

CAPE COD MUNICIPAL HEALTH GROUP – RETIREE PLAN BENEFITS COMPARISON OF Medicare Supplement Plans effective January 1, 2019

Benefit Category	HPHC Medicare Enhance Freedom of Choice	TUFTS Medicare Preferred Supplement Plan Freedom of Choice	BCBS Medex 2 Freedom of Choice
INPATIENT CARE General Hospital: Semi-private room & board, physician services, and special services	Covered in full for unlimited days. Patient must use reserve days after 90 th day if available.	Covered in full for unlimited days. Patient must use reserve days after 90 th day if available.	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	Covered in full up to 100 days per calendar year.	Acute rehabilitation hospital covered the same as General Hospital.	Covered in full for 100 days after 3-day or longer hospital stay. Then \$16 per day from day 101 thru day 365.
Skilled Nursing Facility	Covered in full for 100 days in benefit period.	Covered in full for 100 days in benefit period.	With Medicare – Full coverage of Medicare daily co-insurance for days 21-100. Then \$16 per day from day 101 thru day 365. Without Medicare - \$16 per day per benefit period.
Mental Health & Substance Abuse Care	All Medicare covered days covered in full. Biologically based conditions: Covered in full, unlimited days.	Biologically based conditions: 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 Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital)	Biologically based conditions: General or mental hospital - 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. (Lifetime 365 days are a combination of days in a general or mental hospital

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 CCMHG is not responsible for the accuracy of this summary of benefits. The Description of Benefits document for each health plan is the accurate source of plan benefit information.

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Mental Health & Substance Abuse Care, Continued	Non-Biologically based conditions: Covered in full 60 days per calendar year for psychiatric and 30 days per calendar year for substance abuse.	Non-biologically based conditions: Mental hospital- Covered in full up to 120 days per benefit period (at least 60 days per calendar year), less any days already covered by Medicare or Plan in that benefit period (or calendar year).	Non-biologically based conditions: Mental hospital- Covered in full up to 120 days per benefit period (at least 60 days per calendar year), less any days already covered by Medicare or Medex in that benefit period (or calendar year).
	General hospital- Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up. (Lifetime 365 days are a combination of days in a general, acute rehabilitation and/or mental hospital)	General hospital- Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up.	General hospital- Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up.
OUTPATIENT CARE	HPHC Medicare Enhance	TUFTS Medicare Preferred Supplement Plan	BCBS Medex 2
	Freedom of Choice	Freedom of Choice	Freedom of Choice
Consult & Care by Specialists	\$5 co-pay	\$10 co-pay per visit	Covered in full.
Routine Annual Physical Exams	\$0 co-pay per visit	\$0 co-pay per visit	Not Covered.
Medical Office Visits	\$5 co-pay per visit	\$10 co-pay per visit	Covered in full
Diagnostic Lab & X-ray Services	Covered in full	Covered in full	Covered in full.
Day Surgery	Covered in full	Covered in full	Covered in full
Radiation & Chemotherapy	Covered in full	Covered in full	Covered in full
Urgent & Emergency Care	\$5 co-pay for office; \$30 co-pay for ER, waived if admitted	\$10 co-pay for office; \$50co-pay for ER, waived if admitted	Full coverage for emergency services
OUTPATIENT CARE	HPHC Medicare Enhance	TUFTS Medicare Preferred	BCBS Medex 2

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	Freedom of Choice	Supplement Plan Freedom of Choice	Freedom of Choice
Mental Health & Substance Abuse	Biologically based mental conditions: All Medicare covered services \$5 co-pay	Biologically based mental conditions: - When covered by Medicare, full coverage of deductible and coinsurance after \$10 co-payment per visit. There is no visit limit.	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: Mental health: 24 visits per calendar year, \$5 co-pay per visit Substance abuse: \$500/calendar year, \$5 co-pay per visit	Non-Biologically based mental conditions: - When covered by Medicare, full coverage of deductible and coinsurance after \$10 copayment per visit. There is no visit limit. -Non-biologically-based mental conditions: - When covered by Medicare, full coverage after \$10 copayment per visit * Includes drug addiction and alcoholism.	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. 50% coinsurance from the 25th visit. * Includes drug addiction and alcoholism.
Routine Vision & Hearing Screenings	Not covered	Hearing - \$10 co-pay for the office visit. Hearing Aids – Reimbursement for \$500, then 80% of \$1500 every 2 yrs. for purchase or repair Routine Vision Exam \$10 co-pay (every 2 years) Eyeglasses or contacts - Covered up to \$150 reimbursement per year	One routine eye exam once every two calendar years
OUTPATIENT CARE	HPHC Medicare Enhance Freedom of Choice	TUFTS Medicare Preferred Supplement Plan Freedom of Choice	BCBS Medex 2 Freedom of Choice
Durable Medical Equipment	Covered in full	Covered in full	Covered in full
Preventive Dental	Not covered.	Not covered	Not covered.

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Shingles Vaccine	Covered in full when administered in the Physician's office	Covered in full when administered in the Physician's office	Covered in full when administered in the Physician's office
Ambulance Services	Covered in full	\$50 co-pay per day.	Covered in full (if medically necessary)
Prescription drugs	Retail: \$5 co-pay preferred generic \$10 co-pay non-preferred generic \$25 co-pay brand & specialty for a <u>30</u>-day supply Mail Order: \$10 co-pay preferred generic \$20 co-pay non-preferred generic \$75 co-pay brand & specialty for a <u>90</u>-day supply Provided by Aetna is the Prescription Benefits Manager (PBM) for retail and mail order (<i>formerly Coventry</i>)	Retail: 30-day supply: Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$35 co-pay Mail Order: 90-day supply Tier 1: \$20 co-pay Tier 2: \$40 co-pay Tier 3: \$70 co-pay CVS Caremark is the Prescription Benefits Manager (PBM) for retail and mail order	Retail: <i>up to 30-day supply:</i> Tier 1: \$5 co-pay Tier 2: \$10 co-pay Tier 3: \$25 co-pay Mail Order: <i>up to 90-day supply</i> Tier 1: \$10 co-pay Tier 2: \$20 co-pay Tier 3: \$50 co-pay RX Plan name is- Blue Medicare RX CVS Caremark is the Prescription Benefits Manager (PBM) for retail and mail order.
Other Benefits			
Fitness	Up to \$150 reimb per subscriber per cal. year at a Fitness facility. Discounts also available from participating Health Clubs. See plan details.	Up to \$150 reimbursement per calendar year per subscriber for joining a health club. No Waiting Period.	Fitness Reimbursement \$150. Weight loss Reimbursement \$150

BCBSMA Medex 2 Footnote

*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.

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**CAPE COD MUNICIPAL HEALTH GROUP - RETIREE PLAN BENEFITS
MEDICARE ADVANTAGE HMO PLANS – Effective January 1, 2019**

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Benefit changes or clarifications in red font

PLAN FEATURES	TUFTS Medicare Preferred HMO
	(This Medicare Advantage plan replaces traditional Medicare coverage)
INPATIENT CARE	January Renewal
General Hospital: Semi-private room & board and special services	Covered in full after one time annual deductible \$300
Rehabilitation Hospital	Covered in full for 90 days in benefit period.
Skilled Nursing Facility	Covered in full for 100 days in benefit period. No prior hospital stay is required.
Mental Health & Substance Abuse Care in a Psychiatric Hospital	\$0 co-pay - 190-day lifetime limit max
OUTPATIENT CARE	
Annual Routine Physical Exam	\$0 co-pay per visit
Medical Office Visits	\$10 co-pay to PCP \$15 specialist co-pay
Consult & Care by Specialists	\$15 co-pay per visit
Day Surgery	\$50 per day
Diagnostic Lab & X-ray Services	Covered in full
Radiation & Chemotherapy	Covered in full
Urgent & Emergency Care	\$10 co-pay for office; \$50 co-pay for ER, waived if admitted.
Shingles Vaccine	Covered in full when administered in the Physician's office
PLAN FEATURES	TUFTS Medicare Preferred HMO (a Medicare Advantage HMO)
OUTPATIENT CARE (cont'd)	
Ambulance Services	\$50 member co-pay per day
Mental Health & Substance Abuse	\$15 co-pay per visit

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CAPE COD MUNICIPAL HEALTH GROUP - RETIREE PLAN BENEFITS
MEDICARE ADVANTAGE HMO PLANS – Effective January 1, 2019

Chiropractic Services	
Routine Vision & Hearing Screenings	\$15 co-pay per visit. Up to \$150 per year toward the purchase of eyeglasses or contact lenses at an EyeMed provider. Up to \$90 per year at non-EyeMed providers. \$500 allowance for purchase or repair of hearing aids every 3 years. Other Discounts available through Hearing Care Solutions – see plan document for details.
Preventive Dental	Not covered
Prescription drugs	<i>Retail: 30-day supply</i> \$10 co-pay generic/ \$25 co-pay preferred brand/ \$50 co-pay non-preferred brand for <i>Mail Order: 30/60/90 day supply:</i> Tier 1: \$7/\$14/\$20 Tier 2: \$17/\$33/\$50 Tier 3: \$33/\$67/\$100 After you reach \$5,100 in your annual out-of-pocket drug costs, your cost is reduced to \$3.40 for generic and \$8.50 for brand name drugs.
FITNESS	You Pay
Fitness Center benefit	Fitness benefit – member receives up to \$150 per calendar year. No waiting period to receive reimbursement.

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DENNIS-YARMOUTH REGIONAL SCHOOL DISTRICT

RETIREE INSURANCES MONTHLY

FY19 Supplemental Plans 1/1/2019

FY 19 Insurances for Pre65 Medical, Retiree Dental, Life, Eye Med 7/1/2019

	RETIREE SHARE	DISTRICT SHARE	TOTAL PREMIUM
<u>MEDICARE SUPPLEMENTS</u>			
BCBS MEDEX II	\$147.20	\$220.80	\$368.00
HPHC MEDICARE ENHANCE	\$148.00	\$222.00	\$370.00
TUFTS MEDICARE PREFERRED HMO	\$126.80	\$190.20	\$317.00
TUFTS MEDICARE SUPPLEMENT WITH PDP Plus	\$157.20	\$235.80	\$393.00
<u>HARVARD PILGRIM (HMO)</u>			
INDIVIDUAL	\$340.80	\$511.20	\$852.00
PARENT WITH CHILD	\$681.60	\$1,022.40	\$1,704.00
FAMILY	\$911.60	\$1,367.40	\$2,279.00
<u>HARVARD PILGRIM (PPO)</u>			
INDIVIDUAL	\$374.00	\$561.00	\$935.00
PARENT WITH CHILD	\$748.00	\$1,122.00	\$1,870.00
FAMILY	\$989.60	\$1,484.40	\$2,474.00
<u>BCBS NETWORK BLUE NE HMO</u>			
INDIVIDUAL	\$343.20	\$514.80	\$858.00
PARENT WITH CHILD	\$692.40	\$1,038.60	\$1,731.00
FAMILY	\$921.20	\$1,381.80	\$2,303.00
<u>BCBS BLUE CARE ELECT (PPO)</u>			
INDIVIDUAL	\$448.40	\$672.60	\$1,121.00
PARENT WITH CHILD	\$899.60	\$1,349.40	\$2,249.00
FAMILY	\$1,123.20	\$1,684.80	\$2,808.00
<u>DELTA DENTAL</u>			
INDIVIDUAL	\$16.00	\$24.00	\$40.00
PARENT WITH CHILD	\$31.60	\$47.40	\$79.00
FAMILY	\$41.20	\$61.80	\$103.00
<u>LIFE</u>			
\$1,000	\$0.14	\$0.20	\$0.34
<u>EYEMED VISION PLAN</u>			
(Voluntary plan, not subsidized)			
INDIVIDUAL	\$7.53	\$0.00	7.53
2- Person	\$14.31	\$0.00	14.31
FAMILY	\$21.02	\$0.00	21.02