

Massachusetts Medical Society
PLAN COMPARISON (Harvard Pilgrim, and Tufts)
For Members Who Are Eligible For Medicare

Reflects plan changes effective January 1, 2011

| | Harvard Pilgrim <u>Medicare Enhance 5-RB</u> | Tufts <u>Medicare Preferred "HMO Prime" w/Group Rx</u> | Tufts <u>Medicare Complement w/Rx Plus</u> | Tufts <u>Medicare Preferred "Group Premier Supplemental Plan" with Rx "Preferred PDP"</u> |
|--|--|--|---|--|
| | <i>Requires</i> | <i>Requires</i> | <i>Requires</i> | <i>Requires</i> |
| | <i>Medicare Parts A and B</i> | <i>Medicare Parts A and B</i> | <i>Medicare Parts A and B</i> | <i>Medicare Parts A and B</i> |
| Quarterly rate per person | \$1,348.95 | \$807.75 | \$1,296.15 | \$1,150.95 |
| Rates effective: | 1/1/11 through 12/31/11 | 1/1/11 through 12/31/11 | 1/1/11 through 12/31/11 | 1/1/11 through 12/31/11 |
| Eligibility Service Area; restricted to residents of: | United States | Certain areas of Massachusetts only | All of Massachusetts | United States |
| Provider Network | Any doctor in the US who accepts Medicare | Limited network within Massachusetts | Utilizes entire Tufts Network in Massachusetts | Any doctor in the US who accepts Medicare |
| Part A Deductible (\$1132 for 1st 60 days per benefit period in 2011) | N/A | N/A | N/A | N/A |
| Part B Deductible (\$162 for 2011) | N/A | N/A | N/A | N/A |
| Prescription Drugs From Pharmacy (30 day supply) | | | | |
| Deductible | None | None | None | None |
| Maximum Benefit | Unlimited | Unlimited | Unlimited | Unlimited |
| Copay: | | | | |
| Generic | \$10 | \$10 | \$8 | \$10 |
| Brand Name | \$20 | \$25 | \$20 | \$30 |
| "Non-preferred Drug" | \$35 | \$50 | \$35 | \$65 |
| Rx "Coverage Gap" | None | Benefit changes after \$4550 in out of pocket drug expense | none | none |
| Mail Order Service (90 day supply) | | | | |
| Deductible | None | None | None | None |
| Copay: | | | | |
| Generic | \$20 | \$20 | \$18 | \$20 |
| Brand Name | \$40 | \$50 | \$40 | \$60 |

* of approved charges

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| "Non-preferred Drug" | \$105 | \$100 | \$70 | \$130 |
| Rx "Coverage Gap" | None | Benefit changes after \$4550 in out of pocket drug expense | none | none |
| Hospital Services | | | | |
| Inpatient Coverage | 100% | \$300 calendar year deductible, then 100% | 100% | Covered 100% |
| Outpatient Coverage | 100% | \$50 copay for each Medicare covered ambulatory surgical or outpatient hospital facility center visit | 100% | Covered 100% |
| Emergency Room Care | \$50 copay (waived if admitted) | \$50 copay (waived if admitted) | \$50 copay (waived if admitted) | Covered 100% |
| Ambulance Service | 100% | \$50 copay per day | Covered 100% | Covered 100% |
| Diagnostic Tests | 100% | 100% | 100% | Covered 100% |
| Physician Services (including Surgery) | 100% | 100% | 100% | Covered 100% |
| Ambulatory Services | | | | |
| Physician Office Visits | \$15 copay | \$10 copay | \$10 copay | Covered 100% |
| Specialist | \$15 copay | \$15 copay | \$10 copay | Covered 100% |
| Physical Therapy | \$15 copay | \$15 copay with pcp referral | \$10 per visit(w/PCP referral) | Covered 100% |
| Chiropractic Services | \$15 copay-must meet medicare guidelines | \$15 Spine Manipulation | \$10 per visit(w/PCP referral) | Covered 100% |
| Preventive Care | | | | |
| Annual Physical Exam | 100% once per year | 100% once per year | 100% once per year | 100% once per year |
| Annual Mammography/PAP Smear | 100% once per year | 100% once per year | 100% once per year | 100% once per year |
| Immunizations | Flu & Pneumonia - 100 % | Flu & Pneumonia - 100 % | Flu & Pneumonia - 100 % | Flu & Pneumonia - 100 % |
| Mental Health / Substance Abuse | | | | |

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| Inpatient Coverage | Covered 100% | \$300 per year then 100% | 100% | Covered 100% |
| Lifetime Limit | Biologically Based conditions unlimited; No Lifetime Limit | 190 Days Combined | 190 Days Combined | 190 Days Combined |
| Outpatient Coverage | | | | |
| Copay | \$15 copay | \$15 | \$10 | 100% |
| # of visits | 24 Visits per calendar year; Biologically Based conditions no visit limits | Unlimited | Unlimited | Unlimited |
| Other Facilities & Services If Medically Necessary | | | | |
| Hospice Care | 100% | 100% | 100% | 100% |
| Skilled Nursing Facility | 100% (100 days) | 100% (100 days) | 100% (100 days) | 100% (100 days) |
| Home Health Care | 100% | 100% | 100% | 100% |
| Private Duty Nursing Services | Not covered | Not covered | Not Covered | Not Covered |
| Durable Medical Equipment | 100% | 100% | 100% | 100% |
| Prosthetics | 100% | 100% | 100% | 100% |
| Routine Eye Exams | \$15 copay 1/yr | \$15 copay | \$10 | covered up to \$100 |
| Eyeglasses | Discounts Available | \$150 per year allowed | discount available | \$100 towards eyeglasses \$150 towards contacts |
| Hearing Exams | \$15 copay 1/yr | \$15 copay | \$10 copay | covered up to \$100 |

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| Hearing Aids | Discounts Available | \$500 allowed per 3 yrs. | Not covered | \$500 allowed per 3 yrs. |

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 yo