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| **ATTACHMENT 19** | | | | | |
| **Coverage for High Option Medicare Supplement and MAPD PPO Plans** | | | | | |
| **Medicare Part A (Hospitalization) Services All Benefits are Based on Medicare-Approved Amounts** | | | | | |
| **Indicate Type of Plan:** | | |  |  | |
| **Medicare Supplement** | | |  |  | |
| **MAPD PPO** | | |  |  | |
| **Part A Network Services** | | | **Supplier’s Plan Pays** | **HealthChoice Pays** | |
| **HOSPITALIZATION** | | |  |  | |
| Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies | | |  |  | |
| First sixty 60 days | | |  | 100% of the Part A deductible | |
| Days 61 through 90 | | |  | Coinsurance per day | |
| Days 91 and after while using Medicare's 60 lifetime reserve days | | |  | Coinsurance per day | |
| Once Medicare's lifetime reserve days are used, the plan provides additional lifetime reserve days | | |  | 100% of Medicare eligible expenses  Limited to 365 days | |
| Beyond the plan's lifetime reserve days | | |  | 0% | |
| **SKILLED NURSE FACILITY CARE** | | |  |  | |
| Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year | | |  |  | |
| First 20 days | | |  | 0% (Medicare pays all approved amounts) | |
| Days 21 through 100 | | |  | Coinsurance per day | |
| Days 101 and after | | |  | 0% | |
| **HOSPICE CARE** | | |  |  | |
| Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control | | |  | 0% (Medicare pays all but very limited coinsurance for outpatient palliative drugs or biologics and inpatient respite care) | |
| **BLOOD** | | |  |  | |
| Limited to the first 3 pints unless you or someone else donates blood to replace what you use | | |  | 100% | |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. | | | | | |
|  | | |  |  | |
| **Medicare Part B (Medical) ServicesAll Benefits are Based on Medicare-Approved Amounts** | | | | | |
| **Part B Network Services** | | | **Supplier’s Plan Pays** | **HealthChoice Pays** | |
| **MEDICAL EXPENSES** | | |  |  | |
| Medically necessary outpatient services and supplies  Includes doctor’s visits, out-patient hospital treatment, surgical services, physical and speech therapy and diagnostic tests | | |  | 20% after the Part B deductible | |
| **CLINICAL DIAGNOSTIC LABORATORY SERVICES** | | |  |  | |
| Includes blood tests, urinalysis and tissue pathology | | |  | 0% (Medicare pays 100%) | |
| **HOME HEALTH CARE** | | |  |  | |
| Includes intermittent skilled care and medical supplies | | |  | 0% (Medicare pays 100%) | |
| **DURABLE MEDICAL EQUIPMENT** | | |  |  | |
| Includes items such as nebulizers, wheelchairs and walkers | | |  | 20% after the Part B deductible | |
| **DIABETES MONITORING SUPPLIES** | | |  |  | |
| Includes coverage for glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor | | |  | 20% after the Part B deductible | |
| **OSTOMY SUPPLIES** | | |  |  | |
| Includes ostomy bags, wafers and other ostomy supplies for those who have a need based on their condition | | |  | 20% after the Part B deductible | |
| **BLOOD** | | |  |  | |
| Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use | | |  | 20% after the Part B deductible | |
| **OUTPATIENT PRESCRIPTIONS** | | |  |  | |
| Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs | | |  | 20% after the Part B deductible | |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. | | | | | |
| **Medicare Part B (Preventative) ServicesAll Benefits are Based on Medicare-Approved Amounts** | | | | | |
|  | | |  |  | |
| **Part B Network Services** | | | **Supplier’s Plan Pays** | **HealthChoice Pays** | |
| **INITIAL PREVENTIVE PHYSICAL EXAM** | | |  |  | |
| Includes a onetime “Welcome to Medicare Visit” for Medicare beneficiaries during the first 12 months of Part B coverage | | |  | 0% (Medicare pays 100%) | |
| **ANNUAL WELLNESS VISIT** | | |  |  | |
| Includes one visit every 12 months for Medicare beneficiaries who have been enrolled in Part B for more than 12 months | | |  | 0% (Medicare pays 100%) | |
| **SCREENING MAMMOGRAM** | | |  |  | |
| Once every 12 months for female Medicare beneficiaries ages 40 and older | | |  | 0% (Medicare pays 100%) | |
| **CARDIOVASUCLAR DISEASE SCREENING** | | |  |  | |
| Once every five years for all Medicare beneficiaries | | |  | 0% (Medicare pays 100%) | |
| **PAP TEST AND PELVIC EXAM** | | |  |  | |
| Once every 24 months; includes a clinical breast exam | | |  | 0% (Medicare pays 100%) | |
| Once every 12 months if high risk or abnormal Pap test in preceding 36 months | | |  |  | |
| **BONE MASS MEASUREMENTS** | | |  |  | |
| Once every 24 months for all Medicare beneficiaries at risk of losing bone mass | | |  | 0% (Medicare pays 100%) | |
| **GLAUCOMA SCREENING** | | |  |  | |
| Once every 12 months for Medicare beneficiaries at high risk or a family history of glaucoma | | |  | 20% after the Part B deductible | |
| Must be performed or supervised by an optometrist or ophthalmologist | | |  |  | |
| **COLORECTAL CANCER SCREENING** | | |  |  | |
| For all Medicare beneficiaries ages 50 and older | | |  | 0% (Medicare pays 100%) | |
| **FECAL OCCULT BLOOD TEST** | | |  |  | |
| Once every 12 months | | |  |  | |
| **FLEXIBLE SIGNOIDOSCOPY** | | |  |  | |
| Once every 4 years for those at high risk for colorectal cancer For those at normal risk, once every 4 years, or 119 months after a previous screening colonoscopy | | |  |  | |
| **COLONOSCOPY** | | |  |  | |
| Once every 2 years for those at high risk for colorectal cancer For those at normal risk, once every 10 years, or 47 months after a previous flexible sigmoidoscopy | | |  |  | |
| **BARIUM ENEMA** | | |  |  | |
| Doctor can substitute this test for a sigmoidoscopy or colonoscopy Procedure must be performed in an outpatient hospital setting or an ambulatory surgical center | | |  | 20% coinsurance | |
| **PROSTATE CANCER SCREENING** | | |  |  | |
| For all male Medicare beneficiaries ages 50 and older | | |  |  | |
| **DIGITAL RECTAL EXAM** | | |  |  | |
| Once every 12 months | | |  | 20% after the Part B deductible | |
| **PROSTATE SPECIFIC ANTIGEN TEST (PSA)** | | |  |  | |
| Once every 12 months | | |  | 0% (Medicare pays 100%) | |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. | | | | | |
|  | | |  |  | |
|  | | |  |  | |
| **Preventive Services - Vaccinations** | | | | | |
| Medicare covers the vaccine and administration at 100% if the provider accepts Medicare assignment. | | | | | |
| **Vaccination** | | | **Supplier’s Plan Pays** | **HealthChoice Pays** | |
| **Flu Vaccination** | | |  |  | |
| One per flu season | | |  | 0% | |
| **Pneumonia Vaccination** | | |  |  | |
| One time vaccination | | |  | 0% | |
| **Hepatitis B Vaccination** | | |  |  | |
| Medicare beneficiaries at medium to high risk for Hepatitis B | | |  | 0% | |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. | | | | | |
|  | | |  |  | |
| **Coverage for Additional Medical Services** | | | | | |
|  | | |  |  | |
| **Service** | | | **Supplier’s Plan Pays** | **HealthChoice Pays** | |
| **Foreign Travel** | | |  |  | |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. | | |  | 80% after you pay the first $250 each calendar year. $50,000 lifetime maximum | |
| **Pharmacy Copay Structure for Network Benefits** | | | | |
|  |  |  | | |
| **General Information** | **Supplier’s Plan Pays** | **HealthChoice SilverScript High Option** | | |
| These plans use a formulary |  | No annual deductible and no Coverage Gap. There is an annual out-of-pocket maximum of $4,850. | | |
| Mandatory generic and formulary medications you get at a Network Pharmacy  Some drugs require prior authorization  Quantity limits apply to certain drugs  Only copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximums  Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003  Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003  You will be notified before any changes are made to your plan's formulary | **30- Day Supply** | | | |
|  | **Generic (Tier 1) Drugs** Up to $10 copay | | |
|  | **Preferred (Tier 2) Drugs**  Up to $45 copay | | |
|  | **Non-Preferred (Tier 3) Drugs** Up to $75 copay | | |
|  | **Specialty (Tier 4) Drugs**  Up to $100 copay | | |
|  | **Preferred Tobacco Cessation (Tier 5) Drug**s $0 copay | | |
|  |  | | |
| **31- to 90-Day Supply** | | | |
|  | **Generic (Tier 1) Drugs** Up to $25 copay | | |
|  | **Preferred (Tier 2) Drugs**  Up to a $90 copay | | |
|  | **Non-Preferred (Tier 3) Drugs** Up to $150 copay | | |
|  | **Specialty (Tier 4) Drugs** Specialty drugs are available in only a 30-day supply | | |
|  | **Preferred Tobacco Cessation (Tier 5) Drugs** $0 copay | | |
|  | Once the out-of-pocket maximum of $4,850 is reached, you pay 0% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year. | | |