

Medicare
Part A & B Coverage
Calendar Year Plan

Primex³ Health
Medicare Enhance (30)
Group's Coverage Year Plan

First Seniority Freedom
Premier 1 Plan
2009 Calendar Year Plan

Office Visit	80% after Medicare Part B deductible	Medicare deductible & coinsurance less \$5 office visit copay	Medicare deductible and coinsurance less \$15 office visit copay
Routine Physical Exam	Not Covered	All covered services less \$5 office visit copay	All covered services less \$15 office visit copay
<u>HOSPITALIZATION</u>			
Days 1 - 60	100% after Medicare Part A deductible	Medicare Part A deductible	Medicare Part A deductible
Days 61 - 90	100% after coinsurance	Medicare coinsurance	Medicare coinsurance
Days 91 - 150 (one time lifetime)	100% after coinsurance	Medicare coinsurance	Medicare coinsurance
After 150 days of continuous confinement	Not Covered	Full benefits to the extent medically necessary	Full benefits to the extent medically necessary
Emergency Room (Within US)	80% after Medicare Part B deductible	Medicare deductible & coinsurance less \$30 emergency room copay	Medicare deductible & coinsurance less \$50 emergency visit copay
Emergency Room (Outside US)	Not Covered	All covered services less \$30 emergency room copay	All covered services less \$50 emergency visit copay
<u>SKILLED NURSING</u>			
Days 1 - 20	100%	Not Covered	Not Covered
Days 21 - 100	100% after coinsurance	Daily coinsurance	Daily coinsurance
Days 101 and up	Not Covered	Not Covered	Not Covered

	Medicare	Medicare Enhance	First Seniority Freedom Premier 1 Plan
Routine Hearing Services	80% of Medicare approved amounts for diagnostic hearing exams; Routine exams & hearing aids not covered	Medicare coinsurance less \$5 office visit copay; Routine exams & hearing aids not covered	Medicare coinsurance less \$15 office visit copay; One routine exam & hearing aid fitting / year; \$500 yearly limit for hearing aids
Routine Vision Services	80% for diagnosis & treatment of diseases & conditions of the eye; Routine eye exams & glasses not covered	Medicare coinsurance for diagnosis & treatment of diseases & conditions of the eye less \$5 office visit copay	Up To \$100 reimbursement for routine eye exam 1/yr; \$200 limit for eyewear / 24 months
Prescription Drugs - Retail	Not Covered	\$0/\$20/\$30 for 30 days open formulary	\$5/\$10/\$15 for 30 days
Prescription Drugs - Mail	Not Covered	\$0/\$20/\$30 for 90 days open formulary	\$10/\$20/\$45 for 90 days
Prescription Drugs - Castastrophic	Not Covered	Unlimited	When your calendar year out-of-pocket drug costs reach \$4,350 you pay the greater of: \$2.40 for generic & \$6.00 for all other drugs OR 5% coinsurance
Physical / Occupational / Speech Therapy	80% after Medicare Part B deductible	Medicare deductible and coinsurance less \$5 office visit copay	Medicare deductible and coinsurance less \$15 office visit copay
Chiropractic			
Blood	100% after 3 pints	100% of first 3 pints	100% of first 3 pints
Inpatient Mental Health	100% after Medicare Part A deductible	Medicare deductible 60 days maximum / calendar year	Medicare deductible 190 days lifetime maximum
Outpatient Mental Health	80% of Medicare eligible expenses after psychiatric reduction, if applicable	Medicare coinsurance less \$5 office visit copay; 24 visit maximum / calendar year	Medicare coinsurance less \$15 office visit copay

Comparison based on information provided at time of comparison.

This is only a summary of benefits, please consult appropriate schedule of benefits.

Oct-08

NOTE: Medicare and First Seniority Freedom are calendar year plans. Rates and benefits are subject to change on the first of January each year. The plan year for Medicare Enhance coincides with each employer group's renewal.