		Fallon Health						
	"New" Fallon Senior Plan Flex Enhanced RX HMO	Fallon Senior Plan Super Saver Rx HMO	Fallon Senior Plan Saver HMO	Fallon Senior Plan Saver Enhanced RX HMO	Fallon Senior Plan Saver Enhanced RX HMO-POS	Fallon Senior Plan Standard Enhanced RX HMO	Fallon Senior Plan Plus Enhanced RX HMO	Fallon Senior Plan Plus Enhanced HMO-POS
Plan Number	H9001-034	H9001-032	H9001-029	H9001-030	H9001-013	H9001-015	H9001-031	H9001-033
Barnstable	NA	$18	$86	$107	NA	NA	$222	NA
Berkshire	NA	$17	$59	$87	NA	NA	$197	NA
Bristol	$0	$17	$44	$67	NA	NA	$164	NA
Essex	$0	$24	$43	$72	NA	NA	$172	NA
Franklin	$0	$17	$88	NA	$97	$207.00	$264	NA
Hampden	$0	$17	$17	$52	NA	NA	NA	$142
Hampshire	$0	$17	$17	$52	NA	NA	NA	$142
Middlesex	$0	$17	$44	$67	NA	NA	$164	NA
Norfolk	$0	$17	$44	$67	NA	NA	$164	NA
Plymouth	$0	$17	$44	$67	NA	NA	$164	NA
Suffolk	$0	$24	$43	$72	NA	NA	$172	NA
Worcester	$0	$17	$88	NA	$97	$207.00	$264	NA
CO-PAYS - Beneficiary Costs		**In Network**	**In Network**	**In Network**	**In Network and some services out-of-network**	**In Network**	**In Network**	**In Network and some services out-of-network**
Health Plan Deductible	None	None	None	None	None	None	None	None
PCP	$30	$30	$25	$25	$25	$15	$10	$10
Specialist	$50	$50	$40	$40	$40 In/Out of Network	$30	$20	$20 In/Out of Network
Inpatient Hospital	$360/Day days 1 - 5	Days 1-5 $360/day	$300/day days 1-5	$300/day days 1-5	In-Network: $300/day days 1-5; Out-of-network $350/day days 1-5	$200/ day days 1-5	$225/ stay/Separate $450 out-of-pocket maximums	In-Network $225/stay separate $450 out-of-pocket maximum for acute and rehab: out-of-network $600 per each stay
Outpatient Services/Surgery	Ambulatory: $350 Hospital: $350	Ambulatory: $350 Hospital: $350	Ambulatory: $275 Hospital: $275	Ambulatory: $275 Hospital: $275	Ambulatory and Hospital In-Network $275; Out-of-Network $325	Ambulatory: $160 Hospital: $160	Ambulatory: $100 Hospital: $100	Ambulatory and Hospital In-Network $100; Out-of-Network $200
Outpatient Rehab	Occuplational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $20	Occupational, Physical and Speech/language therapy visit $15	Occupational, Physical and Speech/language therapy visit $15

Diagnostic Tests and Labs	$0 for clinical/diagnostic lab services and radiation therapy. $275 for each CT, PET and MRI scan and nuclear study	$0 for clinical/diagnostic lab services and radiation therapy. $275 for each CT, PET and MRI scan and nuclear study	$0 for clinical/diagnostic lab services and radiation therapy. $225 for each CT, PET and MRI scan and nuclear study ($900 OOPM)	$0 for clinical/diagnostic lab services and radiation therapy. $225 for each CT, PET and MRI scan and nuclear study ($900 OOPM)	**In-Network:** $0 for clinical/diagnostic lab services. $225 for each CT, PET and MRI scan and nuclear study ($900 OOPM) **Out-of-network:** $0 for clinical/diagnostic lab services. 20% of the cost for each CT, PET and MRI scan, nuclear study, s-rays and therapeutic radiology	$0 for clinical/diagnostic lab services and radiation therapy. $150 for each CT, PET and MRI scan and nuclear study ($600 OOPM)	$0 cor clinical/diagnostic lab services and radiation therapy. $125 for each Ct, PET and MRI scan and nuclear study ($500 OOPM)	**In Network:** $0 for clinical/diagnostic lab services and radiation therapy. $125 for each CT, PET and MRI scan and nuclear study ($500 OOPM). **Out of network:** $0 for clinical diagnostic lab services. 20% for each CT, PET and MRI scan, nuclear study, x-rays and therapeutic radiology.
Skilled Nursing	$0 a day for days 1 - 20 $160 a day for days 21 - 44 $0 for days 45 - 100	$0 per day days 1-20; $160 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44; $0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $150 per day days 21-44;$0 per days 45-100	$0 per day days 1-20; $100 per day days 21-44;$0 per days 45-100	$15 day days 1-20; $75 per day days 21-44; $0 per days 45-100	$15 day days 1-20; $75 per days 21-44; $0 per days 45-100
Emergency Room	$80 copay	$80 copay	$80 copay	$80 copay	$80 copay	$80 copay	$100 copay	$100 copay
Ambulance	$250	$250	$175/$700 OOPM	$175/$700 OOPM	$175/$700 OOPM	$100/$400 OOPM	$75/$300 OOPM	$75/$300 OOPM
DME	20%	20%	20%	20%	20%	15%	10%	10%
Diabetic Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Part B Medications	20%	20%	20%	20%	20% In and out-of-network	15%	10%	In-Network: 10% Out-of-Network 20%
Annual Maximum	$6,700	$6,700	$6,700	$6,700	$5000 in-network; $5000 out-of-network	$6,700	$3,400	$3400 in-network; $5000 out-of-network
Drug Deductible	$300 Tiers 3-5	$405	N/A	$300 Tiers 3-5	$300 Tiers 3-5	$200 Tiers 3-5	NA	NA
Preferred Pharmacies Tier 1	$1	$2	NA	$1	$1	$1	$1	$1
Tier 2	$7	$9	NA	$7	$7	$7	$7	$7
Tier 3	$37	$42	NA	$37	$37	$37	$37	$37
Tier 4	$86	$95	NA	$86	$86	$86	$86	$86
Tier 5	27%	25%	NA	27%	27%	29%	33%	33%
Non-Preferred Pharmacies Tier 1	$6	$7	NA	$6	$6	$6	$6	$6
Tier 2	$12	$14	NA	$12	$12	$12	$12	$12
Tier 3	$42	$47	NA	$42	$42	$42	$42	$42
Tier 4	$91	$100	NA	$91	$91	$91	$91	$91
Tier 5	27%	25%	NA	27%	27%	29%	33%	33%
Gap Generic Coverage								
Vision (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hearing (Yes/no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental (Yes/No)	$180 reimbursement towards preventive care	No	Yes	Yes	Yes	Yes	Yes	Yes
Preferred Pharmacies Include: 1) CVS; 2) Target; 3) Wal-Mart; 4) Big Y; 5) Shaws; 6) Stop & Shop; 7)Leader Drug stores (approximately 35 independent pharmacies across Massachusetts) 8. Costco 9.Medicine Shoppe 10. Osco 11. Price Chopper 12. Sams Club 13. Star								