine checkups or physicals	\$15.00 co-pay (No co-pay for 1 routine physical per year)	\$15.00 co-pay (No co-pay for 1 routine physical per year)	Full coverage of Medicare deductible & co-insurance	\$10.00 co-pay Specialist \$15.00 co-pay (No co-pay for 1 routine physical per year)	In Network/Out of Network- \$0
X-rays & laboratory tests	100% coverage	100% coverage	100% coverage	100% coverage	In Network/Out of Network- \$0
Hearing & Vision Tests	\$15.00 co-pay for annual routine vision and \$0 for annual routine hearing exam	\$15.00 co-pay for one routine vision exam per year Routine Hearing Exam not covered Diagnosis ic Hearing Exams and tests \$15.00 copay	No Benefits	\$15.00 co-pay	In network \$10.00 co-pay (Medical) Routine hearing exam once every 12 months \$0 per visit with a TruHearing provider

2026 MEDICARE SUPPLEMENTAL PLAN OFFERINGS INCL. PART D Continued

	MEDICARE ENHANCE W/ AETNA RX (HARVARD PILGRIM)	MANAGED BLUE FOR SENIORS W/ BLUE MEDICARE RX (BLUE CROSS)	MEDEX II W/ BLUE MEDICARE RX (BLUE CROSS) CLOSED TO NEW ENROLLEES (1%Contribution Rate)	TUFTS MEDICARE PREFERRED HMO	MEDICARE PPO BLUE FREEDOM Rx (BLUE CROSS)
Additional Services					
Ambulance (for Medicare covered services)	100% coverage	100% coverage for emergency/ \$40.00 co-pay (one way) for non-emergency medically necessary transport	Medicare deductible & co-Insurance (100% in emergency)	\$50 per day	In Network/Out of Network- \$0
Emergency Room	\$50.00 co-pay (waived if admitted)	\$50.00 co-pay	Full coverage of Medicare deductible & co-Insurance	\$50.00 co-pay	In Network/Out of Network- \$0
Home Health Care	100% coverage.	100% coverage.	100% coverage by Medicare	100% coverage.	In Network/Out of Network- \$0
Annual Vision Benefit	\$150/yr toward, lenses, frames and/or contact lenses	1 routine exam per calendar year - \$15 copay	No routine coverage unless approved by Medicare	\$150 per year towards eyewear at an EyeMed Vision Care participating provider, or \$90 per year at non-participating providers	Eyewear (eyeglasses or contact lenses) - \$200 every 24 months through a EyeMed Provider
Hearing Aids	Covered for the first \$500 once every three (3) years	No Benefit	No Benefit	Up to \$500 toward purchase or repair every three (3) years	In Network- \$699 copay per TruHearing Advances Hearing Aid \$999 copay per TruHearing Premium Hearing Aid (1 TruHearing branded hearing aid per ear every 12 months) Out of Network- Not Covered
Annual Wellness Allowance	\$150 reimbursement per year, Gym, Fitness classes, Virtual class subscriptions, digital nutritional programs, digital mindfulness programs, Cardio/strength equipment	\$150 fitness reimbursement per year for home fitness equipment; health clubs or fitness studios, includes virtual/online membership, subscription program and class.	No Benefit	\$150 per year toward fitness club membership, instructional fitness classes, nutritional counseling, acupuncture, and/or wellness programs such as memory fitness	\$150 fitness reimbursement per year for home fitness equipment; fees paid to health clubs or fitness studios, includes virtual/online membership, subscription, program and class.
Weight Management Programs	Select digital nutritional programs as part of Wellness Reimbursement program, including:Weight Watchers, PlateJoy,Noom, Wondr, My Fitness Pal, and many more	\$150 weight loss reimbursement per calendar year for fees paid to qualified programs focused on eating, physical habits and lifestyle counseling (in-person, phone, online)	No Benefit	\$150 per year towards program fees for weight loss programs such as Weight Watchers or a hospital based weight loss programs	\$150 weight loss reimbursement per calendar year for fees paid to qualified programs focused on eating, physical habits and lifestyle counseling (in-person, phone, online).
Pharmacy					
Prescription Drugs Direct Purchase (up to a 30-day supply)	\$10/\$20/\$50 co-pay generic/brand formulary/brand non-formulary	\$10/\$25/\$45 co-pay generic/ brand / non preferred	\$10/\$25/\$45 co-pay generic / brand / non preferred brand	\$10/\$25/\$50 co-pay generic/ brand / non preferred brand	\$10/\$25/\$45 co-pay generic/brand /non preferred
Mail Order (90-day supply)	\$20/\$40/\$100/NA co-pay generic/preferred brand/ non-preferred brand	\$20/\$50/\$90 co-pay generic/brand/non-preferred brand	\$20/\$50/\$90 co-pay generic / brand/non-preferred brand	\$20/\$50/\$100 co-pay generic/preferred brand/ non-preferred brand	\$20/\$50/\$90 co-pay generic/ brand/non-preferred brand

Some benefits subject to change