Town of Wilbraham 240 Springfield Street Wilbraham MA 01095

OPEN ENROLLMENT
Health Insurance for 2022

For Wilbraham Town Retirees on Medicare and their Spouses

November 1 to November 25, 2021

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's new this year?

The Scantic Valley Regional Health Trust (SVRHT) has replaced the **Health New England MedPlus** plan with a **Health New England MedPlus with HUMANA PDP Plan effective January 1, 2022. This action reduced the monthly premiums from $480 to $370. All retirees and spouses who are currently enrolled in the HNE MedPlus plan will be AUTOMATICALLY ENROLLED in the new HNE MedPlus with HUMANA Prescription Drug Plan (PDP), unless they select a different plan and complete termination and enrollment forms.** The Health New England MedPlus plan remains the same, but there are some changes with the Humana prescription coverage. Members will no longer be eligible to participate in the Good Health Gateway Diabetes Care Program or the Free Prescription Coverage under the CanaRx Program. Coverage of insulin and some diabetes supplies with no co-pays has been added to the new HUMANA PDP but not all diabetic drugs will be covered. The following chart shows how the current coverage compares to the new coverage with HUMANA:

Carrier	Inforce HNE MedWrap Optum Rx - Mail	Humana
Prescription Coverage	**Co-pays**	**Co-pays**
Part D Deductible	$0	$0
Rx Tiers	3 Tier	4 Tier
30 Day Retail		
Tier 1 (Generics) 30-Day	$10	$10
Tier 2 (Brands) 30-Day	$20	$20
Tier 3 (NP Brands) 30-Day	$35	$35
Tier 4 (Specialty) 30-Day	N/A	$35
90 Day Retail		
Tier 1 (Generics) Retail 90-Day	$30	$30
Tier 2 (Brands) Retail 90-Day	$60	$60
Tier 3 (NP Brands) Retail 90-Day	$105	$105
Tier 4 (Specialty) Retail 90-Day	Limited to a one month supply	Limited to a one month supply
90 Day Mail		
Tier 1 (Generics) Mail 90-Day	$20	$20
Tier 2 (Brands) Mail 90-Day	$40	$40
Tier 3 (NP Brands) Mail 90-Day	$105	$70
Tier 4 (Specialty) Mail 90-Day	Limited to a one month supply	Limited to a one month supply
Part D Coverage Specifications		
Member Out-of-Pocket Max	N/A	N/A
Drug Formulary	Most Open	Group Plus - Most Open
Non-Part D Rx Rider	Yes	Yes
Lifestyle Drug Rider	Yes	Yes
Diabetic Testing Supplies & Insulin	Yes via Abbacus	$0
Utilization Management Requirements	PA, QL, & ST	PA, QL, & ST
Custom Catastrophic Details	Member pays copays above	Enhanced - Members pay 5% or the CMS Standard Copays, to a maximum of the above copays
Part D Coverage Gap	Full-Coverage	Full-Coverage

The **Tufts Medicare Supplement** with PDP Plus will change from a fully insured senior plan to a self-funded plan effective January 1, 2022. There are no changes in benefits related to this change.

Blue Cross Blue Shield has put together an informational video about the three Medicare Plans they offer to Scantic Valley Regional Health Trust Retirees. To view the BrainShark video at your leisure, please visit the following link: https://www.brainshark.com/bcbsma/scantic. In addition, they have set up phone office hours with specific dates and times for three Account Education Lines for the Trust's units. **When you call the number below (during the specific time slots listed below), you will be routed directly to a representative who is equipped with materials regarding Scantic Valley's Blue Cross Medicare plans.**

The number to call is 888-258-7908 during these times:

- **Thursday, November 4th (2pm-4pm)**
- **Friday, November 5th (10am-12pm)**
- **Friday, November 12th (10am-12pm)**

Benefit Summaries for all plans are available on the Town's website at www.wilbraham-ma.gov, under Departments/Human Resources/Retiree Benefits. If you would like a hard copy 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 Thursdays at the Wilbraham Town Hall from 9:00 am to 1:00 pm. During Open Enrollment, she will be here from 9 am to 1 pm on Thursday, November 4, on **Friday, November 12**, and Thursday, November 18, 2021. If you need assistance, please call or better email her to make an appointment for a private consult on one of those days.

Medicare Plans Explained

Supplemental Plans – offer the most versatility, allowing the subscriber to receive services anywhere Medicare is accepted. A primary care physician is not necessary and the subscriber can live anywhere in the United States or Puerto Rico. The insurance card and the Medicare card should be presented when services are received. Medicare pays first and the insurance "supplements" the Medicare coverage.

Advantage/Replacement Plans – provide a limited network of providers where the subscriber can receive services. The premiums for these plans tend to be lower and the subscriber is responsible for co-pays that get paid as services are received. These plans tend to offer wellness benefits for eyeglasses, hearing aids, and limited dental coverage. This coverage "replaces" Medicare Parts A&B and if enrolled in one of these plans, the Medicare card should be put away and only the insurance card should be presented when services are received. The subscriber must have a primary care physician and a primary residence within the network area. The rates and benefits of these plans renew annually on the January 1.

Medwrap Plans – With Medicare Wrap Plans the subscriber must present the Medicare card and the insurance card when services are received. Wraps provide a network of providers where a subscriber may receive services. The insurance plan "wraps" around the Medicare and the subscriber usually pays a co-pay for covered services received from in-network providers. The subscriber is responsible for any portion Medicare does not cover for services received out of the plan network. The subscriber must have a primary care physician and a primary residence within the network area.

Scantic Valley Regional Health Trust - Senior Plan Rates for CY22

The SVRHT Board of Directors approved new rates on October 5, 2021, which no change to the Medex 2 and Blue MedicareRX premiums of $378.00, no change to the HNE Medicare Freedom plan at $334.00, a modest 1.2% increase in premium to the Managed Blue for Seniors to $382.36, a 2.9% increase to the Medicare HMO Blue plan and a 4.4% increase to the Tufts Medicare HMO. Changing the Tufts Medicare Supplement with PDP Plus form a self-insured to a self-funded plan with the PDP portion still insured, reduced the premium from $364.00 to $349.00.

Retiree Health Insurance Rate Shares – Medicare eligible (EE 40% - ER 60%)

(January 1, 2022 thru December 31, 2022)

Medex 2 w/BlueMedRx 50-2319356				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Individual	$378.00	$226.80	$151.20	$378.00

Managed Blue for Seniors with BlueMedRx 00-4035757				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$382.36	$229.42	$152.94	$382.36

Medicare HMO Blue (advantage plan)				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$405.31	$243.19	$162.12	$405.31

HNE MedPlus w/Humana				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$370.00	$222.00	$148.00	$370.00

HNE Secure Free (advantage plan) 116184				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$334.00	$200.40	$133.60	$334.00

Tufts Medicare Supp 1856D				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$349.00	$209.40	$139.60	$349.00

Tufts Medicare Pref (advantage plan) 1856				
	Total	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Employee	$356.00	$213.60	$142.40	$356.00

Life Insurance - EE 50% - ER 50%

Boston Mutual Life Insurance 000911-00001			
Basic Life	**Total**	**Employer Share**	**Retiree Share**
$1,000	$0.60	$0.30	$0.30

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. For up to date Medicare information and changes in coverage, deductibles and premiums proposed for 2022, please visit www.medicare.gov.

Retiree Health Insurance Rate Shares –

Non-Medicare eligible

(EE 40% - ER 60% except PPO EE 50% - ER 50%)

(July 1, 2021 thru June 30, 2022)

Blue Care Elect Preferred (PPO) 00-2297984	**Total**	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Individual	$1,453.00	$726.50	$726.50	$1,453.00
Family	$3,162.00	$1,581.00	$12,648.00	$3,162.00

Network Blue N.E. (HMO) 00-2280258	**Total**	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Individual	$852.00	$511.20	$340.80	$852.00
Family	$2,109.00	$1,265.40	$843.60	$2,109.00

HNE (HMO) S03042-0010	**Total**	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Individual	$781.00	$468.60	$312.40	$781.00
Double	$1,587.00	$952.20	$634.80	$1,587.00
Family	$2,137.00	$1,282.20	$854.80	$2,137.00

Tufts Health Plan (HMO) 00-16211-100	**Total**	**Employer Share**	**Retiree Share**	**Surviving Spouse**
Individual	$863.00	$517.80	$345.20	$863.00
Family	$2,155.00	$1,293.00	$862.00	$2,155.00

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 unless the divorce decree states that the retiree must cover the ex-spouse.

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 are offered by the Trust:

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 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.

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.

CONTINUATION OF COVERAGE FOR RETIREES:

Massachusetts General Laws Chapter 32B allows for benefit continuation into retirement. Employees who are enrolled or enroll at the time of retirement are 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 Thursday'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, 2022:

- Increased dollar amounts throughout stages of coverage:
  Initial Coverage Stage: from $4,130 to $4,430
  Catastrophic Coverage: from $6,350 to $6,550
- The maximum allowable deductible for standard Part D plans will be $480 in 2022, up from $445 in 2021.

The Massachusetts Health Connector

The Insurance Marketplace in Massachusetts, set up under the Affordable Care Act, is known as the Massachusetts Health Connector. **The 2022 Open Enrollment for plans on the Health Connector starts on November 1, 2021, and will continue until January 15, 2022 for plans starting on January 1, 2022.** 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).

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 Gallagher 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-serve 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, 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.

Who Do I Call?

Questions about:	Contact	Phone	Email
Enrollment, Eligibility, Premium Payments, Continuation of benefits, Changes, Retirement; Boston Mutual Insurance;	Gloria Congram, Benefits Manager	413-596-2800x 102	gcongram@wilbraham-ma.gov
Coverage of Services	Health Plan Representative	On card	as listed in your plan documents
Wellness Program	Lyn Fioravanti, Wellness Coordinator	413-896-9080	lyn@scantichealth.org
SVRHT Representative	Tom Sullivan, Wilbraham	413-596-2800x 207	tsullivan@wilbraham-ma.gov

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS
Effective January 1, 2022

Medicare Replacement Plans

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.

PLAN FEATURES	**Medicare HMO Blue (BCBS)** **Medicare Advantage HMO** Renews January 1	**Tufts Medicare Preferred HMO** **Medicare Advantage HMO** Renews January 1	**HNE Medicare Secure Freedom HMO-POS** **Medicare Advantage POS** Renews January 1
	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	In-Network: $300 per admission (3 co-pay maximum) Out-of-Network: $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.	In-Network: $300 per admission (3 co-pay maximum) Out-of-Network: $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.	In-Network: *Some services require Prior Authorization* Days 1-5: $0 co-pay Days 6-50: $75 co-pay Days 51–100 $0 co-pay Out-of-Network: *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

PLAN FEATURES	**Medicare HMO Blue (BCBS)** **Medicare Advantage HMO** Renews January 1	**Tufts Medicare Preferred HMO** **Medicare Advantage HMO** Renews January 1	**HNE Medicare Secure Freedom HMO-POS** **Medicare Advantage POS** Renews January 1
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 **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 cardiac imaging tests (imaging costs are waived when performed on the same day as an emergency visit or outpatient day surgery)	Covered in full	Routine lab tests: Covered in full Diagnostic Imaging (CT Scans, MRIs, MRAs, PET Scans, sleep 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

PLAN FEATURES	**Medicare HMO Blue (BCBS) Medicare Advantage HMO** Renews January 1	**Tufts Medicare Preferred HMO Medicare Advantage HMO** Renews January 1	**HNE Medicare Secure Freedom HMO-POS Medicare Advantage POS** Renews January 1
Urgent & Emergency Care (for Medicare covered visits)	Medicare HMO Blue (BCBS) Medicare Advantage HMO Renews January 1 $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

PLAN FEATURES	Medicare HMO Blue (BCBS) Medicare Advantage HMO Renews January 1	Tufts Medicare Preferred HMO Medicare Advantage HMO Renews January 1	HNE Medicare Secure Freedom HMO-POS Medicare Advantage POS Renews January 1
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
Prescriptions	**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 $7,050, then you pay $3.95 for a generic drug, and $9.85 brand and no 5% co insurance. 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 $7,050, then you pay $3.95 for a generic drug, and $9.85 brand and no 5% co insurance. 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 $7,050, then you pay $3.95 for a generic drug, and $9.85 brand and no 5% co insurance. Optum Rx is the Prescription Benefits Manager **Opioid Treatment Program Services** There is no coinsurance, copay or deductible for Opioid Treatment Program services
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

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS
Effective January 1, 2022

Medicare Supplement Plans

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.

Changes/clarifications in red font if applicable

PLAN FEATURES	**TUFTS MEDICARE SUPPLEMENT Plan Freedom of Choice**	**HNE MEDPLUS HMO MEDIWRAP**	**BCBS MANAGED BLUE FOR SENIORS HMO MEDIWRAP**	**MEDEX 2 w/OBRA Indemnity Type Medicare Supplement Freedom of Choice**
INPATIENT CARE	**You Pay**	**You Pay**	**You Pay**	**You Pay**
General Hospital: Semi-private room & board and special services	Covered in Full. Full coverage of lifetime reserve day co-insurance Full coverage for days 91–365 **per benefit period**, when Medicare benefits are used up	Covered in full for unlimited days when medically necessary.	Covered in full for unlimited days when medically necessary	Full coverage of Medicare deductible and co-insurance Full coverage of lifetime reserve day co-insurance Full coverage up to 365 additional hospital days in your **lifetime** when Medicare benefits are used up*
Rehabilitation Hospital	Acute rehabilitation hospital covered the same as General Hospital.	Covered in full up to 100 days per calendar year. (Combined with Skilled Nursing Facility)	Covered in full (365 days in a lifetime after Medicare days end)	Full coverage of Medicare deductible and co-insurance Full coverage of lifetime reserve day co-insurance Full coverage up to 365 additional hospital days in your **lifetime** when Medicare benefits are used up*
Skilled Nursing Facility	Covered in full for 100 days per benefit period: Medicare covers up to 20 days after a hospital stay of 3 days or longer Then Plan covers, in full, Medicare daily coinsurance for days 21-100 per benefit period.	Covered in full up to 100 days per calendar year. (Combined with Rehabilitation Hospital)	Covered in full for 100 days in benefit period.	With Medicare – Full coverage of Medicare daily co-insurance for days 21-100. Then $10 per day from day 101 thru day 365. Without Medicare - $8 per day per benefit period.
Mental Health & Substance Abuse Care in a Psychiatric Hospital	*General or Psychiatric hospital* - Full coverage of Medicare deductible and coinsurance up to 90 days per benefit period. - Full coverage of lifetime reserve day coinsurance **-** Full coverage up to 365 additional hospital days in your lifetime when	Covered in full, no day limit.	**Biologically based mental conditions:** Covered in full, no day limit. **Non-biologically-based mental conditions:** 60 days per calendar year after Medicare days end	*General or Psychiatric hospital* - Full coverage of Medicare deductible and co-insurance up to 90 days per benefit period. - Full coverage for days 91-365 per benefit period, when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general or mental hospital

	Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital)			
OUTPATIENT CARE	**TUFTS MEDICARE Supplement Plan**	**HNE MEDPLUS**	**BCBS MANAGED BLUE FOR SENIORS**	**MEDEX 2 w/OBRA**
	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 Mental Health & Sub Ab cont.	**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. **Non-biologically-based mental conditions:** - When covered by Medicare, full coverage after $10 co-pay per visit ** Includes drug addiction and alcoholism.*	**Biologically based mental conditions:** $10 co-pay per visit; no visit limits on medically necessary services **Non-biologically-based mental conditions:** $10 co-pay per visit on medically necessary services	**Biologically based mental conditions:** $10 co-pay, unlimited visits **Non-biologically-based mental conditions:** 24 visits per member per calendar year when not covered by Medicare	***Biologically-based mental conditions*:** When covered by Medicare, full coverage of deductible and co-insurance w/no visits max. *When not covered by Medicare, full Medex benefits with no visit max.* ***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. ** Includes drug addiction and alcoholism.*

PLAN FEATURES	TUFTS MEDICARE Supplement Plan	HNE MEDPLUS HMO MEDIWRAP	BCBS MANAGED BLUE FOR SENIORS	MEDEX 2 w/OBRA
Routine Vision & Hearing Screenings	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. Hearing and vison items are via reimbursements. You can use any provider and obtain a receipt.	$0 co-pay per visit for annual routine eye $10 co-pay hearing exams	$10 co-pay per visit, per calendar year No coverage for hearing exams or hearing aids	Not covered
Preventive Dental	Not covered	Not covered	Not covered	Not covered
	You Pay	**You Pay**	**You Pay**	**You Pay**
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 (in person or online) or fitness equipment. 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 (in person or online) or fitness equipment. 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.