

**TOWN OF NATICK PLAN COMPARISON OF WSHG AND GIC  
MEDICARE INDEMNITY PLANS**

	<b>WSHG Medex 3 with OBRA</b>	<b>Unicare State Indemnity Plan Medicare Extension (OME) With CIC</b>
<b>General Plan Design Features (All Individual)</b>		
Monthly Premium	\$432.00	\$352.97
Calendar Year Deductible	None	\$35
Out-of-Pocket Maximum	None	\$500 annual out of pocket maximum [on a very limited group of services including home health care and prostheses]
Lifetime Maximum, if applicable	None	None
<b>Services Provided In A Physician's Office</b>		
Primary Care Physician Office Visit	Covered in Full	100% coverage after deductible; \$5 copay for preventive care
Specialist Office Visit	Covered in Full	100% coverage after deductible
<b>Services provided in a Retail Clinic</b>		
Outpatient visit		100% coverage after deductible
<b>Services Provided In A Hospital Setting</b>		
Emergency Room	Covered in Full	\$25 copay
Waived if Admitted		Yes
Per Admission, Hospital	Covered in Full	\$50 copay
Copay Limits	N/A	One copay per quarter
Diagnostic X-Ray and Lab Service	Covered in Full	No copay
Rehabilitation Hospital	Covered in Full	\$50 copay
Duration Limits	365 lifetime days	None
Skilled Nursing Facility (100 days)	Covered in Full	100% coverage, to 100 days per calendar year for days paid by Medicare); 20% coinsurance \$10,000 maximum, for days not paid by Medicare
Duration Limits	100 days per benefit period	100 days
<b>Physical Therapy, Occupational Therapy &amp; Physical Therapy</b>		
Physical Therapy	Covered in Full	100% coverage if Medicare pays; 80% after calendar year deductible, if Medicare does not pay
Annual Visit Limits		No
Occupational Therapy	Covered in Full	100% coverage if Medicare pays; 20% coinsurance after calendar year deductible, if Medicare does not pay
Annual Visit Limits		No
Chiropractic Benefit	Yes	Yes
Copays and Annual Maximums	Full coverage of Medicare approved charges	20% coinsurance after calendar year deductible; Maximum benefit of \$40 per visit; 20 visits per year

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<b>Mental Health Services</b>		
In-patient treatment, biologically-based condition	Covered in Full	No copay
Duration Limits	Unlimited Days	Unlimited days
Out-patient treatment, biologically-based condition	No copay	No Charge, first four visits; \$10 copay, visits five and beyond
Annual Visit Limits	None	None
<b>Pharmacy Services</b>		
Retail Copay		
Tier 1	Generic - Covered in Full	\$10
Tier 2	Brand - Member pays 20%	\$25
Tier 3		\$50
Mail-Order Copay		
Tier 1	Generic - \$2 copay	\$20
Tier 2	Brand - \$15 copay	\$50
Tier 3		\$110
Separate Pharmacy Deductibles	Retail only - \$50 annual	No
<b>Vision Care</b>		
Vision Exam Coverage	No	No
Frequency	N/A	N/A
Copay	N/A	N/A
<b>Hearing Testing &amp; Services</b>		
Hearing Exams	No	Yes
Frequency	N/A	When medically necessary
Copay	N/A	None
Hearing Aids	No	
Benefit	N/A	100% of first \$500; 20% coinsurance of next \$1,500
Limits	N/A	Benefit available every two years
Ambulance Service Copay	Covered in Full	No copay

*The information contained in this spreadsheet is for illustrative purposes only and based on publicly available information. The detailed plan design information for the Group Insurance Commission (GIC) plans and/or the municipal plan(s) has not been approved by either the GIC or the GIC's insurance carriers or by the municipality or the municipality's insurance carriers. With respect to the GIC benefits shown, complete information about specific benefits is contained in the "Summary Plan Descriptions" (known as the GIC's health plans' "Plan Handbooks") for each program, which are available from the GIC. More detailed information about a municipality's plan may be obtained from the municipality. Boston Benefit Partners, LLC does not represent or warrant that the information provided herein specifically reflects any program.*