

MINUTEMAN NASHOBA HEALTH GROUP

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

Effective date 1/1/2012

All Senior Plans Renew on January 1st

Benefit Category	Fallon Senior Plan Premier	Tufts Medicare Preferred HMO	TUFTS MEDICARE PREFERRED GROUP SUPPLEMENT PLAN NEW – Effective 1/1/2012
INPATIENT CARE	Medicare Advantage HMO	Medicare Advantage HMO	Freedom-of-Choice Medicare supplement plan
General Hospital: Semi-private room & board and special services	Covered in full when medically necessary	Covered 100% after one-time annual deductible of \$300	Covered at 100% Full coverage of: -Medicare deductible and coinsurance up to 90 days per benefit period -Lifetime reserve day coinsurance -Up to 365 additional hospital days in your lifetime when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital)
Rehabilitation Hospital	Covered in full for 90 days per benefit period.	Covered in full for 90 days in benefit period.	Acute rehabilitation hospital covered the same as General Hospital.
Skilled Nursing Facility	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 per benefit period: -Medicare covers up to 20 days after a hospital stay of 3 days or longer -Then Plan covers, in full, Medicare daily coinsurance for days 21-100 per benefit period.
OUTPATIENT CARE			
Medical Office Visits	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Consult & Care by Specialists	\$20 co-pay per visit	\$15 co-pay per visit	\$10 co-pay per visit
Annual Routine Physical Exam	\$0 co-pay once per year	\$0 co-pay per visit	\$0 co-pay per visit
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full
Day Surgery	\$75 co-pay for each service	\$50 per day	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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Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full
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OUTPATIENT CARE	Medicare Advantage HMO	Medicare Advantage HMO	Freedom-of-Choice Medicare supplement plan
Urgent & Emergency Care	\$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; \$50co-pay for ER
Outpatient Mental Health & Substance Abuse	For Medicare covered mental health services - \$10 or \$20 co-pay for each individual or group therapy visit	\$15 co-pay per visit	Biologically based mental conditions: - When covered by Medicare, full coverage of deductible and coinsurance after \$10 copayment per visit. There is no visit limit. - When not covered by Medicare, \$10 copayment per visit for up to 24 visits per calendar year. Non-biologically-based mental conditions: - When covered by Medicare, full coverage after \$10 copayment per visit - When not covered by Medicare, \$10 copayment per visit for up to 24 visits per calendar year. <i>* Includes drug addiction and alcoholism.</i>
Routine Vision & Hearing Screenings	\$20 specialist co-pay for each routine eye exam, limited to 1 exam every 12 months. Eyewear allowance of \$150 every 12 months. \$20 co-pay for each Medicare covered hearing exam. \$500 toward the purchase of hearing aid every 36 months	\$15 co-pay per exam. Up to \$150 per year toward the purchase of eyeglasses or contacts, but not both. \$500 allowance for purchase or repair of hearing aids every 3 years	Hearing - \$10 copay for the office visit. (\$1,700 every 2 yrs for purchase or repair of hearing aid) Routine Vision Exam \$10 copay (every 2 years) (Covered up to \$150 per year for eyeglasses or contacts.

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OUTPATIENT CARE	Medicare Advantage HMO	Medicare Advantage HMO	Freedom-of-Choice Medicare supplement plan
Preventive Dental	\$10 co-pay for cleaning, oral exam, bitewing x-rays & fluoride treatment every 6 months	Not covered	Not covered
Occupational, physical and speech therapy	\$10 co-pay	\$15 co-pay	\$10 co-pay
Ambulance (medically necessary)	\$0 co-pay	\$50 per day	\$0 co-pay

Prescription Drugs	<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 \$4,700 in annual out-of-pocket drug costs you pay \$2.60 for generic & \$6.50 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 \$4,700 in annual out-of-pocket drug costs you pay \$2.60 for generic & \$6.50 for brand name or 5% coinsurance, whichever is greater.</p>	<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: \$70 co-pay</p>
OTHER BENEFITS			
Fitness Benefit	SilverSneakers™ Fitness Program provides fitness classes and paid membership at contracted facilities. Weightwatchers®	Fitness Benefit each year – Up to \$150 Cash reimbursement at any fitness center. No waiting period.	Up to \$150 reimbursement per calendar year per subscribe for joining a health club.

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