



Town of Wilbraham 240 Springfield Street Wilbraham MA 01095

Health Insurance 2020



October 15 to November 18, 2019

For Retirees on Medicare and their Spouses

This document is available, upon request, in alternate formats including large print. Please direct your request to: Herta Dane, Human Resources Coordinator 240 Springfield Street, Wilbraham, MA 01095 or call (413) 596-2800 extension 100. It is also viewable on the town's website at: www.wilbraham-ma.gov.

What do I need to do?

The open enrollment period is the only time to make changes that are not due to a qualifying event. If you are happy with your current benefits then you do not need to do anything during this period. Your current coverage will continue automatically unless you fill out forms to change it. However this is the time to switch to a different plan, terminate or add coverage and/or eligible dependents.

If changes are not made during open enrollment you will not have another opportunity to do so until the next open enrollment period unless there is a qualifying event. It is your responsibility to notify us within 30 days if you have a qualifying event that affects eligibility. Enrollment will begin with the date you lost coverage and there will be no lapse in coverage unless you contact us more than 30 days after the event. You will then have to wait until the next open enrollment period. Qualifying events include marriage, divorce, birth, death, adoption, move into or out of network area, or a dependent turning 26 years old. If you do not notify us that your dependent has lost coverage due to age then this could affect their COBRA rights.

Which Plan Do I Choose?

The Town offers Medicare Wrap, Supplement and Replacement/Advantage plans. All this information can be very confusing and it is important to consider monthly premiums, co-pays and prescription costs to determine the overall affordability of a particular plan. Do you go to the doctor's office often? Do you have a lot of prescriptions? Do you wear glasses or hearing aids? Do your providers and facilities participate in a particular plan's network?

Medicare Wrap Plans – provide excellent coverage when services are received from participating providers and/or facilities. The nearest hospital is covered in emergency situations. Out-of-pocket costs are limited to minimal co-pays. Services can be obtained from non-network providers/facilities that accept Medicare however you will be responsible for whatever Medicare does not pay.

Supplemental Plans – offer the most versatility. Services can be received from any provider and/or facility that accept Medicare. Supplemental plans pay whatever Medicare does not cover for any Medicare covered service. However, if Medicare does not cover the service, the plan usually does not either. Our Supplements also offer a fitness benefit for reimbursement for gym memberships. The Tufts Medicare Supplement plan has co-pays for office visits but provides wellness benefits not covered by Medicare such as allowances for eyeglasses and hearing aids.

Advantage/Replacement Plans – generally have lower premiums and offer additional wellness benefits such as fitness clubs and/or weightwatchers reimbursements as well as dental, eyeglass and/or hearing aid allowances. However they may have a deductible, co-pays at the time of service for office visits, hospital admissions and high imaging diagnostics including PET scans, CT scans and MRIS. They have limited provider and/or facility networks with no coverage for services received out of the participating network except for emergency services. Health New England's Secure Freedom of Choice POS plan does provide for out of network services with increased co-pays for services received from non-participating providers/facilities.

Individual Plan Changes: What's new?

Tufts: There are no benefit changes to the Tufts Medicare Supplement or Medicare Preferred HMO plans.

Health New England: The HNE Secure Freedom Plan has a 10.4% reduction in premiums (From \$366 to \$328 per month) and enhanced coverage, including a new Post Hospitalization Meals Program: After you are discharged from an inpatient stay at a hospital, 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. The home meal benefit must be requested within 30 days of discharge from an acute inpatient hospital. Upon your discharge, a member of the case management team will coordinate your meals benefit. The case management team may schedule delivery depending on your health care needs, diagnosis, and/or recommendations made by your provider. There is no copay, coinsurance or deductible for the meals program. The Plan is also offering coverage for a new Opioid Treatment Program with no copay, coinsurance, or deductible. The HNE Medwrap Plan increased the reimbursement per calendar year for weight watchers or for an eligible health club to \$200 per individual and \$400 per family.

Blue Cross Blue Shield: The BCBS HMO Blue Plan requires prior authorization for certain outpatient mental health services.

If you need assistance in reviewing your options or have any questions, please call Benefits Manager Gloria Congram at 413-596-2800 extension 102, or email her at gcongram@wilbraham-ma.gov. Gloria has office hours on Mondays at the Wilbraham Town Hall from 9:00 am to 1:00 pm. During Open Enrollment, she will be here on October 21, 28, November 4 and 18. If you need assistance, please call or better email her and make an appointment for a private consult.

Medicare & You

Massachusetts State Laws mandate that if municipal retiree and/or dependents are eligible for premium free Medicare Part A they must enroll in Medicare Parts A & B to remain eligible for group health insurance through the Town. The retiree is responsible to make sure that the premiums get paid to social security to maintain enrollment in Medicare Parts A&B. Failure to do so could result in claims not being paid and termination of coverage in the group insurance.

Eligible Spouse & Dependents

An eligible spouse is the subscriber's legal spouse.

Dependent children are eligible to remain on the health and dental insurance until they are 26 years old. You must enroll in premium free Medicare Part A when you become eligible and for Medicare B which has a monthly premium, however, you may be allowed to remain on the active employee plan if you have children that are also eligible for coverage. A copy of a long-form, state issued birth certificate, a Court Order, or adoption papers must be provided to enroll a dependent child in the insurance coverage.

If a retiree is divorced, the ex-spouse is not eligible to be covered under the Town's group health plan. In certain cases, the divorce decree will rule as to whether or not the ex-spouse can remain on the plan.

The surviving spouse and dependents of a retiree are eligible to continue coverage on the Town's group health insurance coverage provided they are covered at the retiree's time of death. Participation may continue as long as the dependents meet all plan eligibility rules. The surviving spouse must be enrolled for the dependents to be covered by the Town's group health insurance. Once the surviving spouse remarries, eligibility for participation ends as of the date of the marriage. Surviving spouses **MUST** provide written notification to the Benefits Administrator within thirty (30) days of any change in marital status.

The Scantic Valley Regional Health Trust

The Town of Wilbraham is a member of the Scantic Valley Regional Health Trust (SVRHT) which is a joint purchase group through which the Town purchases health plans. The Scantic Valley Regional Health Trust (SVRHT) meets regularly in open session at the Wilbraham Town Office Building. Meeting minutes are posted on the SVRHT website at www.scantichealth.org. The following programs offered by the trust may save you money:

Wellness Program

The Scantic Valley Regional Health Trust (SVRHT) employs a Wellness Coordinator who works on developing programs designed to help you stay healthy and manage illnesses such as diabetes. The Wellness Program offers disease screening incentives (such as \$100 paid to you for having a screening colonoscopy), exercise programs and general behavior risk reduction programs (i.e. weight management, smoking cessation). SVRHT Wellness Program is a voluntary wellness program. The participation in some of these incentive programs does require some personal health information to be exchanged throughout the program. By law we are required to maintain the privacy and security of your personally identifiable health information.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees and retirees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Wellness Coordinator Lyn Fioravanti at (413) 896-9080 and she will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

There are additional incentive programs for Health New England MedPlus subscribers. Subscribers to these plans have access to *My Medication Advisor*, a voluntary alternative buying program for free prescription medications and These programs help reduce the cost of some maintenance medications and in turn help to keep the premiums as low as possible. Please have your insurance card available when contacting these programs so they can verify your coverage.

To learn more please go to the website or contact: Lyn Fioravanti, Regional Wellness Coordinator, Scantic Valley Regional Health Trust Lyn@scantichealth.org Phone: (413) 896-9080.

High Technology Imaging

The SVRHT voted to waive co-payments for high technology imaging services when members select from a list of non-hospital based imaging centers for scheduled services. Mention this to your doctor at the time an imaging test (x-ray, CAT scan, MRI etc.) is scheduled. The list for BCBS and HNE non-hospital based imaging centers is posted on the SVRHT website at www.scantichealth.org. You can also get a copy by calling the Benefits Administrator at 413-596-2800 extension 102 or by calling your member services number on your insurance card. Tufts Health Plan has not issued a list, you will need to call Tufts to find out if the particular imaging center will require a co-payment or not.

Free Maintenance Prescription Drugs (HNE Med Plus only!)

SVRHTCanaRx is a voluntary prescription medication savings program provided free of charge as part of the benefits package for retirees who are enrolled in self-insured health plans. Currently, the HNE Med Plus is the only plan who qualifies for this program. Enrollment information and the medication lists are posted on the SVRHT website. If you are enrolled in the HNE Med Plus Plan and are interested in getting free prescription medications sent directly to your house, call toll free CanaRx Group, Inc. 1-866-893-6337.

Good Health Gateway

This program offers free diabetes medications and supplies for subscribers. Currently, the HNE Med Plus is the only plan who qualifies for this program. Enrollment information and the medication lists are posted on the SVRHT website. If you are enrolled in the HNE Med Plus Plan visit www.GoodHealthGateway.com or call 1(800) 643-8028.

CONTINUATION OF COVERAGE FOR RETIREES:

Massachusetts General Laws Chapter 32B allow for benefit continuation into retirement. Employees who are enrolled and retire are therefore eligible to continue their coverage into retirement. However, if a retiree DISCONTINUES his/her health insurance coverage with the Town (that is, cancels coverage at any time for any reason), the retiree is not allowed to re-enroll at a later time!

Medicare D Creditable Coverage

The Medicare Modernization Act of 2003 requires all employers that offer prescription drug coverage to notify covered employees and retirees who are Medicare eligible, or who may be Medicare eligible, as to the value of the current prescription drug benefit compared to that of the optional Medicare Part D drug benefit that went into effect on January 1, 2006. This is to inform you that **all of the health plans that the Town of Wilbraham offers have prescription drug benefits that are at least as good as the standard Medicare Part D prescription drug benefit, and these plans are considered to be “creditable coverage”**. This statement is based on reviews performed by qualified actuaries of the prescription drug benefits and spending by the employer on each health plan compared to what Medicare would pay. Therefore, **if you plan to continue to be covered under the Town of Wilbraham’s health benefits plans, you do not need to purchase Medicare Part D***. If in the future you should want to purchase Part D for whatever reason, because you have been

covered by a plan that has benefits as good as or better than Part D benefits, you would not be charged the Part D late enrollment premium penalty.

If you have any questions about this, please contact Benefits Manager Gloria Congram, at 413-596-2800 x 102, or at gcongram@wilbraham-ma.gov, or in person at the Wilbraham Town Hall, most Monday's from 9 am to 1 pm.

* There is a possibility that Medicare eligible retirees who meet the Medicare Part D low-income guidelines and who qualify for a government subsidy could do better under Part D than under the current Rx benefits offered through the Town of Wilbraham. Individuals who think they might qualify for the Medicare Part D low-income subsidy should seek assistance from the local social security office. If you buy Part D, please inform us as soon as possible.

Changes to Medicare D Coverage

The Center for Medicare and Medicaid Services (CMS) has made the following adjustments to Part D plan coverage effective January 1, 2020:

- Increased dollar amounts throughout stages of coverage:
Initial Coverage Stage: from \$3,830 to \$4,020
Catastrophic Coverage: from \$5,100 to \$6,350
- Once the retiree reaches catastrophic coverage drug co-pays will increase
- Increase in generic prescription drugs from \$3.40 to \$3.60 per prescription
- Increase in brand name prescriptions from \$8.50 to \$8.95 per prescription

The Massachusetts Health Connector

The Insurance Marketplace in Massachusetts, set up under the Affordable Care Act, is known as the Massachusetts Health Connector. The 2020 Open Enrollment for plans on the Health Connector starts on **Friday, November 1 and ends on Sunday, December 15, 2019**. for plans starting on January 1, 2019. You can enroll for dental insurance at any time during the year. (NOTE: Dental Insurance is NOT offered to retirees by the Town of Wilbraham, if you are looking for dental insurance, please contact the Health Connector.)

Please visit <https://www.mahealthconnector.org> or call 1-877-MAENROLL (1-877-623-6765) for more information.

Children's Health Insurance Program (CHIP) or Medicaid (MassHealth)

If your children need health coverage, they may be eligible for the Children's Health Insurance Program (CHIP). If they qualify, you won't have to buy an insurance plan to cover them.

CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid (MassHealth). If you apply for MassHealth coverage, you'll also find out if your children qualify for

CHIP. To **apply for CHIP** call 1-800-318-2596 (TTY: 1-855-889-4325), or complete an application through the Health Connector. If it looks like anyone in your household qualifies for Medicaid or CHIP, the HealthConnector will send your information to your state agency and they will contact you about enrollment. When you submit your Marketplace application, you'll also find out if you qualify for an individual insurance plan with savings based on your income instead. There's no limited enrollment period for either Medicaid or CHIP. If you qualify, your coverage can start immediately.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees/retirees and qualified beneficiaries the right to continue health insurance coverage for up to 18 months (longer in certain circumstances) under the town's group health plan when a "qualifying event" would normally result in loss of eligibility. Included are such events as resignation, termination of employment, retirement, a reduction in an employee's work hours, an unpaid leave of absence, divorce or legal separation, a dependent child no longer meeting eligibility requirements or the death of an employee/retiree. Under COBRA the employee or beneficiary pays the full cost of the premium at the Town of Wilbraham's group rate. Coverage is subject to timely premium payments to the Town of Wilbraham. For more information please contact the benefits administrator or visit the website of the U.S. Department of Labor at: <http://www.dol.gov/dol/topic/health-plans/cobra.htm> or call Gloria Congram.

Women's Health and Cancer Rights Act – WHCRA Notice

The Women's Health and Cancer Rights Act (WHCRA) helps protect many women with breast cancer who choose to have their breasts rebuilt (reconstructed) after a mastectomy. Mastectomy is surgery to remove all or part of the breast. This federal law requires most group insurance plans that cover mastectomies to also cover breast reconstruction. It was signed into law on October 21, 1998. The United States Departments of Labor and Health and Human Services oversee this law. The law applies to group health plans for plan years starting on or after October 1, 1998, and to group health plans, health insurance companies, and HMOs, as long as the plan covers medical and surgical costs for mastectomy.

Under the WHCRA, mastectomy benefits must cover:

- Reconstruction of the breast that was removed by mastectomy Surgery and reconstruction of the other breast to make the breasts look symmetrical or balanced after mastectomy
- Any external breast prostheses (breast forms that fit into your bra) that are needed before or during the reconstruction
- Any physical complications at all stages of mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery)
- Mastectomy benefits may have a yearly deductible and may require that you pay *co-insurance*. Co-insurance is when less than the full amount of the bill is paid by the insurance company and the patient must pay the difference.

HIPAA Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please be advised that the Town of Wilbraham is a member of the Scantic Valley Regional Health Trust (SVRHT), a joint purchasing group. SVRHT contracts with Group Benefits Strategies (GBS) to administer the health insurance program for the member communities. Even for self-insured plans, the Town of Wilbraham does not directly pay for services and does not receive Private Health Information (PHI). The Town of Wilbraham may ask the subscribers written permission to receive such information in certain circumstances.

MassHealth Buy-In Programs

Buy-In Programs are MassHealth programs that pay all or part of Medicare health insurance expenses for eligible low-income Medicare recipients. There are three MassHealth Medicare Buy-In programs that help pay Medicare expenses:

- **Qualified Medicare Beneficiary (QMB) Program (Senior Buy-In).** This program pays for your Medicare premiums, annual deductibles, and co-payments. If you owe a Part A premium, QMB pays for Part A as well as Part B. QMB recipients qualify for Extra Help from Social Security to pay for basic Part D drug coverage. Your countable monthly income must be no greater than 100% of the Federal Poverty Guidelines (FPG).
- **Buy-In for Specified Low-Income Medicare Beneficiaries (SLMB).** This program pays your Medicare Part B premium. SLMB and QI recipients also qualify for extra help from Social Security to pay for basic Part D drug coverage. For SLMB, your countable monthly income must be between 100% and 120% of the FPG.
- **Buy-In for Qualifying Individuals (QI)** also pays your Medicare Part B premium. For QI your countable income must be between 120% and 135% of the FPG. *(Note: Funding for the QI program is limited and is given on a first-come first-served basis).*

Call the MassHealth Enrollment Center at 1-800-408-1253 (TTY: 1-888-665-9997 for people with partial or total hearing loss) to request more information or obtain a MassHealth Buy-In Application.

Shine Program

The SHINE (Serving Health Insurance Needs of Elders) program provides free, unbiased and up-to-date health insurance information, counseling and assistance from trained community volunteers. SHINE Counselors provide information on Medicare (Part A & Part B), Medigap insurance, Medicare HMOs, retiree insurance plans, Medicaid and free or reduced cost health care programs, and can help with claim forms and applications.

To locate a SHINE Counselor in your community, please contact the Central Massachusetts Association of Councils on Aging at the Milford Senior Center 1-800-AGE-INFO /1-800-243-4636.

Where do I go for help?

Questions about:	Contact	Phone	Email
Enrollment, Eligibility, Premium Payments, Continuation of benefits, Changes, Retirement; Boston Mutual Insurance;	Gloria Congram, Benefits Manager	413-596-2800 x 102	gcongram@wilbraham-ma.gov
Coverage of Services	Health Plan Service Representative	as listed on membership card	as listed in your plan documents
Wellness Program	Lyn Fioravanti, Regional Wellness Coordinator, SVRHT	413-896-9080	lyn@scantichealth.org
Scantic Valley Regional Health Trust	Tom Sullivan, Wilbraham Representative	413-596-2800 x 207	tsullivan@wilbraham-ma.gov
Free unbiased consultation regarding my options	SHINE Counselor	413-596-8379	Wilbraham Senior Center

Disclaimer:

The comparison charts on the following pages are a high level overview of the plans offered. They do not describe full and complete plan details. Contact your Benefits Administrator or the carrier directly for specific coverage questions you may have. The SVRHT is not responsible for the accuracy of this summary of benefits.

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS **Effective January 1, 2020**
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 <i>Prior Authorization Required</i> (3 co-pay maximum) NEW: 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 <i>Prior Authorization Required</i> (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> <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 <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

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	<u>In-Network (190 day lifetime limit):</u> \$300 per admission (3 co-pay maximum) <u>Out-of-Network:</u> \$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	\$10 co-pay to PCP \$15 specialist co-pay	Primary care doctor visit for Medicare covered benefits: <u>In-Network:</u> \$15 co-pay <u>Out-of-Network:</u> \$55 co-pay
Consult & Care by Specialists	\$35 co-pay per visit	\$15 co-pay per visit	Specialist visit for Medicare covered benefits: <u>In-Network:</u> \$15 co-pay <u>Out-of-Network:</u> \$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	<u>In-Network</u> - \$0 co-pay <u>Out-of-Network:</u> \$0 co-pay
Diagnostic Lab & X-ray Services	\$10/day for routine lab tests; out-patient diagnostic lab tests. \$150/day co-pay for PET, CT, MRI scans, and nuclear cardiology services	Covered in full	Routine lab tests: Covered in full Diagnostic Imaging (CT Scans, MRIs, MRAs, PET Scans, sleep 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	\$0 to \$150 co-pay \$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

This is an abbreviated description of benefits. Details of coverage are available from each health plan provider. Health plans provided the information in this summary. The SVRHT is not responsible for the accuracy of this summary of benefits.

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS **Effective January 1, 2020**

Medicare Replacement Plans

Changes/clarifications, if any, in red font

OUTPATIENT CARE (<i>cont'd</i>)	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- <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	\$100 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.
Routine Vision & Hearing Screenings	\$35 co-pay per visit. One routine eye exam per 12 months. Davis Vision Network provider required Eyewear including contact lenses - up to \$150 every 24 months. Davis Vision network provider required Hearing exams One exam every 12 months; \$15 PCP; \$35 Specialist Up to \$400 for hearing aids every 36 months	\$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. <u>After cataract surgery-</u> \$0 co-pay - one pair of glasses or contact lenses <u>In-Network</u> : \$15 co-pay <u>Out-of-Network</u> \$55 co-pay -Exams to diagnose and treat diseases and conditions of the eye. Hearing- <u>In-Network</u> : \$15 co-pay

			<p><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>
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SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS
Medicare Replacement Plans

Effective January 1, 2020
 Changes/clarifications, if any, in red font

Prescription Drugs & Other Benefits	Medicare HMO Blue (BCBS) You Pay	TUFTS Medicare Preferred HMO You Pay	HNE Medicare Secure Freedom HMO-POS 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	<p>Retail: <u>30 day</u> supply: \$10 generic \$25 preferred brand \$45 non-preferred brand</p> <p>Mail Order: <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 \$6,350, then you pay \$3.60 for a generic drug, and \$8.95 for all other drugs.</p> <p>Express Scripts is the Prescription Benefits Manager</p>	<p>Retail: <u>30 day</u> supply: \$10 generic \$20 preferred brand \$35 non-preferred brand</p> <p>Mail Order: <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 \$6,350, then you pay \$3.60 for a generic drug, and \$8.95 for all other drugs</p> <p>CMS Caremark is the Prescription Benefits Manager</p>	<p>Retail: <u>30 day</u> supply: \$4 preferred generic \$10 generic \$25 preferred brand \$45 non-preferred brand \$50 Specialty Tier</p> <p>Mail Order: <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 \$6,350, then you pay \$3.60 for a generic drug, and \$8.95 for all other drugs</p>
			<p>Optum Rx is the Prescription Benefits Manager</p> <p>NEW: Opioid Treatment Program Services There is no coinsurance, copay or deductible for Opioid Treatment Program services</p>
FITNESS			
Fitness Center benefit	<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/ Safety Items/ Acupuncture / Activity/Fitness Tracker/ Over-the-Counter Item Allowance</p>

SCANTIC VALLEY REGIONAL HEALTH TRUST- RETIREE SUPPLEMENT PLAN BENEFITS – Effective: 1-1-2020

Changes/clarifications in red font if applicable

OUTPATIENT CARE				
	You Pay	You Pay	You Pay	You Pay
Medical Office Visits	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit	Covered in full
Consult & Care by Specialists	\$10 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit (& referral from PCP)	Covered in full.
Routine Physical Exams	\$0 co-pay per visit	\$0 co-pay per visit	\$10 co-pay per visit	Not Covered
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full	Covered in full
Day Surgery	Covered in full	\$10 co-pay in physician office	Covered in full in hospital and other day surgical setting \$10 co-pay per visit in an office setting	Covered in full
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full	Covered in full
Urgent & Emergency Care	\$10 co-pay for office; \$50 co-pay for ER (waived if admitted)	\$10 co-pay for urgent care office visit; \$50 co-pay per visit for ER (waived if admitted)	\$50 co-pay per visit for ER (waived if admitted)	Full coverage for emergency services
Ambulance Services	Covered in full	\$25 co-pay per member per day	Emergency Transportation covered in full. Medically necessary transportation \$40 member co-pay	Covered in full
Mental Health & Substance Abuse	<p>Biologically based mental conditions: - When covered by Medicare, full coverage of deductible and coinsurance after \$10 co-pay per visit. There is no visit limit.</p> <p>Non-biologically-based mental conditions: - When covered by Medicare, full coverage after \$10 co-pay per visit</p> <p><i>* Includes drug addiction and alcoholism.</i></p>	<p>Biologically based mental conditions: \$10 co-pay per visit; no visit limits on medically necessary services</p> <p>Non-biologically-based mental conditions: \$10 co-pay per visit on medically necessary services</p>	<p>Biologically based mental conditions: \$10 co-pay, unlimited visits</p> <p>Non-biologically-based mental conditions: 24 visits per member per calendar year when not covered by Medicare</p>	<p>Biologically-based mental conditions: When covered by Medicare, full coverage of deductible and co-insurance w/no visits max. <i>When not covered by Medicare, full Medex benefits with no visit max.</i></p> <p>Non-biologically-based mental conditions *: - Covered in full when covered by Medicare. - When not covered by Medicare – full coverage up to 24 visits per calendar year. <i>* Includes drug addiction and alcoholism.</i></p>
Routine Vision & Hearing Screenings	<p>Hearing - \$10 co-pay Hearing Aid – First \$500 covered in full, then 80% of next \$1,500 up to a total of \$1700 every 2 yrs purchase or repair Vision – \$10 co-pay Glasses or contacts - covered up to \$150 per calendar year.</p> <p>Hearing and vision items are via reimbursements. You can use any provider and obtain a receipt.</p>	<p>\$0 co-pay per visit for annual routine eye</p> <p>\$10 co-pay hearing exams</p>	<p>\$10 co-pay per visit, per calendar year</p> <p>No coverage for hearing exams or hearing aids</p>	Not covered
Preventive Dental	Not covered	Not covered	Not covered	Not covered

SCANTIC VALLEY REGIONAL HEALTH TRUST- RETIREE SUPPLEMENT PLAN BENEFITS – Effective: 1-1-2020

Changes/clarifications in red font if applicable

FITNESS	TUFTS MEDICARE Supplement Plan	HNE MEDWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX 2 w/OBRA
Fitness Center Benefit	Up to \$150 reimbursement per calendar year at any participating fitness club. No Waiting Period. See plan for details.	Up to \$200 ind/\$400 family reimbursement per calendar year for weight watchers or for an eligible health club per family See plan for details.	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.	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.

BCBSMA Medex Plans Footnotes

Medex Enhanced 2

*The 365 additional days per lifetime are a combination of days in a general or mental hospital.

** A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

Prescription drugs	<p>Retail: 30 day supply: \$10 generic \$20 preferred brand \$35 non-preferred brand</p> <p>Mail Order: 90 day supply: \$20 generic \$40 preferred brand \$70 non-preferred brand</p> <p>CVS Caremark is the Prescription Benefits Manager</p>	<p>Retail: 30 day supply: Generic: \$10 co-pay Formulary: \$20 co-pay Non-Formulary: \$35 co-pay</p> <p>Mail Order: 90 day supply: (maintenance medication) Generic: \$20 co-pay Formulary: \$40 co-pay Non-Formulary: \$105 co-pay</p> <p>OptumRx is the Prescription Benefits Manager for retail and mail order.</p>	<p><i>NO DEDUCTIBLE</i> Retail: up to 30-day supply: Tier 1: \$5 co-pay Tier 2: \$10 co-pay Tier 3: \$25 co-pay</p> <p>Mail order: up to 90-day supply Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$50 co-pay</p> <p><i>RX Plan name is- Blue Medicare RX</i></p> <p>CVS Caremark is the Prescription Benefits Manager (PBM) for retail and mail order.</p>	<p>(Medicare Part D Prescription Plan) Retail: up to 30-day supply: Tier 1: \$5 co-pay Tier 2: \$10 co-pay Tier 3: \$25 co-pay</p> <p>Mail order: up to 90-day supply Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$50 co-pay</p> <p><i>RX Plan name is- Blue Medicare RX</i></p> <p>CVS Caremark is the Prescription Benefits Manager (PBM) for retail and mail order.</p>
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