

**TOWN OF NATICK PLAN COMPARISON HPHC MEDICARE PLANS**

	<b>HPHC First Seniority Freedom PFFS</b>	<b>HPHC Enhance</b>	<b>Harvard Pilgrim Health Care Medicare Enhance</b>
<b>General Plan Design Features (All Individual)</b>			
Monthly Premium	\$245.00	\$406.00	\$349.97
<b>Services Provided In A Physician's Office</b>			
Primary Care Physician Office Visit	\$15 copay	\$5 copay	\$10 copay
Specialist Office Visit	\$15 copay	\$5 copay	\$10 copay
<b>Services provided in a Retail Clinic</b>			
Outpatient visit			\$10 copay
<b>Services Provided In A Hospital Setting</b>			
Emergency Room	\$50 copay	\$30 copay	\$50 copay
Waived if Admitted	Yes	Yes	Yes
Per Admission, Hospital	No copay	No copay	No copay
Copay Limits	N/A	N/A	N/A
Diagnostic X-Ray and Lab Service	No copay	No copay	No copay
Rehabilitation Hospital	No copay	No copay	No copay
Duration Limits	Up to 100 days per benefit period	Up to 100 days per calendar year	Up to 90 days per benefit period
Skilled Nursing Facility (100 days)	No copay	No copay	No copay
Duration Limits	Up to 100 days per benefit period	Up to 100 days per benefit period	100 days
<b>Physical Therapy, Occupational Therapy &amp; Chiropractic</b>			
Physical Therapy	\$15 copay	\$5 copay	\$10 copay
Annual Visit Limits			No
Occupational Therapy	\$15 copay	\$5 copay	\$10 copay
Annual Visit Limits			No
Chiropractic Benefit	Yes	Yes	Yes
Copays and Annual Maximums	\$15 copay	\$5 copay	\$10 copay
<b>Mental Health Services</b>			
In-patient treatment, biologically-based condition	No copay	No copay	No copay
Duration Limits	Unlimited Days	Unlimited Days	Unlimited days
Out-patient treatment, biologically-based condition	\$15 copay	\$5 copay	\$10 copay
Annual Visit Limits	None	None	None
<b>Pharmacy Services</b>			
Retail Copay			
Tier 1	\$10	\$5	\$10
Tier 2	\$25	\$10	\$25
Tier 3	\$50	\$25	\$50

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Mail-Order Copay			
Tier 1	\$20	\$10	\$20
Tier 2	\$40	\$20	\$50
Tier 3	\$105	\$75	\$110
Separate Pharmacy Deductibles	No	No	No
<b>Vision Care</b>			
Vision Exam Coverage	Yes		Yes
Frequency	Once every year		Once every 24 months
Copay	\$0 copay up to \$100		\$10 copay
<b>Hearing Testing &amp; Services</b>			
Hearing Exams	Yes	Yes	Yes
Frequency	Once every 12 months		Once every 12 months
Copay	\$15	\$5	\$10 copay
Hearing Aids			
Benefit	Up to \$500		100% of first \$500; 20% coinsurance of next \$1,500
Limits	Benefit available every year		Benefit available every two years
Ambulance Service Copay	No copay	No copay	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.*