

2008 Plan Benefits	Tufts Medicare Preferred HMO Prime	Tufts Medicare Complement
2008 Rate	\$173 per month unlimited prescriptions	\$333 per month (unlimited prescriptions) \$176 per month (without prescription drug coverage)
INPATIENT CARE		
Inpatient hospitalization, including Substance Abuse: semi-private room and board and special services for Medicare-covered hospital stays	Covered 100% after one-time annual deductible of \$200	Covered 100%
Skilled Nursing	\$0 copay per day. 100 days covered for each benefit period. No prior hospital stay required.	\$0 copay per day. 100 days covered for each benefit period. No prior hospital stay required.
Mental Health Care in Psychiatric Hospital	\$0 copay, 190 day lifetime maximum	\$0 copay, 190 day lifetime maximum
Inpatient Rehabilitation	90 days per benefit period. Covered 100%.	90 days per benefit period. Covered 100%.
OUTPATIENT CARE		
Primary Care Physician Office Visit	\$10 copay per visit	\$10 copay per visit
Specialist Office Visit	\$15 copay per visit	\$10 copay per visit
Routine Physical exam	\$10 copay per visit	\$10 copay per visit
Lab and Therapeutic Radiology	Covered 100%	Covered 100%
Diagnostic Radiology (MRI, PET scan, CAT scan, X-ray)	Covered 100%	Covered 100%
Outpatient Hospital/Ambulatory Care	\$0 to \$50 copay for each Medicare-covered ambulatory surgical or outpatient hospital facility center visit	Covered 100%
Home Health Care	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.
Durable Medical Equipment	\$0 copay for Medicare-covered items	\$0 copay for Medicare-covered items
Urgent and Emergency	\$10 copay for office visit, \$50 copay for emergency room	\$10 copay for office visit, \$50 copay for emergency room
Ambulance Services	There is no copay for Medicare-covered ambulance services	There is no copay for Medicare-covered ambulance services
Mental Health	\$15 copay per visit	\$10 copay per visit
Substance Abuse	\$15 copay per visit	\$10 copay per visit
Routine Eye Exams	\$15 copay. One pair of eyeglasses covered after each cataract surgery. Up to \$69 towards one pair of glasses every year.	\$10 copay Discounts on lenses, frames and contacts.
Hearing Aids	\$500 allowance for purchase or repair of hearing aids every 3 years	Not covered
Physical, Occupational and Speech Therapy	Covered 100%	\$10 copay per visit
Prescription Drugs	30 Day Supply Retail: Tier 1 - \$10 Tier 2 - \$25 Tier 3 - \$50 Mail Order: Tier 1 - \$7 Tier 2 - \$17 Tier 3 - \$33 60 Day Supply Retail: Tier 1 - \$20 Tier 2 - \$50 Tier 3 - \$100 Mail Order: Tier 1 - \$14 Tier 2 - \$33 Tier 3 - \$67 90 Day Supply Retail: Tier 1 - \$30 Tier 2 - \$75 Tier 3 - \$150 Mail Order: Tier 1 - \$20 Tier 2 - \$50 Tier 3 - \$100	WITH PRESCRIPTION DRUG COVERAGE: 30 day supply Tier 1 - \$8 Tier 2 - \$20 Tier 3 - \$35 Mail Order: up to a 90 day supply Tier 1 - \$16 Tier 2 - \$40 Tier 3 - \$70 WITHOUT PRESCRIPTION DRUG COVERAGE: Not Covered

2008 Plan Benefits	Tufts Medicare Preferred Private Fee for Service Prime	Tufts Medicare Preferred Private Fee for Service Basic	
2008 Rate	\$185 per month unlimited prescriptions	\$89 per month unlimited prescriptions \$3500 maximum out-of-pocket per year	
INPATIENT CARE			
Inpatient hospitalization, including Substance Abuse: semi-private room and board and special services for Medicare-covered hospital stays	Covered 100% after one-time annual deductible of \$200	Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day Additional Days: \$0 copay per day	
Skilled Nursing	\$0 copay per day. 100 days covered for each benefit period. No prior hospital stay required.	Days 1-10: \$0 copay per day; Days 11-100: \$100 copay per day 100 days covered for each benefit period. No prior hospital stay required.	
Mental Health Care in Psychiatric Hospital	\$0 copay 190 day lifetime maximum	Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day; 190 day lifetime maximum	
Inpatient Rehabilitation	90 days per benefit period. Covered 100%.	90 days per benefit period. Covered 100%.	
OUTPATIENT CARE			
Primary Care Physician Office Visit	\$15 copay per visit	\$25 copay per visit	
Specialist Office Visit	\$15 copay per visit	\$25 copay per visit	
Routine Physical exam	\$15 copay per visit	\$25 copay per visit	
Lab and Therapeutic Radiology	Covered 100%	Covered 100%	
Diagnostic Radiology (MRI, PET scan, CAT scan, X-ray)	Covered 100%	\$0 to \$50 copay	
Outpatient Hospital/Ambulatory Care	\$0 to \$50 copay for each Medicare-covered ambulatory surgical or outpatient hospital facility center visit	\$0 to \$150 copay for each Medicare-covered ambulatory surgical or outpatient hospital facility center visit	
Home Health Care	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.	
Durable Medical Equipment	\$0 copay for Medicare-covered items	\$1-\$50 copay for Medicare-covered items	
Urgent and Emergency	\$15 copay for office visit \$50 copay for emergency room	\$25 copay for office visit \$50 copay for emergency room	
Ambulance Services	There is no copay for Medicare-covered ambulance services	\$50 copay for Medicare-covered ambulance services	
Mental Health	\$15 copay per visit	\$25 copay per visit	
Substance Abuse	\$15 copay per visit	\$25 copay per visit	
Routine Eye Exams	\$15 copay. One pair of eyeglasses covered after each cataract surgery. Up to \$69 towards one pair of glasses every year.	\$25 copay. One pair of eyeglasses covered after each cataract surgery. Up to \$69 towards one pair of glasses every year.	
Hearing Aids	\$500 allowance for purchase or repair of hearing aids every 3 years	\$500 allowance for purchase or repair of hearing aids every 3 years	
Physical, Occupational and Speech Therapy	Covered 100%	Covered 100%	
Prescription Drugs	30 Day Supply Retail: Mail Order: Tier 1 - \$10 Tier 1 - \$7 Tier 2 - \$25 Tier 2 - \$17 Tier 3 - \$50 Tier 3 - \$33	60 Day Supply Retail: Mail Order: Tier 1 - \$20 Tier 1 - \$14 Tier 2 - \$50 Tier 2 - \$33 Tier 3 - \$100 Tier 3 - \$67	90 Day Supply Retail: Mail Order: Tier 1 - \$30 Tier 1 - \$20 Tier 2 - \$75 Tier 2 - \$50 Tier 3 - \$150 Tier 3 - \$100

2008 Plan Benefits	Tufts Medicare Preferred PPO Prime					
2008 Rate	\$187 per month, unlimited prescriptions					
	In Plan			Out of Plan \$3000 maximum out-of-pocket per year		
INPATIENT CARE						
Inpatient hospitalization, including Substance Abuse: semi-private room and board and special services for Medicare-covered hospital stays	Covered 100% after one-time annual deductible of \$200			Covered 100% after \$500 copay per admission		
Skilled Nursing	\$0 copay per day. 100 days covered for each benefit period. No prior hospital stay required.			Days 1-100: \$25 copay per day for skilled nursing. 100 days covered for each benefit period. No prior hospital stay required.		
Mental Health Care in Psychiatric Hospital	\$0 copay 190 day lifetime maximum			100% coverage after \$500 deductible per admission. 190 day lifetime maximum		
Inpatient Rehabilitation	90 days per benefit period. Covered 100%.			90 days per benefit period. Covered 100%.		
OUTPATIENT CARE						
Primary Care Physician Office Visit	\$10 copay per visit			\$30 copay per visit		
Specialist Office Visit	\$15 copay per visit			\$30 copay per visit		
Routine Physical exam	\$10 copay per visit			\$30 copay per visit		
Lab and Therapeutic Radiology	Covered 100%			20% of the cost		
Diagnostic Radiology (MRI, PET scan, CAT scan, X-ray)	Covered 100%			20% of the cost		
Outpatient Hospital/Ambulatory Care	\$0 to \$50 copay for each Medicare-covered ambulatory surgical or outpatient hospital facility center visit			20% of the charges for each Medicare-covered ambulatory surgical or outpatient hospital facility center visit		
Home Health Care	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.			20% of the charges for each Medicare-covered home health visit. Authorization rules may apply for services. Contact plan for details.		
Durable Medical Equipment	\$0 copay for Medicare-covered items			20% of the cost for Medicare-covered items		
Urgent and Emergency	\$10 copay for office visit, \$50 copay for emergency room			\$30 copay for office visit, \$50 copay for emergency room		
Ambulance Services	There is no copay for Medicare-covered ambulance services			There is no copay for Medicare-covered ambulance services		
Mental Health	\$15 copay per visit			\$30 copay per visit		
Substance Abuse	\$15 copay per visit			\$30 copay per visit		
Routine Eye Exams	\$15 copay. One pair of eyeglasses covered after each cataract surgery. Up to \$69 towards one pair of glasses every year.			\$30 copay. One pair of eyeglasses covered after each cataract surgery. Up to \$69 towards one pair of glasses every year.		
Hearing Aids	\$500 allowance for purchase or repair of hearing aids every 3 years			\$500 allowance for purchase or repair of hearing aids every 3 years		
Physical, Occupational and Speech Therapy	Covered 100%			20% of the cost		
Prescription Drugs	30 Day Supply	Retail:	Tier 1 - \$10	Tier 2 - \$25	Tier 3 - \$50	
		Mail Order:	Tier 1 - \$7	Tier 2 - \$17	Tier 3 - \$33	
	60 Day Supply	Retail:	Tier 1 - \$20	Tier 2 - \$50	Tier 3 - \$100	
		Mail Order:	Tier 1 - \$14	Tier 2 - \$33	Tier 3 - \$67	
	90 Day Supply	Retail:	Tier 1 - \$30	Tier 2 - \$75	Tier 3 - \$150	
		Mail Order:	Tier 1 - \$20	Tier 2 - \$50	Tier 3 - \$100	