

SCANTIC VALLEY REGIONAL HEALTH TRUST - RETIREE PLAN BENEFITS

Medicare Replacement Plans (Health plan changes effective 01-01-11 in red font)

PLAN FEATURES	Medicare HMO Blue (BCBS) Medicare Advantage HMO Renews January You Pay	Tufts Medicare Preferred HMO Medicare Advantage HMO Renews July You Pay	HNE Medicare Secure Freedom HMO-POS NEW PLAN Eff 7/1/2010 Medicare Advantage POS Renews January You Pay
General Hospital: Semi-private room & board and special services	\$150 co-pay per day up to \$750 per calendar year (combined with Inpatient Mental Health Admissions)	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> \$600 per admission (3 co-pay maximum)
Rehabilitation Hospital	\$150 co-pay per day (days 1-5) \$750 annual maximum	Covered in full for 90 days in benefit period.	<u>In-Network:</u> \$300 per admission (3 co-pay maximum) <u>Out-of-Network:</u> \$600 per admission (3 co-pay maximum)
Skilled Nursing Facility	\$50 co-pay per day for day (up to \$1,000 per calendar year)	Covered in full for 100 days in benefit period. No prior hospital stay is required.	<u>In-Network:</u> Days 1-5: \$0 co-pay Days 6-100: \$75 per day <u>Out-of-Network:</u> Days 1-5: \$0 co-pay Days 6-100: \$100 per day
Mental Health & Substance Abuse Care in a Psychiatric Hospital	\$150 co-pay per day (up to \$750 per calendar year combined with general hospital stays)	\$0 co-pay - 190-day lifetime limit max	<u>In-Network:</u> \$300 per admission (3 co-pay maximum) <u>Out-of-Network:</u> \$600 per admission (3 co-pay maximum)

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OUTPATIENT CARE (cont'd)	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; \$30 specialist co-pay	\$10 co-pay to PCP \$15 specialist co-pay	<u>In-Network:</u> \$15 co-pay for each primary care doctor visit for Medicare covered benefits. <u>Out-of-Network:</u> \$30 co-pay for each primary care doctor visit for Medicare covered benefits.
Consult & Care by Specialists	\$30 co-pay per visit	\$15 co-pay per visit	<u>In-Network:</u> \$15 co-pay for each specialist visit for Medicare covered benefits <u>Out-of-Network:</u> \$30 co-pay for each specialist visit for Medicare covered benefits
Routine Annual Physical Exams (one per calendar year)	\$0 co-pay per visit	\$0 co-pay per visit	<u>In-Network:</u> \$0 co-pay for routine exam. <u>Out-of-Network:</u> \$0 co-pay for routine exam.
Diagnostic Lab & X-ray Services	Covered in full for routine lab tests; 10% of total costs for outpatient diagnostic lab tests, PET, CT, MRI scans, and nuclear cardiology services	Covered in full	Covered in full for routine lab tests; High Cost Imaging: <u>In-Network:</u> \$50 co-pay <u>Out-of-Network:</u> \$100 co-pay
Day Surgery	\$0 to \$150 co-pay	\$50 per service	<u>In-Network:</u> \$150 co-pay for each Medicare covered ambulatory surgical center visit. <u>Out-of-Network:</u> \$300 co-pay for each Medicare covered ambulatory surgical center visit.

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	You Pay	You Pay	You Pay
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full
Urgent & Emergency Care (for Medicare covered visits)	\$15 co-pay for PCP office; \$30 co-pay in specialist office; \$50 co-pay for ER	\$10 co-pay for office; \$50 co-pay for ER, waived if admitted.	<u>Urgent Care-</u> In-Network: \$15 co-pay Out-of-Network: \$30 co-pay <u>Emergency-</u> \$50 co-pay, waived if admitted.
Durable Medical Equipment (DME)/Prosthetics			<u>In-Network:</u> \$0 coinsurance <u>Out-of-Network:</u> 20% coinsurance
Ambulance Services	\$0 to \$100 member co-pay per day, waived if admitted	\$50 per day	\$50 co-pay for Medicare covered ambulance benefits per trip. Except in an emergency, your plan provider must obtain prior authorization.
Preventive Dental	\$30 co-pay for one cleaning and one oral exam every 6 mos. Incl. 1 set of 2 bitewing x-rays every 6 mos.	Not covered	\$150 annual allowance dental benefit per calendar year.
Routine Vision & Hearing Screenings	\$30 co-pay per visit. One routine eye exam and one hearing test per 12 months. Eyewear incl. contacts up to \$150 every 24 months. Up to \$400 for hearing aids every 36 mos	\$15 co-pay per visit. Up to \$150 per year toward the purchase of eyeglasses. \$500 allowance for purchase or repair of hearing aids every 3 years.	<u>Vision-</u> \$0 co-pay for up to 1 routine eye exam every two years. \$150 vision care allowance every two calendar years. <u>Glasses or contacts-</u> \$0 co-pay for one pair of eyeglasses or contact lenses after each cataract surgery, up to 1 pair of eyeglasses every year; \$100 allowance towards a new pair of glasses every 2 years.

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			<p><u>In-Network:</u> \$15 co-pay for exams to diagnose and treat diseases and conditions of the eye. \$0 co-pay for up to 1 routine eye exam every two years. <u>Out-of-Network:</u> \$30 co-pay for exams to diagnose and treat diseases and conditions of the eye. <u>Hearing-</u> <u>In-Network:</u> \$15 co-pay for diagnostic hearing exams. \$15 co-pay for up to 1 routine hearing test each year <u>Out-of-Network:</u> \$30 co-pay for diagnostic hearing exams. \$30 co-pay for up to 1 routine hearing test each year</p>
OUTPATIENT CARE (cont'd)	Medicare HMO Blue (BCBS)	TUFTS Medicare Preferred HMO	HNE Medicare Secure Freedom HMO-POS
	You Pay	You Pay	You Pay
Mental Health & Substance Abuse	\$15 co-pay (applies to both biologically-based and non-biologically-based mental conditions.)	\$15 co-pay per visit	<p><u>In-Network:</u> \$15 co-pay for each Medicare covered individual or group therapy visit. <u>Out-of-Network:</u> \$30 co-pay for each Medicare covered individual or group therapy visit.</p>
Prescription drugs	<p>Retail: <u>30-day</u> supply \$10 co-pay Generic \$25 co-pay Preferred Brand Name \$45 co-pay Non-Preferred Brand Name</p> <p><i>Mail Order:</i> Up to a 90-day supply \$20 co-pay Generic \$50 co-pay Preferred Brand -Name \$90 co-pay Non-Preferred Brand</p>	<p>Retail: 30-day supply \$10 co-pay generic/\$25 co-pay preferred brand/\$50 co-pay non-preferred brand for 30-day supply</p> <p><i>Mail Order:</i> 30/60/90 day supply: Tier 1: \$7/\$14/\$20 Tier 2: \$17/\$33/\$50 Tier 3: \$33/\$67/\$100</p>	<p>Retail: <u>30 day</u> supply: Tier 1: \$10 co-pay Tier 2: \$25 co-pay Tier 3: \$45 co-pay</p> <p>Mail Order*: <u>90 day</u> supply:</p>

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	Name \$4,550 in your annual out-of-pocket drug costs, your cost is reduced to the greater of 5% or \$2.50 for generic and \$6.30 for brand name drugs.	\$4,550 in your annual out-of-pocket drug costs, your cost is reduced to the greater of 5% or \$2.50 for generic and \$6.30 for brand name drugs.	Tier 1: \$20 co-pay Tier 2: \$50 co-pay Tier 3: \$135 co-pay *Co-payments doubled for brands in the coverage gap and then 50% CMS discount applies
FITNESS			
Fitness Center benefit	Fitness benefit each year – All costs after \$300 Weightwatchers® each year – All costs after \$300	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 or Weight Watchers.

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