

**MINUTEMAN NASHOBA HEALTH GROUP**

**COMPARISON OF HEALTH PLANS for RETIREES WITH MEDICARE PART A & PART B** (health plan changes in red font)

**Effective date 1/1/2010**

**All Senior Plans Renew on January 1<sup>st</sup>**

Benefit Category	Harvard Pilgrim First Seniority FREEDOM Premier PFFS	Fallon Senior Plan Premier	Tufts Medicare Preferred HMO (formerly Secure Horizons)	Tufts Medicare Complement (TMC)	Medicare Complement Plan (MCP) Administered by Tufts
<b>INPATIENT CARE</b>	Medicare Advantage Private Fee For Service (PFFS) plan	Medicare Advantage HMO	Medicare Advantage HMO	Medi-gap HMO	Freedom-of-Choice Medicare supplement plan
General Hospital: Semi-private room & board and special services	Covered in full.	Covered in full when medically necessary	Covered 100% after one-time annual deductible of <b>\$300</b>	Covered in full.	Covered in full. For inpatient MH/Substance Abuse, after the 190-day Medicare lifetime limit is reached, covered in full up to 120 days per benefit period in a general hospital, mental health, or a substance abuse facility. Limits do not apply to biologically based mental health services.
Skilled Nursing Facility	Covered in full for 100 days in benefit period.	Covered in full for up to 100 days per benefit period.	Covered in full for 100 days in benefit period. No prior hospital stay is required.	Covered in full for 100 days in benefit period.	Covered in full for 100 days in benefit period. Any charges over \$16 per day from day 101-365 are not covered.
<b>OUTPATIENT CARE</b>					
Medical Office Visits	\$15 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Consult & Care by Specialists	\$15 co-pay per visit	\$20 co-pay per visit	\$15 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Routine Physical Exams	\$15 co-pay per visit	<b>\$0 co-pay once per year</b>	\$15 co-pay per visit	\$10 co-pay per visit	Not covered
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Day Surgery	Covered in full	\$75 co-pay for each service	<b>\$50</b> per day	Covered in full	Covered in full
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

*This is an abbreviated description of benefits. Details of coverage are available from each health plan provider. Health plans provided the information in this summary. The MNHG is not responsible for the accuracy of this summary of benefits.*

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<b>OUTPATIENT CARE</b>	Medicare Advantage Private Fee For Service (PFFS) plan	Medicare Advantage HMO	Medicare Advantage HMO	Medi-gap HMO	Freedom-of-Choice Medicare supplement plan
Urgent & Emergency Care	\$15 co-pay for office; \$50 co-pay for ER, waived if admitted	\$10 co-pay for office; \$50 co-pay for ER, waived if admitted	\$15 co-pay for office; \$50 co-pay for ER, waived if admitted	\$10 co-pay for office; \$50 co-pay for ER, waived if admitted	Covered in full for emergency room care
Outpatient Mental Health & Substance Abuse	\$15 co-pay per visit	For Medicare covered mental health services - \$10 or \$20 co-pay for each individual or group therapy visit	\$15 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit for up to 12 office visits per calendar year. Limits do not apply to biologically based mental health services
Routine Vision & Hearing Screenings	Members will receive up to \$100 in reimbursement for 1 routine eye exam per calendar year; \$200 eyewear allowance every 24 months;  \$15 Routine hearing test. \$500 hearing aid allowance per year	\$10 PCP or \$20 specialist co-pay for each routine eye exam limited to 1 exam every 2 years. \$150 eyewear allowance every 24 months;  \$10 PCP or \$20 specialist co-pay for each Medicare covered hearing exam. \$500 allowance for purchase of hearing aids every 36 months.	\$15 co-pay per visit. Up to \$150 per year toward the purchase of glasses.  \$500 allowance for purchase or repair of hearing aids every 3 years.	\$10 co-pay per routine visit for eye exams.  Discounts available through network optometrists for purchase of glasses. Hearing aids are not covered.	Not covered.
Preventive Dental	Not Covered	\$10 co-pay for cleaning, oral exam, bitewing x-rays & fluoride treatment every 6 months	Not covered	Not covered	Not covered
Occupational, physical and speech therapy	\$15 co-pay for each Medicare-covered visit	\$10 co-pay	<b>\$15 co-pay</b>	\$10 co-pay when referred by PCP	\$10 co-pay
Ambulance (medically necessary)	\$0 co-pay	\$0 co-pay	<b>\$50 per day</b>	\$0 co-pay	\$0 co-pay

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<b>OUTPATIENT CARE</b>	Medicare Advantage Private Fee For Service (PFFS) plan	Medicare Advantage HMO	Medicare Advantage HMO	Medi-gap HMO	Freedom-of-Choice Medicare supplement plan
Prescription Drugs	<p>Retail: 30-day supply: Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$35 co-pay</p> <p>Mail Order: 90-day supply: Tier 1: \$20 co-pay Tier 2: \$40 co-pay Tier 3: \$105 co-pay</p> <p>After reaching \$4,550 in annual out-of-pocket drug costs you pay \$2.50 for generic &amp; \$6.30 for brand name or 5% coinsurance, whichever is greater.</p>	<p>Retail: 30-day supply: Tier 1: \$10 co-pay Tier 2: \$25 co-pay Tier 3: \$45 co-pay</p> <p>Mail Order: 90-day supply: Tier 1: \$20 co-pay Tier 2: \$50 co-pay Tier 3: \$90 co-pay</p> <p>After reaching \$4,550 in annual out-of-pocket drug costs you pay \$2.50 for generic &amp; \$6.30 for brand name or 5% coinsurance, whichever is greater.</p>	<p>Retail: 30-day supply: Tier 1: \$10 co-pay Tier 2: \$25 co-pay Tier 3: \$50 co-pay</p> <p>Mail Order: 90-day supply: Tier 1: \$20 co-pay Tier 2: \$50 co-pay Tier 3: \$100 co-pay</p> <p>After reaching \$4,550 in annual out-of-pocket drug costs you pay \$2.50 for generic &amp; \$6.30 for brand name or 5% coinsurance, whichever is greater.</p>	<p>Retail: 30-day supply: Tier 1: \$8 co-pay Tier 2: \$20 co-pay Tier 3: \$35 co-pay</p> <p>Mail Order: 90-day supply: Tier 1: \$16 co-pay Tier 2: \$40 co-pay Tier 3: \$70 co-pay</p>	<p>Retail: 30-day supply: Tier 1: \$5 co-pay Tier 2: \$10 co-pay Tier 3: \$25 co-pay</p> <p>Mail Order: 90-day supply: Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$50 co-pay</p> <p>After reaching \$4,550 in annual out-of-pocket drug costs you pay \$2.50 for generic &amp; \$6.30 for brand name or 5% coinsurance, whichever is greater.</p>

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