

**SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS**

**Effective January 1, 2023**

**Medicare Replacement Plans**

Changes/clarifications, if any, in red font

PLAN FEATURES	<b>Medicare HMO Blue (BCBS) Medicare Advantage HMO</b> Renews January	<b>Tufts Medicare Preferred HMO Medicare Advantage HMO</b> Renews January	<b>HNE Medicare Secure Freedom HMO-POS Medicare Advantage POS</b> Renews January
	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
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	<p><u>In-Network:</u> \$300 per admission (3 co-pay maximum)</p> <p><u>Out-of-Network:</u> \$900 per admission <i>Prior Authorization Required</i> (3 co-pay maximum)</p> <p><b>Meals Programs - Post Hospitalization:</b> 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.</p>
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.	<p><u>In-Network:</u> \$300 per admission (3 co-pay maximum)</p> <p><u>Out-of-Network:</u> \$900 per admission <i>Prior Authorization Required</i> (3 co-pay maximum)</p>
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.	<p><u>In-Network:</u> <i>Some services require Prior Authorization</i>                      Days 1-5: \$0 co-pay                      Days 6-50: \$75 co-pay                      Days 51-100 \$0 co-pay</p> <p><u>Out-of-Network:</u> <i>Prior Authorization Required</i>                      Days 1-5: \$0 co-pay                      Days 6-50: \$100 co-pay                      Days 51-100: \$0 co-pay</p>

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			<p><b>Meals Programs - Post Hospitalization:</b> 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</p>
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	<p><u>In-Network (190 day lifetime limit):</u> \$300 per admission (3 co-pay maximum)</p> <p><u>Out-of-Network:</u> \$900 per admission (3 co-pay maximum)</p>
<b>OUTPATIENT CARE</b>	<b>Medicare HMO Blue (BCBS)</b>	<b>TUFTS Medicare Preferred HMO</b>	<b>HNE Medicare Secure Freedom HMO-POS</b>
	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
Medical Office Visits	<p>\$15 co-pay to PCP; \$35 specialist co-pay</p> <p>\$75 per each office visit for urgently needed services outside of the United States (telehealth visits not covered)</p>	<p>\$10 co-pay to PCP \$15 specialist co-pay</p>	<p>Primary care doctor visit for Medicare covered benefits: <u>In-Network:</u> \$15 co-pay <u>Out-of-Network:</u> \$55 co-pay</p> <p><b>Telehealth Services are now \$0 copay</b> <i>Teladoc:</i> In Network: \$0 Out-of-Network: Not applicable <i>Primary Care Physician:</i> \$0 for In-Network and Out-of-Network services. <i>Specialist:</i> \$0 for In-Network and Out-of-Network services.</p>
Consult & Care by Specialists	\$35 co-pay per visit	\$15 co-pay per visit	<p>Specialist visit for Medicare covered benefits: <u>In-Network:</u> \$15 co-pay <u>Out-of-Network:</u> \$55 co-pay</p>
Routine Annual Physical Exams (one per calendar year)	\$0 co-pay per visit (Once every 12 months)	\$0 co-pay per visit	<p><u>In-Network - \$0 co-pay</u> <u>Out-of-Network:</u> \$0 co-pay</p>
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	<p>Routine lab tests: Covered in full</p> <p>Diagnostic Imaging (CT Scans, MRIs, MRAs, PET Scans, sleep</p>

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	cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery)		studies, nuclear cardiology) : <u>In-Network</u> : \$50 co-pay <i>Some services require Prior Authorization</i> <u>Out-of-Network</u> : \$200 co-pay <i>Prior Authorization Required</i>
Day Surgery	\$15 PCP Office \$35 Specialist Office \$150 Ambulatory Surgical Center	\$50 per service	Medicare covered ambulatory surgical center visit: <u>In-Network</u> : \$150 co-pay <i>Some services require Prior Authorization</i> <u>Out-of-Network</u> : \$450 co-pay <i>Prior Authorization Required</i>
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full
<b>OUTPATIENT CARE (cont'd)</b>	<b>Medicare HMO Blue (BCBS)</b>	<b>TUFTS Medicare Preferred HMO</b>	<b>HNE Medicare Secure Freedom HMO-POS</b>
	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
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- <u>In-Network</u> : \$15 co-pay <u>Out-of-Network</u> : \$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	<u>In-Network</u> : \$0 coinsurance; <i>Some services require Prior Authorization</i> <u>Out-of-Network</u> : 20% coinsurance <i>Prior Approval Required</i>
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; <i>Some services require Prior Authorization</i> . 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.

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<p>Routine Vision &amp; Hearing Screenings</p>	<p>\$0 co-pay per visit. Routine refractive eye exam once every 12 months with an EyeMed® provider (you must use an EyeMed provider)</p> <p>Eyewear including contact lenses - up to \$200 every 24 months. EyeMed network provider required</p> <p>Hearing exams One exam every 12 months; \$0 copay, must see a TruHearing Provider</p>	<p>\$15 co-pay per visit.</p> <p>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.</p> <p>\$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.</p>	<p><b>Vision-</b> \$0 co-pay - 1 routine eye exam each calendar year. <b>\$200</b> allowance towards a new pair of glasses every 2 years. <u>After cataract surgery-</u> \$0 co-pay - one pair of glasses or contact lenses</p> <p><u>In-Network: \$15 co-pay</u> <u>Out-of-Network \$55 co-pay</u> -Exams to diagnose and treat diseases and conditions of the eye.</p> <p><b>Hearing-</b> <u>In-Network: \$15 co-pay</u> <u>Out-of-Network \$55 co-pay</u> -for diagnostic hearing exams. -One routine hearing test each yr.</p> <p>Hearing Aid Benefit – TruHearing \$699 co-pay per aid for Advance Aids <u>\$999 co-pay per aid for Premium Aids</u></p>
<p><b>Prescription Drugs &amp; Other Benefits</b></p>	<p><b>Medicare HMO Blue (BCBS)</b></p>	<p><b>TUFTS Medicare Preferred HMO</b></p>	<p><b>HNE Medicare Secure Freedom HMO-POS</b></p>
	<p><b>You Pay</b></p>	<p><b>You Pay</b></p>	<p><b>You Pay</b></p>
<p>Mental Health &amp; Substance Abuse</p>	<p>\$35 co-pay (applies to both biologically-based and non-biologically-based mental conditions.) Prior authorization is required for certain outpatient mental health services.</p>	<p>\$15 co-pay per visit</p>	<p>For Medicare covered individual or group therapy visits. <u>In-Network: \$15 co-pay</u> <u>Out-of-Network: \$55 co-pay</u></p>
<p>Prescription Drugs</p>	<p><b>Retail:</b> <u>30 day supply:</u> \$10 generic \$25 preferred brand \$45 non-preferred brand</p>	<p><b>Retail:</b> <u>30 day supply:</u> \$10 generic \$20 preferred brand \$35 non-preferred brand</p>	<p><b>Retail:</b> <u>30 day supply:</u> <b>Tier1: \$4 standard \$0 preferred</b> <b>Tier2: \$10 standard \$ 5 preferred</b> <b>Tier3: \$25 standard \$ 20 preferred</b> <b>Tier4:\$45 standard \$40 preferred</b> <b>Tier5: \$50 standard \$45 preferred</b></p>

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	<p><b>Mail Order:</b>  <u>90 day</u> supply:                  \$20 generic                  \$50 preferred brand                  \$90 non-preferred brand</p> <p>Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach <b>\$7,400</b>, then you pay <b>\$4.15</b> for a generic drug, and <b>\$10.35</b> brand and no 5% co insurance.</p> <p><b>CVS Caremark</b> is the Prescription Benefits Manager</p>	<p><b>Mail Order:</b>  <u>90 day</u> supply:                  \$20 generic                  \$40 preferred brand                  \$70 non-preferred brand</p> <p>Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach <b>\$7,400</b>, then you pay <b>\$4.15</b> for a generic drug, and <b>\$10.35</b> brand and no 5% co insurance.</p> <p>CVS Caremark is the Prescription Benefits Manager</p>	<p>Please review the <b>2023 Pharmacy Directory</b> to see if your pharmacy is preferred or standard</p> <p><b>Mail Order:</b>  <u>90 day</u> supply:                  \$8 preferred generic                  \$20 generic                  \$50 preferred brand                  \$135 non-preferred brand</p> <p>Prescription drug copayments apply until your out-of-pocket prescription drug costs for covered Part D drugs reach <b>\$7,400</b>, then you pay <b>\$4.15</b> for a generic drug, and <b>\$10.35</b> brand and no 5% co insurance.</p> <p>Optum Rx is the Prescription Benefits Manager</p> <p><b>Over the Counter (OTC) Allowance</b>                  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</p> <p><b><u>Opioid Treatment Program Services</u></b>                  There is no coinsurance, copay or deductible for Opioid Treatment Program services</p>
<p><b>FITNESS</b></p>			

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<p><b>Fitness Center benefit</b></p>	<p>Up to \$150 reimbursement per calendar year per subscriber for health club or group class based fitness programs.</p> <p>Up to \$150 reimbursement per calendar year per subscriber for hospital based weight loss programs and qualified non-hospital based programs.</p> <p>See plan for details.</p> <p>Fitness benefit each year includes Council on Aging sites.</p> <p>Paid receipts no longer needed when sending in claim reimbursement forms..</p>	<p>Fitness Benefit each year – \$150 towards membership at any participating fitness club, with no waiting period</p>	<p>Fitness Benefit each year- \$150 toward at an eligible health club/Weight Watchers/ Acupuncture / Activity/Fitness Tracker/ Over-the-Counter Item Allowance</p> <p>See plan for details</p>
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