

BENEFIT COMPARISON		Acton Public/Acton Boxborough
BENEFIT	MEDEX 3 - OBRA (INCLUDES MEDICARE BENEFITS)	Tufts Medicare Preferred Private Fee For Service (INCLUDES MEDICARE BENEFITS)
Deductible	\$50 per calendar year only for prescription drugs purchased from a retail pharmacy	None
Calendar Year Coinsurance Maximum	None	None
Lifetime Benefit Maximum	None	None
INPATIENT	YOU PAY	YOU PAY
General Hospital (semi-private room and board and special services)	Nothing to 90 days per benefit period (plus 365 Medex lifetime benefit days) benefit maximum	One time annual deductible of \$200 per calendar year for services received at a network hospital. You are covered for unlimited days per benefit period.
Physician Services	Nothing	Covered after deductible
Skilled Nursing Facility	Nothing to 100 days per benefit period; then \$16 per day for days 101-365 benefit maximum	No copayment for services received at a skilled nursing facility. No prior hospital stay required. You are covered for 100 days per benefit period.
Rehabilitation Hospital	Nothing to 100 days per benefit period; then \$16 per day for days 101-365 benefit maximum	You are covered 90 days per benefit period. You may use your 60 lifetime reserve days to supplement care in rehabilitation or long term hospital.
OUTPATIENT HOSPITAL	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care	Nothing *Worldwide coverage.	You pay \$50 for each Medicare covered Emergency Room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. *Worldwide coverage.
Emergency Room Visits for Medical Care	Nothing	\$50 for Emergency Room \$15 copay for Dr's office ER visit
Surgery	Nothing	Outpatient Surgery-20% of charges up to \$50 per day.
Radiation and Chemotherapy	Nothing	Nothing
Diagnostic X-ray and Lab	Nothing	Nothing
Hemodialysis	Nothing	Nothing

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Physical Therapy	Nothing	Nothing
PHYSICIAN'S OFFICE	YOU PAY	YOU PAY
Medical Care	Nothing	\$15 copay for Dr's office visit
Routine GYN Exam	Nothing (1 visit every 24 months)	\$15 copay - you are covered for one per year.
Routine Vision Exam	All charges	\$15 copay - you are covered for one per year.
Adult Routine Physicals	All charges	\$15 copay for one routine physical per year.

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MENTAL HEALTH	YOU PAY	YOU PAY
BIOLOGICALLY-BASED CONDITIONS+		
- Inpatient admissions in a general or mental hospital	Nothing to 90 days per benefit period (plus 365 Medex lifetime benefit days) benefit maximum	There is no copayment for services received at a hospital.
		Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime except in an emergency.
- Outpatient visits	Nothing	\$15 copayment for each individual or group visit.
NON-BIOLOGICALLY-BASED MENTAL CONDITIONS (Includes drug addiction and alcoholism)		Please see above
- Inpatient admissions in a general hospital	Nothing to 90 days per benefit period (plus 365 Medex lifetime benefit days) benefit maximum	
- Inpatient admissions in a mental hospital or substance abuse treatment facility	Nothing to 120 days per benefit period benefit maximum (at least 60 days per calendar year)	
- Outpatient visits	Up to 24 visits per calendar year for Medicare covered services, nothing from 25th visit.	\$15 copayment for each individual or group visit.

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ALCOHOLISM TREATMENT (IN ADDITION TO NON-BIOLOGICALLY BASED MENTAL CONDITIONS)		A one time annual \$200 deductible for services received at a hospital. Covered for unlimited days each benefit period. No copayment required for inpatient hospital services received at a hospital.
- Inpatient admissions in a general hospital	Nothing	
- Inpatient admissions in a substance abuse treatment facility	Nothing (up to 30 days per calendar year)	
- Outpatient visits++	Up to 8 visits per calendar year for Medicare covered services, nothing from 9th visit.	

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OTHER OUTPATIENT	YOU PAY	YOU PAY
Visiting Nurse - Home Health Care	Nothing	There is no copayment for Medicare covered home health visits.
Prosthetic Devices	Nothing	No copayment for Medicare covered Prosthetic devices.
Durable Medical Equipment	Nothing	No copayment for Medicare covered DME.
Ambulance	Nothing	Covered in full for emergency services only.
Wheelchair Vans		
Chiropractor Visits	Nothing only for manual manipulation of the spine to correct a subluxation that can be shown by x-ray. All charges for other services.	\$15 per visit. Covered for the manual manipulation of the spine to correct subluxation.
Removal of Impacted Teeth	All charges	Non routine dental care is limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

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Retail Prescription Drugs	After a \$50 calendar-year deductible: <ul style="list-style-type: none"> • Full Coverage (generic drugs) • 80% coverage (brand name drugs) Purchased at participating pharmacies inside Massachusetts or any pharmacy outside of Massachusetts. Administered by Express Scripts	\$10 tier 1/\$25 tier 2/\$50 tier 3 -30 day retail supply \$20 tier 1/\$50 tier 2/\$100 tier 3 - 60 day retail supply \$30 tier 1/\$75 tier 2/\$150 tier 3 - 90 day retail supply Administered by Caremark
Mail-Service Prescription Drugs	Full coverage after a: <ul style="list-style-type: none"> • \$2 copayment (generic drugs) • \$10 copayment (brand-name drugs) Up to a 90-day supply - generic or brand-name when purchased from the mail service pharmacy. Administered by Express Scripts	\$7 tier 1/\$17 tier 2/\$33 tier 3 -30 day mail order supply \$14 tier 1/\$33 tier 2/\$67 tier 3 - 60 day mail order \$20 tier 1/\$50 tier 2/\$100 tier 3 - 90 day mail order No annual limit on prescription drug coverage. You must use Caremark services for mail orders. Authorization may be required for some prescription drugs. Administered by Caremark
<p>++The value of these visits is at least \$500 in each calendar year.</p> <p>These pages summarize benefits of the plan(s). The Subscriber Certificate(s) and applicable riders define the terms and conditions of these benefits in greater detail. Should any questions arise, the certificate(s) and riders will govern.</p> <div data-bbox="296 1273 705 1479" data-label="Image"> </div>		<p>A Medicare Advantage Private Fee-For-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies.</p> <div data-bbox="1060 1289 1444 1487" data-label="Image"> </div>

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Tufts Health Plan Medicare Preferred (INCLUDES MEDICARE BENEFITS)	FSEN Freedom Premier - OBRA (INCLUDES MEDICARE BENEFITS)
None	None
None	None
None	None
YOU PAY	YOU PAY
One time annual deductible of \$200 per calendar year for services received at a network hospital. You are covered for unlimited days per benefit period.	There is no copayment for services received at a hospital. You are covered for unlimited days each benefit period.
Covered after deductible	Nothing
No copayment for services received at a skilled nursing facility. No prior hospital stay required. You are covered for 100 days per benefit period.	There is no copayment for services received at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period.
You are covered 90 days per benefit period. You may use your 60 lifetime reserve days to supplement care in rehabilitation or long term hospital.	There is no copayment for services received at a rehabilitation hospital. You are covered for unlimited days each benefit period.
YOU PAY	YOU PAY
You pay \$50 for each Medicare covered Emergency Room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. *Worldwide coverage.	You pay \$50 for each Medicare covered Emergency Room visit; you do not pay this amount if you are admitted to the hospital within 3 day(s) for the same condition. *Worldwide coverage. Members are no longer covered for urgently needed care worldwide. Worldwide coverage for emergency care only.
Nothing	No coverage.
Outpatient Surgery-20% of charges up to \$50 per day.	Nothing
Nothing	Nothing
Nothing	Nothing
Nothing	Nothing

Tufts Health Plan Medicare Preferred (INCLUDES MEDICARE BENEFITS)	FSEN Freedom Premier - OBRA (INCLUDES MEDICARE BENEFITS)
You pay \$15 for each Medicare covered visit.	You pay \$15 for each Medicare covered visit.
YOU PAY	YOU PAY
\$10 primary care & \$15 specialist copay. PCP referrals are required for specialist visits.	You pay \$15 for each primary care doctor office visit for Medicare covered services.
\$15 copay - you are covered for one per year.	You pay \$15 for each primary care doctor office visit for Medicare covered services. One visit per 12 month period.
\$15 copay - you are covered for one per year.	There is no copayment for the following items: Medicare covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) Glasses - You Pay: \$15 for each Medicare covered eye exam (diagnosis & treatment for diseases and conditions of the eye). Members will receive up to \$100 in reimbursement for 1 routine eye exam per calendar year. You are covered up to \$200 for eyewear every two years.
\$10 copay - you are covered for one routine physical per year.	You pay \$15 for each exam. You are covered up to 1 exam every year.

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YOU PAY	YOU PAY
There is no copayment for services received at a network hospital.	There is no copayment for services received at a hospital.
Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime except in an emergency. The Provider must obtain authorization from Tufts Health Plan.	Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime except in an emergency. You must get authorization from Harvard Pilgrim Health Care before you get this service. Failure to get authorization can result in significantly higher cost to you.
\$15 copayment for each individual or group visit. PCP referral is required.	For Medicare covered Mental Health services you pay \$15 for each individual/group therapy visit.
Please see above	
	There is no copayment for services received at a hospital
	There is no copayment for services received at a hospital.
\$15 copayment for each individual or group visit. PCP referral required - no limit.	For Medicare covered services you pay a \$15 copay for each individual/group therapy visit.

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A one time annual \$200 deductible for services received at a network hospital. Covered for unlimited days each benefit period. No copayment required for inpatient hospital services received at a network hospital.	
	There is no copayment for services received at a hospital.
	\$15 for each individual/group therapy visit

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YOU PAY	YOU PAY
There is no copayment for Medicare covered home health visits.	You pay \$0 for Medicare covered home health visits.
No copayment for Medicare covered Prosthetic devices. PCP referral required.	You pay \$0 for each Medicare covered item.
No copayment for Medicare covered DME. PCP referral required.	You pay \$0 for each Medicare covered item.
Covered in full for emergency services only.	Nothing
	No coverage for wheelchair vans.
\$15 per visit. PCP referral required. Covered for the manual manipulation of the spine to correct subluxation.	You pay \$15 for each Medicare covered visit (manual manipulation of the spine to correct subluxation).
Non routine dental care is limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	All charges - There is no coverage for a routine dental examination or cleaning.

<p align="center">Tufts Health Plan Medicare Preferred</p> <p align="center">(INCLUDES MEDICARE BENEFITS)</p>	<p align="center">FSEN Freedom Premier - OBRA</p> <p align="center">(INCLUDES MEDICARE BENEFITS)</p>
<p>\$10 tier 1/\$25 tier 2/\$50 tier 3 -30 day retail supply \$20 tier 1/\$50 tier 2/\$100 tier 3 - 60 day retail supply \$30 tier 1/\$75 tier 2/\$150 tier 3 - 90 day retail supply</p> <p>Administered by Caremark</p>	<p>\$10 for tier 1 drugs up to a 30 day supply \$20 for tier 2 drugs up to a 30 day supply \$35 for tier 3 drugs up to a 30 day supply</p>
<p>\$7 tier 1/\$17 tier 2/\$33 tier 3 -30 day mail order supply \$14 tier 1/\$33 tier 2/\$67 tier 3 - 60 day mail order \$20 tier 1/\$50 tier 2/\$100 tier 3 - 90 day mail order No annual limit on prescription drug coverage. You must use Caremark services for mail orders. Authorization may be required for some prescription drugs.</p> <p>Administered by Caremark</p>	<p>\$20 for mail order tier 1 drugs up to a 90 day supply \$40 for mail order tier 2 drugs up to a 90 day supply \$105 for mail order tier 3 drugs up to a 90 day supply</p> <p>There is no annual limit on prescription drugs. Authorization may be required for some prescription drugs.</p>
	

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