Massachusetts Medical Society

PLAN COMPARISON (Harvard Pilgrim, Tufts and AmWins (United American)
For Members Who Are Eligible For Medicare

Reflects plan changes effective January 1, 2010

	Harvard Pilgrim	Tufts	Tufts	Tufts	AmWins (UA)	AmWins (UA)
	First Seniority Freedom Premier 2	**Medicare Preferred "HMO Prime" w/Group Rx**	**Medicare Complement w/Rx Plus**	**Medicare Preferred "Group Premier Supplemental Plan" with Rx "Preferred PDP"**	**Medical Plan A with Rx Plan 1**	**Medical Plan A without Rx**
	Requires	***Requires***	***Requires***	***Requires***	***Requires***	***Requires***
	Medicare Parts A and B	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*
Quarterly Premium Rate * Per Person	***$972.75***	***$692.25***	***$1,190.50***	***$1,094.85***	***$781.20***	***$477.60***
**** Rates Effective:***	***1/1/10 through 12/31/10***	***1/1/10 through 12/31/10***	***1/1/10 through 12/31/10***	***1/1/10 through 12/31/10***	***1/1/10 through 12/31/10***	***1/1/10 through 12/31/10***
Eligibility Service Area; restricted to residents of:	***United States***	***Certain areas of Massachusetts only***	***All of Massachusetts***	***United States***	***United States***	***United States***
Provider Network	***None but must accept Medicare plus First Seniority's Terms and Conditions***	***Limited network within Massachusetts***	***Utilizes entire Tufts Network in Massachusetts***	***Any doctor in the US who accepts Medicare***	***None but must accept Medicare***	***None but must accept Medicare***
Part A Deductible ($1100 for 1st 60 days per benefit period in 2010)	N/A	N/A	N/A	N/A	Not covered	Not covered
Part B Deductible ($155 for 2010)	N/A	N/A	N/A	N/A	Not covered	Not covered
Prescription Drugs From Pharmacy (30 day supply)						
Deductible	None	None	None	None	none	n/a
Maximum Benefit	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**	**Unlimited**	Not covered
Copay:						
Generic	$10	$10	$8	$10	$10	Not covered
Brand Name	$20	$25	$20	$30	$40	Not covered
"Non-preferred Drug"	$35	$50	$35	$65	$60	Not covered
Rx "Coverage Gap"	Benefit changes after $4550 in out of pocket drug expense	Benefit changes after $4550 in out of pocket drug expense	none	none	No gap for generic	n/a
Mail Order Service (90 day supply)						
Deductible	None	None	None	None	None	Not covered
Copay:						
Generic	$20	$20	$16	$20	$20	Not covered
Brand Name	$40	$50	$40	$60	$80	Not covered
"Non-preferred Drug"	$105	$100	$70	$130	$120	Not covered
Rx "Coverage Gap"	Benefit changes after $4550 in out of pocket drug expense	Benefit changes after $4550 in out of pocket drug expense	none	none	No gap for generic	n/a
Hospital Services						

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	Requires *Medicare Parts A and B*	***Requires*** *Medicare Parts A and B*	***Requires*** *Medicare Parts A and B*	***Requires*** *Medicare Parts A and B*	***Requires*** *Medicare Parts A and B*	***Requires*** *Medicare Parts A and B*
Inpatient Coverage	100%	$300 calendar year deductible, then100%	100%	Covered 100%	After Medicare deductible Medicare covers 1st 60 days @100%; 61 through 90 except $275 per day; 91 through 150 except $550per day;Plan A covers balance of days 61-90 plus add'l. 365 days	After Medicare deductible Medicare covers 1st 60 days @100%; 61 through 90 except $275 per day; 91 through 150 except $550per day;Plan A covers balance of days 61-90 plus add'l. 365 days
Outpatient Coverage	100%	$50 copay for each Medicare covered ambulatory surgical or outpatient hospital facility center visit	100%	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Emergency Room Care	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$50 copay (waived if admitted)	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Ambulance Service	100%	$50 copay per day	Covered 100%	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Diagnostic Tests	100%	100%	100%	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Physician Services (including Surgery)	100%	100%	100%	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Ambulatory Services						
Physician Office Visits	$15 copay	$10 copay	$10 copay	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Specialist	$15 copay	$15 copay	$10 copay	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Physical Therapy	$15 copay	$15 copay with pcp referral	$10 per visit(w/PCP referral)	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Chiropractic Services	$15 copay-must meet medicare guidelines	$15 Spine Manipulation	$10 per visit(w/PCP referral)	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Preventive Care						
Annual Physical Exam	$15 copay	$15 copay	$10 copay	100%	Not covered	Not covered
Annual Mammography/PAP Smear	once per year	100% once per year	100% once per year	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Immunizations	100%	Flu & Pneumonia - 100 %	Flu & Pneumonia - 100 %	Flu & Pneumonia - 100 %	Flu & Pneumonia - 100 %	Flu & Pneumonia - 100 %

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Mental Health / Substance Abuse						
Inpatient Coverage	100%	$200 / year, then100%	100%	Covered 100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Lifetime Limit	190 Days Combined	190 Days Combined	190 Days Combined	190 Days Combined	Medicare covers 190 days; Plan A covers up to 565 days	Medicare covers 190 days; Plan A covers up to 565 days
Outpatient Coverage						
Copay	$15 copay	$15	$10	100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
# of visits	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Other Facilities & Services If Medically Necessary						
Hospice Care	100%	100%	100%	100%	100%	100%
Skilled Nursing Facility	100% (100 days)	100% (100 days)	100% (100 days)	100% (100 days)	Medicare covers 20 days @ 100%, days 21 through 100 except $133.50 per day Patient covers balance of 21-100 then 100% beyond that	Medicare covers 20 days @ 100%, days 21 through 100 except $133.50 per day Patient covers balance of 21-100 then 100% beyond that
Home Health Care	100%	100%	100%	100%	Medicare covers @ 100%	Medicare covers @ 100%
Private Duty Nursing Services	Not covered	Not covered	Not Covered	Not Covered	Not covered	Not covered
Durable Medical Equipment	100%	100%	100%	100%	Medicare covers 1st $100 @100%, then 80% of balance; Plan A pays balance	Medicare covers 1st $100 @100%, then 80% of balance; Plan A pays balance
Prosthetics	100%	100%	100%	100%	After Deductible, Medicare covers 80% *; Plan A covers 20% *	After Deductible, Medicare covers 80% *; Plan A covers 20% *
Routine Eye Exams	Up to $100 reimbursement for routine eye exam 1/yr.	$15 copay	$10	covered up to $100	Not covered	Not covered
Eyeglasses	$200 per 24 months allowed	$69 per year allowed	discount available	$100 towards eyeglasses $150 towards contacts	Not covered	Not covered
Hearing Exams	$15 copay 1/yr	$15 copay	$10 copay	covered up to $100	Not covered	Not covered
Hearing Aids	$500 per 12 months allowed	$500 allowed per 3 yrs.	Not covered	$500 allowed per 3 yrs.	Not covered	Not covered

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	Medicare Parts A and B	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*	*Medicare Parts A and B*

Please Note: This outline of benefits is intended to be a broad overview and is subject to change. Final determination of covered services and exclusions will be made by Medicare and the respective health plan.

Tufts Medicare Complement, Tufts Medicare Preferred are NOT available to individuals who reside in Massachusetts less than nine months per year.

Tufts Medicare Preferred and Tufts Medicare complement are "Managed Care" plans that *require* you to use participating providers in order to receive benefits. Tufts Medicare Complement utilizes the entire Tufts network, Medicare Preferred has fewer participating providers.

A restricted number of hospitals and physicians are included in each of the networks. Make sure acceptable Providers participate in the plan before you join.

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