Fiscal Year 2014 – 2015

MAYFLOWER MUNICIPAL HEALTH GROUP

COMPARISON OF BENEFITS FOR RETIREES ENROLLED IN MEDICARE A & B

Comparison of Medicare and the following Medicare supplement plans:

BLUE CROSS BLUE SHIELD MEDEX III

HARVARD PILGRIM HPHC MEDICARE ENHANCE

****MEDICARE RETIREES EFFECTIVE 7/1/2014****

****MEDICARE RETIREES EFFECTIVE 7/1/2014****

FY15 Mayflower Municipal Health Group Plan Benefit
Comparison of Medicare Plans

Effective 7-1-2014		BLUE CROSS BLUE SHIELD	HARVARD PILGRIM
	Medicare A & B	Medex III Includes medicare benefit	HPHC Medicare Enhance Includes medicare benefit
Deductible	Part A - $1,216 inpatient per benefit period. Part B - $147 per calendar year	None	None
Calendar Year Coinsurance Maximum	None	None	None
Lifetime Benefit Maximum	None	None	None
BENEFIT	**Medicare A & B**	**Medex III**	**HPHC Medicare Enhance**
INPATIENT	**YOU PAY**	**YOU PAY**	**YOU PAY**
General Hospital, *Mental Hospital, Substance Abuse Facility* (semi-private room and board and special services)	Nothing after $1,216 inpatient deductible for 60 days; then $304 daily coinsurance days 61-90; then $608 daily coinsurance for 60 lifetime reserve days.	Nothing to 365 days	Nothing to 365 days
Physician Services, Surgical Charges, Anesthesia and Consultations.	20% coinsurance	Nothing to 365 days	Nothing to 365 days
Skilled Nursing Facility	Nothing for 20 days; $152 daily coinsurance days 21-100. All costs for each day after day 100 in a benefit period	Nothing up to 100 days per benefit period, then the amount in excess of $16 per day from day 101 thru day 365	Nothing up to 100 days per benefit period
Rehabilitation Hospital	Nothing after $1,216 inpatient deductible for 60 days; then $304 daily coinsurance days 61-90; then $608 daily coinsurance for 60 lifetime reserve days.	Nothing to 100 days per benefit period; then $16 per day from day 101 thru day 365	Nothing up to 100 days per benefit period
OUTPATIENT			
Emergency Room Visits for Emergency or Accident Care	20% coinsurance	Nothing	$30 copay (waived if admitted)
OutPatient Surgery	20% coinsurance	Nothing	Nothing in General Hospital; Physicians office $5 copay
Radiation and Chemotherapy	20% coinsurance	Nothing	Nothing

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OUTPATIENT cont.	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hemodialysis	20% coinsurance	Nothing	Nothing
Physical Therapy	20% coinsurance	Nothing	$5 copay per visit
Mental Health & Substance Abuse	**Please see Medicare Benefits as described in your Medicare Benefits Handbook for mental health.**	Nothing	Biologically based mental conditions: $5 copay Non-biologically based mental conditions: $5 copay up to 24 visits per Calendar Year
Alcoholism treatment	**Please see Medicare Benefits as described in your Medicare Benefits Handbook for mental health.**	Nothing	All charges in excess of combined Medicare/HPHC Medicare Enhance benefit Maximum
Routine Physical Exams	$0 co-pay for "Welcome to Medicare" visit within the first 12-months that you have Part B. $0 co-pay annual physical once per calendar year after 12 months of Part B.	All charges (when not covered by Medicare)	$5 copay per visit (when not covered by Medicare)
Routine GYN Exam	$0 (1 visit every 24 months or 1 visit every 12 months if at high risk)	Nothing (1 visit every 2 years)	$5 copay per visit
Routine Vision & Hearing Screenings	All Charges	All charges	$5 copay per visit
Office Visit -Clinic , Medical, Specialist	20% coinsurance after $147 calendar year deductible met	Nothing	$5 copay per visit
Diagnostic Lab & X-Ray	20% coinsurance after $147 calendar year deductible met	Nothing	Nothing
Visiting Nurse **Home Health Care**	Nothing	Nothing	Nothing
Durable Medical Equipment	20% coinsurance	Nothing	Nothing

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Comparison of Medicare Plans

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OUTPATIENT cont.	**YOU PAY**	**YOU PAY**	**YOU PAY**
Ambulance (when medically necessary)	20% coinsurance	Nothing	Nothing
Chiropractor Visits	20% coinsurance after $147 Part B deductible only for manual manipulation of the spine to correct a subluxation that can be shown by x-ray. All charges for other services.	Nothing only for manual manipulation of the spine to correct a subluxation that can be shown by x-ray. 80% of the allowed charge by a chiropractor when covered by Medicare.	$5 copay (except for x-rays taken in chiropractor's office) limited coverage
Prescription Drugs			
Retail pharmacy & mail order	All charges	Formulary drugs: **Retail Pharmacy:** $5 copay for Generic $10 copay for brand formulary $25 copay for Brand non-formulary **Mail order:** $10 copay for Generic $20 copay for brand formulary $50 copay for Brand non-formulary 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges	Formulary drugs: **Retail Pharmacy:** $5 copay for Generic $15 copay for brand formulary $35 copay for Brand non-formulary **Mail order:** $5 copay for Generic $15 copay for brand formulary $35 copay for Brand non-formulary 30-day supply retail pharmacy or 90-day supply mail service Non-formulary drugs: all charges
OTHER BENEFITS			
Fitness	N/A	$150 Fitness club reimbursement benefit per calendar year.	$150 Fitness club reimbursement benefit per calendar year.
MMHG Wellness Program	**"BENEFICIAL WELLNESS NEWS" QUARTERLY NEWSLETTER, WALKING PROGRAMS, "TO GO KITS" (SMOKING CESSATION/STRESS MANAGEMENT/BACK CARE BASICS), MONTHLY HEALTH LINKS, WELLNESS SEMINARS/SCREENINGS, INCENTIVE PROGRAMS, FITNESS CENTER DISCOUNTS, WORKPLACE FLU CLINICS, HEALTHY RESOURCES POSTED ON OUR WEBSITE/FACEBOOK/TWITTER & MORE** **(PARTICIPATION IN CERTAIN PROGRAMS MAY VARY BY MEMBER UNIT. PLEASE CHECK WITH YOUR BENEFIT COORDINATOR OR WELLNESS COORDINATOR AND OUR WEBSITE -www.MMHG.org- FOR MORE INFORMATION)**		

*****ALL SUBSCRIBERS MUST MAINTAIN ENROLLMENT IN MEDICARE PARTS A & B TO BE A ELIGIBLE FOR ANY OF THE ABOVE NAMED SUPPLEMENTAL PLANS*****

HPHC Medicare Enhance and Medex Subscribers can live anywhere in the US; may see any doctor who accepts Medicare, do not need to select a PCP and do not need referrals.

ANYTHING THAT APPEARS IN ITALIC BOLD TYPE INDICATES A CHANGE IN THE BENEFIT OR WORDING FROM THE PREVIOUS YEAR. PLEASE NOTE THAT CHANGES TO THE DEDUCTIBLE AND COINSURANCE AMOUNTS FOR MEDICARE ARE BASED ON CALENDAR YEAR

Disclaimer: This comparison summarizes benefits of the plan(s) and is not a definitive statement of benefits. The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.
Please call the "member service" phone number on your ID card for specific coverage questions.

Reviewed by Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care.