Boston and Northeastern Counties 2017	*Blue Cross Blue Shield of Massachusetts 1-800-678-2265*									
	Medicare HMO Blue ValueRx HMO	**Medicare HMO Blue PlusRx HMO**	**Medicare PPO Blue SaverRx**		**Medicare PPO Blue PlusRx PPO**		**Medicare PPO Blue ValueRx**		**Medicare HMO Blue FlexRx (HMO POS)**	
Plan Number	H2261-019	H2261-005	H2230-017		H2230-002		H2230-016		H2261-021	
Essex	$39	$295	$0		$230		$79		$99	
Middlesex	$39	$295	$0		$230		$79		$99	
Norfolk	$39	$295	$0		$230		$79		$99	
Suffolk	$39	$295	$0		$230		$79		$99	
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Health Plan Deductible	None	None	None	None	None	None	None	None	None	None
PCP	$20	$15	$25	$25	$15	$45	$20	$20	$15	$65
Specialist	$40	$35	$45	$45	$35	$45	$40	$40	$35	$65
Inpatient Hospital	$275/day (days 1-5) $0/day (after day 5) per admis/ no annual OOP max	$150/ day (days 1-5) $0/ day(after day 5) per admis/ no annual OOP	$350/day (days 1-5) $0/day (after 5/days)per admis/no annual OOP maximum	$350/day (days 1-5) $0/day (after 5/days)per admis/no annual OOP maximum	$150/day (days 1-5) $0/ day (after 5 days) per admis/ no annual OOP	20% Co-ins	$250/day (days 1-5) $0/day (after day 5) Per admission	$250/day (days 1-5) $0/day (after day 5) Per admission	$200 (days 1-5) $0/ day (after 5 days) per admis/ no annual OOP	20% Co-ins
Outpatient Services/Surgery	Ambulatory $250/visit	Ambulatory: $150/visit	$300/visit	$300/visit	Ambulatory:- $150/visit	20% Co-ins	$225/visit	$225/visit	Ambulatory:- $200/visit	20% Co-ins
Outpatient Rehab	$20/ visit	$15/visit	$40/visit	$40/visit	$15/visit	20% Co-ins	$20/visit	$20/visit	$15/visit	20% Co-ins
Diagnostic Tests and Labs	$30/day Labs and tests, $20/day X-Rays $250/day High Tech Imaging	$10/day Labs& Diag tests, $10/day X-Rays $150/day High Tech Imaging	$30/day Labs & Diag tests $30/day X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$30/day Labs & Diag tests $30/day X-Rays $325/day High Tech Imaging $60/visit Radiologic Serv	$10/day Labs $10 Tests, X-Rays $150/day High Tech Imaging	20% Co-ins tests and labs, 40% high tech imaging	$20/day labs $20 /day tests and xrays, $250/day High Tech imaging	$20/day labs $20 /day tests and xrays, $250/day High Tech imaging	$15/day Labs & Diag tests $15/day X-Rays $200/day High Tech Imaging	20% Co-ins tests and labs, 40% high tech imaging
Skilled Nursing/Per benefit Period	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	$20/day (days 1-20) $100/day (days 21-44) $0/day (days 45-100)	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$20/day (days 1-20) $100/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$0/day (days 1-20) $160/day (days 21-44) $0/day (days 45-100)	20% Co-ins	$0/day (days 1-20) $140/day (days 21-44) $0/day (days 45-100)	20% Co-ins
Emergency Room	$75	$75	$75	$75	$75	$75	$75	$75	$75	$75
Urgent Care										
Ambulance	$100/trip	$100/trip	$250/trip	$250/trip	$100/trip	$100/trip	$100/trip	$100/trip	$100/trip	$100/trip
DME	20%	10%	20%	20%	10%	20% Co-ins	20%	20%	10%	20% Co-ins
Diabetic Supplies	$0	$0	$0	$0	$0	20% Co-ins	$0	$0	$0	20% Co-ins
Part B Medications	15%	10%	20%	20%	10%	10%	15%	15%	10%	10%
Annual Maximum	$4,900	$3,400	$6,700		$3,400	$5,100 combined	$4,900		$3,900 in network	$9,900 out of network
Drug Deductible	$320 on Tiers 3-5	$200 on Tiers 3-5	$400 on tiers 3-5		$200 on tiers 3-5		$320 on tiers 3-5		$260 on tiers 3-5	
Drug Co-pays Tier 1	$4	$2	$6		$2		$4		$2	
Tier 2	$8	$6	$12		$6		$8		$6	
Tier 3	$45	$45	$45		$45		$45		$45	
Tier 4	$95	$95	$95		$95		$95		$95	
Tier 5	26%	25%	25%		25%		26%		26%	
Gap Generic Coverage	No	No	No		No		No		No	
Vision (Yes/No)	Yes	Yes	No		Yes		Yes		Yes	No
Hearing (Yes/no)	Yes	Yes	No		Yes		Yes		Yes	Yes
Dental (Yes/No)	Yes	Yes	Yes		Yes		Yes		Yes	Yes

Boston and Northeastern Counties 2017	*Fallon Community Health Plan 1-888-377-1980*			
	FSP Super Saver Rx HMO	**FSP Saver HMO**	**FSP Saver Enhanced RX HMO**	**FSP Plus Enhanced RX HMO**
Plan Number	H9001-032	H9001-029	H9001-030	H9001- 031
Essex	$0	$19	$54	$164
Middlesex	$0	$29	$49	$156
Norfolk	$0	$29	$49	$156
Suffolk	$0	$19	$54	$164
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**
Health Plan Deductible	None	None	None	None
PCP	$20	$25	$25	$10
Specialist	$45	$40	$40	$20
Inpatient Hospital	Days 1-5 $360/day	$275/day days 1-5	$275/day days 1-5	$200/ stay/Separate $400 out-of-pocket maximums
Outpatient Services/Surgery	Ambulatory: $300 Hospital: $300	Ambulatory: $275 Hospital: $275	Ambulatory: $275 Hospital: $275	Ambulatory: $100 Hospital: $100
Outpatient Rehab	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $15
Diagnostic Tests and Labs	$0 for clinical/diagnostic lab services and radiation therapy. $200 for each CT, PET and MRI scan and nuclear study	$0 for clinical/diagnostic lab services and radiation therapy. $175 for each CT, PET and MRI scan and nuclear study ($700 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $175 for each CT, PET and MRI scan and nuclear study ($700 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $125 for each Ct, PET and MRI scan and nuclear study ($500 OOPM)
Skilled Nursing/Per benefit Period	$0 per day days 1-20; $160 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44; $0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	$15 day days 1-20; $75 per day days 21-44; $0 per days 45-100
Emergency Room	$75 copay	$75 copay	$75 copay	$75 copay
Urgent Care				
Ambulance	$250	$175/$700 OOPM	$175/$700 OOPM	$75/$300 OOPM
DME	20%	20%	20%	10%
Diabetic Supplies	$0	$0	$0	$0
Part B Medications	20%	20%	20%	10%
Annual Maximum	$6,700	$6,700	$6,700	$3,400
Drug Deductible	$400	N/A	$300 Tiers 3-5	NA
Drug Co-pays Tier 1	Pref $2/Non-Pref $7	NA	Pref $1/Non-Pref $6	Pref $1/Non-Pref $6
Tier 2	Pref $7/Non-Pref $12	NA	Pref $6/Non-Pref $11	Pref $6/Non-Pref $11
Tier 3	Pref $42/Non-Pref $47	NA	Pref $32/Non-Pref $37	Pref $32/Non-Pref $37
Tier 4	Pref $95/Non-Pref $100	NA	Pref $86/Non-Pref $91	Pref $86/Non-Pref $91
Tier 5	25%	NA	27%	33%
Gap Generic Coverage	No	No	No	No
Vision (Yes/No)	Yes	Yes	Yes	Yes
Hearing (Yes/No)	Yes	Yes	Yes	Yes
Dental (Yes/No)	No	Yes	Yes	Yes

FALLON PREFERRED PHARMACIES
1) CVS; 2) Target; 3) Wal-Mart; 4) Big Y; 5) Shaws; 6) Stop & Shop; 7)Leader Drug stores (approximately 35 independent pharmacies across Massachusetts)

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Boston and Northeastern Counties 2017	Tufts Health Plan Medicare Preferred HMO 1-866-974-0118							
	TMP Saver Rx HMO	TMP Basic No Rx HMO	TMP Basic Rx HMO	TMP Value No Rx HMO	TMP Value Rx HMO	TMP Prime No Rx HMO	TMP Prime Rx HMO	TMP Prime Rx+ HMO
Plan Number	H2256-028	H2256-042	H2256-026	H2256-019	H2256-018	H2256-016	H2256-015	H2256-001
Essex	$0	$34	$59	$117	$145	$154	$182	$214
Middlesex	$0		$39	$97	$125	$131	$159	$193
Norfolk	$0		$39	$97	$125	$131	$159	$193
Suffolk	$0	$34	$59	$117	$145	$154	$182	$214
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Health Plan Deductible	None	None	None	None	None	None	None	None
PCP	$20	$10	$10	$10	$10	$10	$10	$10
Specialist	$40	$30	$30	$20	$20	$15	$15	$15
Inpatient Hospital	days 1-5: $350/day	days 1–5: $275/day	days 1–5: $275/day	days 1–5: $200/day	days 1–5: $200/day	$300 copay per vist up to $900 per year	$300 copay per vist up to $900 per year	$200 copay per vist up to $400 per year
Outpatient Services/Surgery	Ambulatory: $350 Hospital: $350	Ambulatory: $250 Hospital: $250	Ambulatory: $250 Hospital: $250	Ambulatory: $150 Hospital: $150	Ambulatory: $150 Hospital: $150	Ambulatory: $75 Hospital: $75	Ambulatory: $75 Hospital: $75	Ambulatory: $75 Hospital: $75
Outpatient Rehab	$40/visit	$30/visit	$30/visit	$20/visit	$20/visit	$15/visit	$15/visit	$15/visit
Diagnostic Tests and Labs	$10: Labs,Tests, & X-Rays $0: Therapeutic Radiology $300/day: Diagnostic Radiology	$10: Labs,Tests, & X-Rays $0: Therapeutic Radiology $250/day: Diagnostic Radiology	$10: Labs,Tests, & X-Rays $0: Therapeutic Radiology $250/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$5: Labs,Tests, & X-Rays $0: Therapeutic Radiology $100/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology	$0: Labs,Tests, Therapeutic Radiology & X-Rays 20% up to $75/day: Diagnostic Radiology
Skilled Nursing/Per benefit Period	days 1–20 $0/day days 21–44 $160/day days 45–100 $0	days 1–20 $20/day days 21–44 $140/day days 45–100 $0	days 1–20 $20/day days 21–44 $140/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $100/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–44 $60/day days 45–100 $0	days 1–20 $20/day days 21–100 $0
Emergency Room	$75	$75	$75	$75	$75	$75	$75	$75
Urgent Care								
Ambulance	$300	$250	$275	$200	$225	$100	$110	$90
DME	20%	20%	20%	10%	10%	10%	10%	10%
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Part B Medications	$0	$0	$0	$0	$0	$0	$0	$0
Annual Maximum	$3,900	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400	$3,400
Drug Deductible	$350 (Tier 3, Tier 4, Tier 5)	N/A	$300 (Tier 3, Tier 4, Tier 5)	N/A	$250 (Tier 3, Tier 4, Tier 5)	N/A	None	None
Drug Co-pays Tier 1	$6		$4		$4		$4	$2
Tier 2	$12		$8		$8		$8	$4
Tier 3	$47		$47		$47		$47	$30
Tier 4	$100		$100		$100		$100	$80
Tier 5	26%		27%		28%		33%	33%
Gap Generic Coverage	No		No		No		No	Yes, T1 and T2
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional

For SHINE Counselor Use Only
For official plan details, consult the plan's Summary of Benefits

Boston and Northeastern Counties 2017	*Harvard Pilgrim Health Care 1-877-906-4742*	
	Stride HMO Value RX	**Stride HMO Value Rx Plus**
Plan Number	H1660-009	H1660-001
Essex	$57	$148
Middlesex	$57	$148
Norfolk	$57	$148
Suffolk	$57	$148
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**
Health Plan Deductible	$0	$0
PCP	$20	$10
Specialist	$40	$30
Inpatient Hospital	D1-D5:$275 p/day (no limit)	D1-D5:$150 p/day ($750 annual limit)
Outpatient Services/Surgery	$200	$100
Outpatient Rehab	$20	$15
Diagnostic Tests and Labs	$20 lab/xray, $150 imaging	$0 lab/xray, $60 imaging
Skilled Nursing/Per benefit Period	D1-20: $20 p/day, D21-100:$100 p/day	D1-20: $0 p/day, D21-44:$100 p/day
Emergency Room	$75	$75
Urgent Care	$40	$30
Ambulance	$100	$100
DME	20% co-insurance	20% co-insurance
Diabetic Supplies	$0	$0
Part B Medications	20%	10%
Annual Maximum	$3,400	$3,400
Drug Deductible	$320 tier 3,4, and 5	$0
Drug Co-pays Tier 1	30d $0, 90d mail$0	30d $0, 90d mail$0
Tier 2	30d$10 ,90d mail$20	30d$10, 90d mail $20
Tier 3	30d$47, 90d mail$94	30d$47, 90d mail$94
Tier 4	30d$100, 90d mail/$250	30d$100, 90d mail/$250
Tier 5	26%	33%
Gap Generic Coverage	Not covered	tier 1 $0/$0
Vision (Yes/No)	Yes	Yes
Hearing (Yes/no)	Yes	Yes
Dental (Yes/No)	Yes	Yes

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Boston and Northeastern Counties 2017	***UnitedHealthCare 1-800-547-5514***							
	AARP MedicareComplete Plan 1 HMO		**AARP MedicareComplete Plan 2 HMO**		**AARP MedicareComplete Plan 3 HMO**		**AARP MedicareComplete Choice REGIONAL PPO**	
Plan Number	H1944-001	H1944-007	H1944-004	H1944-008	H-1944-021	H-1944-023	R7444-001	
Essex		$0		$42		$76	$47	
Middlesex	$0		$42		$76		$47	
Norfolk	NA	NA	NA	NA	NA		$47	
Suffolk	$0		$42		$76		$47	
CO-PAYS - Beneficiary Costs	**In Network**	**In Network**	**In Network**		**In Network**		**In Network**	**Out of Network**
Health Plan Deductible	$0	$0	$0	$0	$0	$0	$0	$0
PCP	$15	$15	$5	$10	$5	$5	$20	30%
Specialist	$40	$45	$30	$25	$20	$20	$45	$50
Inpatient Hospital	$395 co-pay per day for days 1-4/$0 co-pay for days 5-unlimited	$335 co-pay per day for days 1-5/$0 co-pay for days 6-unlimited	$295 co-pay per day for days 1-6/$0 co-pay for days 7-unlimited	$295 co-pay per day for days 1-6/$0 co-pay for days 7-unlimited	$275 co-pay per day for days 1-5/$0 co-pay for days 6-unlimited	$275 co-pay per day for days 1-5/$0 co-pay for days 6-unlimited	$395 co-pay per day for days 1-4/$0 co-pay for days 5-unlimited	30%
Outpatient Services/Surgery	20% co-insurance	20% co-insurance	$275 co-pay	$275 co-pay	$250 co-pay	$250 co-pay	20% co-insurance	30% co-insurance
Outpatient Rehab	$40	$40	$30	$30	$20	$20	$40	$50
Diagnostic Tests and Labs	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $9 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	Diagnostics tests 20% of the cost/Labs $10 co-pay/x-rays $14 co-pay	20% of the cost	30% of the cost
Skilled Nursing/Per benefit Period	$0 for days 1-20/$160 for days 21-62	$0 for days 1-20/$160 for days 21-62	$0 for days 1-20/$160 for days 21-45	$0 for days 1-20/$160 for days 21-45	$0 for days 1-20/$160 for days 21-42	$0 for days 1-20/$160 for days 21-42	20%	30%
Emergency Room	$75	$75	$75	$75	$75	$75	$75	$75
Ambulance	$225	$250	$225	$225	$225	$225	$250	$250
DME	20%	20%	20%	20%	20%	20%	20%	50%
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0	30%
Part B Medications	20%	20%	20%	20%	20%	20%	20%	30%
Annual Maximum	$6,700	$6,700	$3,900	$3,900	$3,400	$3,400	$5,500	$10,000
Drug Deductible	None	None	None	None	None	None	None	$0 for Tier 1 and Tier 2; $280 for Tier 3, Tier 4 and Tier 5
Drug Co-pays Tier 1	$3	$3	$3	$2	$2	$2	$2	$2
Tier 2	$11	$9	$11	$8	$8	$8	$12	$12
Tier 3	$45	$45	$45	$45	$45	$45	$47	$47
Tier 4	$95	$95	$95	$95	$95	$95	$100	$100
Tier 5	28%	28%	29%	29%	33%	33%	27%	27%
Gap Generic Coverage								
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	No	No	No	No	No	No	No	No