SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS Effective January 1, 2021

Medicare Replacement Plans

Changes/clarifications, if any, in red font

PLAN FEATURES	**Medicare HMO Blue (BCBS)** **Medicare Advantage HMO** Renews January	**Tufts Medicare Preferred HMO** **Medicare Advantage HMO** Renews January	**HNE Medicare Secure Freedom HMO-POS** **Medicare Advantage POS** Renews January
	You Pay	**You Pay**	**You Pay**
General Hospital: Semi-private room & board and special services	$150 co-pay per day (days 1-5 of each admission), then no cost.	Covered in full after one time annual deductible $300	<u>In-Network:</u> $300 per admission (3 co-pay maximum) <u>Out-of-Network:</u> $900 per admission *Prior Authorization Required* (3 co-pay maximum) **Meals Programs - Post Hospitalization:** you may qualify to have up to 28 fully-prepared, nutritious home-delivered meals (2 meals per day for 14 days) delivered to your home by a plan approved vendor at no cost.
Rehabilitation Hospital	$150 co-pay per day (days 1-5 of each admission), then no cost.	Covered in full for 90 days per Medicare benefit period.	<u>In-Network:</u> $300 per admission (3 co-pay maximum) <u>Out-of-Network:</u> $900 per admission *Prior Authorization Required* (3 co-pay maximum)
Skilled Nursing Facility	Days 1-20: $20 co-pay Days 21-44: $100 co-pay Days 45-100: $0 co-pay per benefit period	Covered in full for 100 days per Medicare benefit period. No prior hospital stay is required.	<u>In-Network:</u> *Some services require Prior Authorization* Days 1-5: $0 co-pay Days 6-50: $75 co-pay Days 51–100 $0 co-pay <u>Out-of-Network:</u> *Prior Authorization Required* Days 1-5: $0 co-pay Days 6-50:$100 co-pay Days 51-100: $0 co-pay

			Meals Programs - Post Hospitalization: you may qualify to have up to 28 fully-prepared, nutritious home-delivered meals (2 meals per day for 14 days) delivered to your home by a plan approved vendor at no cost
Mental Health & Substance Abuse Care in a Psychiatric Hospital	$150 co-pay per day (days 1-5 of each admission), then no cost.	$0 co-pay - 190-day lifetime limit max	In-Network (190 day lifetime limit): $300 per admission (3 co-pay maximum) Out-of-Network: $900 per admission (3 co-pay maximum)
OUTPATIENT CARE	**Medicare HMO Blue (BCBS)**	**TUFTS Medicare Preferred HMO**	**HNE Medicare Secure Freedom HMO-POS**
	You Pay	**You Pay**	**You Pay**
Medical Office Visits	$15 co-pay to PCP; $35 specialist co-pay $75 per each office visit for urgently needed services outside of the United States (telehealth visits not covered)	$10 co-pay to PCP $15 specialist co-pay	Primary care doctor visit for Medicare covered benefits: In-Network: $15 co-pay Out-of-Network: $55 co-pay **NEW: Telehealth Services are now $0 copay** *Teladoc:* In Network: $0 Out-of-Network: Not applicable *Primary Care Physician*: $0 for In-Network and Out-of-Network services. *Specialist*: $0 for In-Network and Out-of-Network services.
Consult & Care by Specialists	$35 co-pay per visit	$15 co-pay per visit	Specialist visit for Medicare covered benefits: In-Network: $15 co-pay Out-of-Network: $55 co-pay
Routine Annual Physical Exams (one per calendar year)	$0 co-pay per visit (Once every 12 months)	$0 co-pay per visit	In-Network - $0 co-pay Out-of-Network: $0 co-pay
Diagnostic Lab & X-ray Services	5 per day for X-rays, $10 per day for lab tests and other diagnostic tests; $150 per day for CT scans, MRIs, PET scans, and nuclear	Covered in full	Routine lab tests: Covered in full Diagnostic Imaging (CT Scans, MRIs, MRAs, PET Scans, sleep

	cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery)		studies, nuclear cardiology) : In-Network: $50 co-pay *Some services require Prior Authorization* Out-of-Network: $200 co-pay *Prior Authorization Required*
Day Surgery	$0 to $150 co-pay $15 PCP Office $35 Specialist Office $150 Ambulatory Surgical Center	$50 per service	Medicare covered ambulatory surgical center visit: In-Network: $150 co-pay *Some services require Prior Authorization* Out-of-Network**:** $450 co-pay *Prior Authorization Required*
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full
OUTPATIENT CARE *(cont'd)*	**Medicare HMO Blue (BCBS)**	**TUFTS Medicare Preferred HMO**	**HNE Medicare Secure Freedom HMO-POS**
	You Pay	**You Pay**	**You Pay**
Urgent & Emergency Care (for Medicare covered visits)	$15 co-pay for PCP office; $35 co-pay in specialist office; $75 co-pay for ER Emergency care worldwide	$10 co-pay for office; $50 co-pay for ER, waived if admitted.	Urgent Care- In-Network: $15 co-pay Out-of-Network: $55 co-pay World Wide Emergency Room care- $65 co-pay, waived if admitted.
Durable Medical Equipment (DME)/Prosthetics	10% of the cost (no cost for diabetes equipment and supplies)	Covered in full	In-Network: $0 coinsurance*; Some services require Prior Authorization* Out-of-Network: 20% coinsurance *Prior Approval Required*
Ambulance Services	$75 member co-pay per trip: waived if admitted for observation or inpatient	$50 per day	$75 co-pay for Medicare covered ambulance benefits per trip; *Some services require Prior Authorization*. Except in an emergency, plan provider must obtain prior authorization.
Preventive Dental	$35 co-pay for one cleaning and one oral exam every 6 mos. Incl. 1 set of 2 bite-wing x-rays every 6 mos. Emergency oral exams when needed	Not covered	$250 annual allowance dental benefit per calendar year.

Routine Vision & Hearing Screenings	$0 co-pay per visit. Routine refractive eye exam once every 12 months with an EyeMed® ´ provider (you must use an EyeMed provider) Eyewear including contact lenses - up to $200 every 24 months. EyeMed network provider required Hearing exams One exam every 12 months; $0 copay, must see a TruHearing Provider	$15 co-pay per visit. Up to $150 per year reimbursement toward the purchase of eyeglasses or contacts, but not both at an Eyemed provider. Up to $90 at any other provider. $500 allowance for purchase or repair of hearing aids every 3 years. Member discounts provided when using Hearing Care Solutions (HCS) facilities. Contact member services for details.	**Vision-** $0 co-pay - 1 routine eye exam each calendar year. $100 allowance towards a new pair of glasses every 2 years. After cataract surgery- $0 co-pay - one pair of glasses or contact lenses In-Network: $15 co-pay Out-of-Network $55 co-pay -Exams to diagnose and treat diseases and conditions of the eye. **Hearing-** In-Network: $15 co-pay Out-of-Network $55 co-pay -for diagnostic hearing exams. -One routine hearing test each yr. Hearing Aid Benefit – TruHearing $699 co-pay per aid for Advance Aids $999 co-pay per aid for Premium Aids
Prescription Drugs & Other Benefits	**Medicare HMO Blue (BCBS)**	**TUFTS Medicare Preferred HMO**	**HNE Medicare Secure Freedom HMO-POS**
	You Pay	**You Pay**	**You Pay**
Mental Health & Substance Abuse	$35 co-pay (applies to both biologically-based and non-biologically-based mental conditions.) Prior authorization is required for certain outpatient mental health services.	$15 co-pay per visit	For Medicare covered individual or group therapy visits. In-Network: $15 co-pay Out-of-Network: $55 co-pay
Prescription Drugs	**Retail:** 30 day supply: $10 generic $25 preferred brand $45 non-preferred brand	**Retail:** 30 day supply: $10 generic $20 preferred brand $35 non-preferred brand	**Retail:** 30 day supply: $4 preferred generic $10 generic $25 preferred brand $45 non-preferred brand $50 Specialty Tier

	Mail Order: 90 day supply: $20 generic $50 preferred brand $90 non-preferred brand Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach $6,550, then you pay $3.70 for a generic drug, and $9.20 for all other drugs. Express Scripts is the Prescription Benefits Manager	**Mail Order:** 90 day supply: $20 generic $40 preferred brand $70 non-preferred brand Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach $6,550, then you pay $3.70 for a generic drug, and $9.20 for all other drugs CVS Caremark is the Prescription Benefits Manager	**Mail Order:** 90 day supply: $8 preferred generic $20 generic $50 preferred brand $135 non-preferred brand Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach $6,550, then you pay $3.70 for a generic drug, and $9.20 for all other drugs Optum Rx is the Prescription Benefits Manager **Opioid Treatment Program Services** There is no coinsurance, copay or deductible for Opioid Treatment Program services
FITNESS			

Fitness Center benefit	Up to $150 reimbursement per calendar year per subscriber for health club or group class based fitness programs. Up to $150 reimbursement per calendar year per subscriber for hospital based weight loss programs and qualified non-hospital based programs. See plan for details. Fitness benefit each year includes Council on Aging sites. Paid receipts no longer needed when sending in claim reimbursement forms..	Fitness Benefit each year – $150 towards membership at any participating fitness club, with no waiting period	Fitness Benefit each year- $150 toward at an eligible health club/Weight Watchers/ Acupuncture / Activity/Fitness Tracker/ Over-the-Counter Item Allowance **NEW: Over the Counter (OTC) Allowance** In-Network: Limited to $40 every three months for specific over the counter drugs and other health-related pharmacy products, as listed in the OTC catalog. Not applicable for Out-of-Network