Blue Medicare Advantage

Drexel University Medicare Plan Compare

	Personal Choice 65 Standard $10/$15 In-Network	Personal Choice 65 Standard $10/$15 Out-of-Network	Secure Preferred PPO In-Network	Secure Preferred PPO Out-of-Network
Benefit				
Annual Deductible	**$0**	**$250**	**$0**	**$0**
Annual Maximum Out-of-Pocket Amount	**$6,700**	**$10,000**	**$6,700**	**$10,000**
Inpatient Hospital Care	**$0 copay/day**	**20% after deductible**	**$0 copay per admission**	**20% coinsurance**
Observation Stay	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Outpatient Services & Surgery	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Ambulatory Surgery Center	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Primary Care Physician Visits	**$10 copay**	**20% after deductible**	**$10 copay per visit**	**20% coinsurance**
Physician Specialist Visits	**$15 copay**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Medicare-covered Preventive Services	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Emergency Care; Worldwide	**$40 copay (waived if admitted)**	**$40 copay no deductible (waived if admitted)**	**$40 copay per visit, 72 hours cost share waived if admitted for the same condition**	**$40 copay per visit, 72 hours cost share waived if admitted for the same condition**
Urgent Care Center	**$15 copay**	**$15 copay no deductible**	**$15 copay per visit, 72 hours cost share waived if admitted for the same condition**	**$15 copay per visit, 72 hours cost share waived if admitted for the same condition**
Diagnostic Radiology MRI and CT scans	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Lab Services	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**$0 copay per visit**
Diagnostic testing & procedures	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by service area.

Outpatient X-rays	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Routine Hearing Screening (We cover one every twelve months)	**$15 copay**	**Refer to Evidence of Coverage (EOC)**	**$0 copay for routine hearing exams, 1 exam every calendar year**	**$0 copay for routine hearing exams, 1 exam every calendar year**
Medicare Covered Hearing Examination	**$15 copay**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Routine hearing exams	**Not Covered**	**Not Covered**	**Routine hearing exams and fitting evaluations limit $70 per ear with a maximum benefit of Hearing Exams $0 copay for routine hearing exams, 1 exam every calendar year**	**Must use Hearing Care Plus**
Hearing Aids	**$699 copay Advanced digital; $999 copay Premium digital**	**Refer to Evidence of Coverage (EOC)**	**$0 copay for hearing aids, supplied by hearing care solutions, $500 per ear with a maximum benefit of, $1,000 every three calendar years combined in-network and out-of-network**	**Must use Hearing Care Plus**
Hearing aid fitting evaluations	**$0 copay**	**Refer to Evidence of Coverage (EOC)**	**$0 copay for hearing aid fitting evaluations, 1 evaluation per covered hearing aid**	**Must use Hearing Care Plus**
Medicare Covered Dental Non-routine care covered by Medicare.	**Not Covered**	**Not Covered**	**$15 copay per visit**	**20% coinsurance**
Medicare covered eye exams.	**$15 copay**	**$20% after deductible**	**$0 copay per visit, 1 visit every calendar year, $70 maximum, every calendar year**	**$0 copay per visit, 1 visit every calendar year, $70 maximum, every calendar year**

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Vision Eyewear Reimbursement	**$0 copay for eyewear, maximum benefit, $100 every two calendar years**	**Not Covered**	**$0 copay for eyewear, maximum benefit, $100 every two calendar years**	**$0 copay for eyewear, maximum benefit, $100 every two calendar years**
Inpatient Mental Health Care	**$0 copay per day**	**$20% after deductible**	**$0 copay per admission**	**20% coinsurance**
Outpatient Mental Health Care Individual visit	**$15 copay**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Inpatient Substance Abuse	**$0 copay per day**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Outpatient Substance Abuse Individual visit	**$15 copay**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Skilled Nursing Facility (SNF) Care	**$0 copay per day, 1-100 days per benefit period**	**20% after deductible, 1-100 days per benefit period**	**$0 copay per day, 1-100 days per benefit period**	**20% coinsurance, 1-100 days per benefit period**
Outpatient Rehabilitation Services	**$15 copay per visit**	**20% after deductible**	**$15 copay per visit**	**20% coinsurance**
Ambulance Services	**$0 copay**	**$0 copay no deductible**	**$0 copay per one way trip**	**$0 copay per one way trip**
Medicare Part B Prescription Drugs	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**15% coinsurance**
Chiropractic Services Medicare covered benefits only.	**$10 copay**	**20% after deductible**	**$10 copay per visit**	**20% coinsurance**
Routine Chiropractic Care	**$10 copay; 6 visits per year**	**20% after deductible; 6 visits per year**	**$10 copay per visit, 6 visits per year**	**20% coinsurance, 6 visits per year**
Diabetic Supplies	**$0 copay**	**20% after deductible**	**$0 copay**	**20% coinsurance, 30 days per supply**
Durable Medical Equipment/ Prosthetic Devices	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Home Health Agency Care	**$0 copay**	**20% after deductible**	**$0 copay per visit**	**20% coinsurance**
Podiatry Services Medicare covered benefits only.	**$15 copay**	**20% after deductible**	**$10 copay per visit**	**20% coinsurance**

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Routine foot care	**$15 copay per visit, 6 visits per year**	**20% after deductible, 6 visits per year**	**$10 copay per visit, 12 visits per year**	**20% coinsurance, 12 visits per year**
Telehealth	**$0 copay**	**Refer to Evidence of Coverage (EOC)**	**$0 copay per visit (LiveHealth Online)**	**N/A**
Foreign travel emergency (outside U.S. territories) Emergency care	**$40 copay (waived if admitted)**	**$40 copay no deductible (waived if admitted)**	**$40 copay per visit, 72 hours cost share waived if admitted for the same condition**	**$40 copay per visit, 72 hours cost share waived if admitted for the same condition**
Health and wellness programs	**One Pass™ physical, mental, and social fitness membership**	**One Pass™ physical, mental, and social fitness membership**	**$0 copay per visit;** SilverSneakers® Take virtual fitness classes at home or visit us at a participating gym.	**N/A**
Healthy Meals Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition*	**Not Covered**	**Not Covered**	**$0 copay per qualifying event, 14 meals per qualifying event, four (4) events per year, 56 meals in total**	**$0 copay per qualifying event, 14 meals per qualifying event, four (4) events per year, 56 meals in total**
Medicare Community Resource Support	**Not Covered**	**Not Covered**	**$0 copay per visit**	**$0 copay per visit**

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Part D Prescription Drug				
	Personal Choice 65 Standard $10/$15		Medicare PPO Plan 10H	
Benefit				
Deductible	$0		$0	
Initial Coverage	After you pay your annual deductible, you pay the following copays until you reach the initial coverage limit (paid by member and plan)		After you pay your annual deductible, you pay the following copays until you reach the initial coverage limit (paid by member and plan)	
	Preferred Pharmacy	Standard Pharmacy	Preferred Pharmacy	Standard Pharmacy
30-day supply at network retail pharmacy				
Tier 1 Select Generic Drugs	N/A	N/A	$0 copay	$0 copay
Tier 1 Generic Drugs	$5 copay	$10 copay	$5 copay	$10 copay
Tier 2 Preferred Brand Drugs	$15 copay	$15 copay	$5 copay	$15 copay
Tier 3 Non-Preferred Brand Drugs	$30 copay	$30 copay	$20 copay	$30 copay
90-day supply at network retail pharmacy				
Tier 1 Select Generic Drugs	N/A	N/A	$0 copay	$0 copay
Tier 1 Generic Drugs	$15 copay	$30 copay	$15 copay	$30 copay
Tier 2 Preferred Brand Drugs	$45 copay	$45 copay	$15 copay	$45 copay
Tier 3 Non-Preferred Brand Drugs	$90 copay	$90 copay	$60 copay	$90 copay
30-day supply at network mail-order pharmacy				
Tier 1 Select Generic Drugs	N/A	N/A	N/A	N/A
Tier 1 Generic Drugs	$5 copay	N/A	N/A	N/A
Tier 2 Preferred Brand Drugs	$15 copay	N/A	N/A	N/A
Tier 3 Non-Preferred Brand Drugs	$30 copay	N/A	N/A	N/A
90-day supply at network mail-order pharmacy				
Tier 1 Select Generic Drugs	N/A	N/A	$0 copay	N/A

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Tier 1 Generic Drugs	**$5 copay**	**N/A**	**$5 copay**	**N/A**
Tier 2 Preferred Brand Drugs	**$15 copay**	**N/A**	**$5 copay**	**N/A**
Tier 3 Non-Preferred Brand Drugs	**$30 copay**	**N/A**	**$20 copay**	**N/A**

Coverage Gap			
Please see your Evidence of Coverage (EOC)	**The coverage gap begins after the initial coverage limit cost has been reached (paid by member and plan):**	**Benefits have been paid by your Group Part D plan and this plan for covered prescription drugs, you will be responsible for the amounts shown above.**	
Catastrophic Coverage*			
	Once your annual out-of-pocket drugs cost has been reached, you pay the greater of:	**Retail & Mail-Order Cost Sharing**	
Generics (including brand drugs treated as generic)	**$4.15 or 5%**	**Tier 1 Select Generic Drugs**	**$0 copay**
All other drugs	**$10.35 or 5%**	**Tier 1 Generic Drugs**	**$0 copay**
		Tier 2 Brand-Name Drugs	**$0 copay**

* The Medicare cost-sharing amounts listed are for 2023 and are subject to change in 2024.

The green highlight reflects positive changes from the current coverage.

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