# Health New England Medicare Supplement Plus

GIC Retirees with Medicare: Effective 7/1/2022, choose the providers you want to see - no network restrictions, no referrals. You can see any provider who accepts Medicare. Use your Medicare Part A and Part B covered benefits - then we cover your cost sharing amounts, leaving little to no out-of-pocket cost for you. And with us, you get the benefit of a local health plan with an award winning customer service team. We're here to help you get the most out of your Medicare plan.

## Member Services Telephone Numbers

Group Medicare Supplement
**(413) 787-0010 or (877) 443-3314**

Representatives are available
Monday through Friday, 8:00 a.m. – 6:00 p.m.
Or visit **healthnewengland.org/gic**
TTY toll-free number is 711

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak any language other than English, language assistance services, free of charge, are available to you. Call (413) 787-0010 or TTY 711. Health New England cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (413) 787-0010 o TTY 711. Health New England cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (413) 787-0010 ou TTY 711.

# Health New England Medicare Supplement Plus

## Plan Highlights

Basic Benefits: Included in the plan.

Hospitalization: Part A coinsurance coverage for the first 90 days per benefit period and the 60 Medicare lifetime reserve days. This shall also include benefits for biologically based mental disorders.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments. This shall also include benefits for biologically based mental disorders.

Foreign Travel: Services you receive outside of the United States and its territories to treat an unexpected emergency medical condition.

## Read Your Handbook Carefully

This is only an outline describing your Plan's most important features. You must read the Handbook itself to understand all of the rights and duties of both you and the Plan. This outline of coverage does not give all the details of Original Medicare coverage. We cannot explain everything here. If you have questions about your coverage that are not answered here, read your Handbook. If you still have questions, call Member Services at (877) 443-3314. TTY users should call 711. We are open from 8:00 a.m. to 6:00 p.m. You may also wish to get a copy of Medicare & You, a small book put out by Medicare that describes Medicare benefits. To obtain this document contact Medicare at (800) 633-4227. TTY users should call (877) 486-2048. Or visit https://www.medicare.gov.

# Outline of Health New England Medicare Supplement Plus coverage

| Medicare Pays | Medicare Supplement Plus Pays | You Pay |
|---|---|---|
| **Ambulance Services** | | |
| Full benefits, except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Blood Services – Inpatient** | | |
| First 3 pints of blood per Calendar Year – Medicare pays | • All costs | • Nothing |
| Beyond 3 pints per Calendar Year – Medicare pays all costs | • Nothing | • Nothing |
| **Blood Services – Outpatient** | | |
| First 3 pints per Calendar Year – Medicare pays nothing | • All costs | • Nothing |
| After the first 3 pints, charges up to the Part B Deductible – Medicare pays nothing | • Part B Deductible | • Nothing |
| Remainder of Medicare approved amounts – Medicare pays 80% | • Part B Coinsurance | • Nothing |
| **Cardiac Rehabilitation** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |
| **Diabetic Supplies** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Diabetic Services** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit (screenings and diabetic management training) |
| **Diagnostic Tests: Laboratory and Radiology** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Durable Medical Equipment and Prosthetic Devices** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Dialysis Services** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |

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| **Emergency Room Care** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $50 Copay per visit (waived if admitted) |
| **Eye Care (Routine)** | | |
| When not covered by Medicare:<br>• Nothing<br><br>(*Refractions are only covered as part of an annual eye exam*) | When not covered by Medicare:<br>• Allowed amount charged less member copayment. Covered for 1 routine eye exam every 24 months. | • $15 Copay per visit |
| **Foreign Travel – Services received outside of the United States – Emergency Services Only** | | |
| • Nothing for emergency services Medicare does not cover because the services were received outside of the United States | • All expenses for emergency services that Medicare would have paid for if you received the services in the United States, plus the remainder of the emergency charges | • $50 copay per visit (waived if admitted) |
| **Hearing Aids over 21** | | |
| • Nothing | • First $500 covered in full, then remaining $1,500 covered at 80% (for both ears combined) | • 20% Coinsurance after the first $500 and all charges in excess of the benefit limit (for both ears combined) |
| **Home Health Care** | | |
| When covered by Medicare: Medicare covered home health care visits – covered in full | • Nothing | • Nothing |
| When covered by Medicare: Durable medical equipment covered by Medicare – full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| When not covered by Medicare:<br>• Nothing | When not covered by Medicare:<br>• Services paid in full | • Nothing |
| **Hospice Services** | | |
| When covered by Medicare: Full benefits for most services | When Medicare does not provide full benefits:<br>• The difference between the amount Medicare pays and the Allowed Charge | When covered by Medicare:<br>• Nothing |
| When not covered by Medicare:<br>• Nothing | When not covered by Medicare:<br>• Services paid in full | When not covered by Medicare: Nothing |

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| **Inpatient Hospital Admissions in a General Hospital – Medical and Surgical Care** | | |
| Hospital charges per Benefit Period –<br>full semi-private benefits except:<br>• Day 1–60: Part A Deductible<br>• Day 61-90: Part A Coinsurance<br>• 60 Lifetime Reserve Days: Part A Coinsurance | Per Benefit Period:<br>• Day 1-60: Part A Deductible<br>• Day 61-90: Part A Coinsurance<br>• 60 Lifetime Reserve Days: Part A Coinsurance | Per Benefit Period<br>• Day 1-60: Nothing<br>• Day 61-90: Nothing<br>• 60 Lifetime Reserve Days: Nothing<br>• After the above, you pay all charges |
| **Inpatient Hospital Admissions in a General Hospital – Physician and Professional Provider** | | |
| Physician and other professional Provider services – full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Inpatient Behavioral Health Services** | | |
| Inpatient stay in a general or behavioral health hospital, per Benefit Period – full benefits except:<br>• Day 1–60: Part A Deductible<br>• Day 61-90: Part A Coinsurance<br>• 60 Lifetime Reserve Days: Part A Coinsurance<br>Note: Medicare benefits in a behavioral health hospital are limited to 190 days per lifetime. | Inpatient stay in a general or behavioral health hospital Per Benefit Period:<br>• Day 1-60: Part A Deductible<br>• Day 61-90: Part A Coinsurance<br>• 60 Lifetime Reserve Days: Part A Coinsurance | Inpatient stay in a general or behavioral health hospital Per Benefit Period:<br>• Day 1-60: Nothing<br>• Day 61-90: Nothing<br>• 60 Lifetime Reserve Days: Nothing<br>• After the above, you pay all charges |
| Inpatient physician and other covered professional behavioral health Provider services for as many days as Medically Necessary – full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | Inpatient physician and other covered professional behavioral health Provider services covered by Medicare and the Plan for as many days as Medically Necessary in a general Hospital:<br>• Part B Deductible<br>• Part B Coinsurance<br>• Covered Services for as many days as Medically Necessary in a general hospital, and up to 120 additional days per benefit period (at least 60 days per Calendar Year) in a behavioral hospital when covered only by the Plan | Inpatient physician and other covered professional behavioral health Provider services:<br>• Nothing for as many days as Medically Necessary |

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| **Medical Care – Specialist, Clinic, Office and Home Visits (Applies to Medical and Behavioral** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |
| **Outpatient Hospital Care – Medical or Surgical** | | |
| Charges in a general Hospital facility or Ambulatory Surgical Center – full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Oxygen and Equipment** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Podiatry Services** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |
| **Prescription Drugs** | | |
| Outpatient Drug Coverage under Medicare Part B<br>When covered by Medicare, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | When covered by Medicare:<br>• Part B Deductible<br>• Part B Coinsurance | When covered by Medicare:<br>• Nothing |
| Outpatient Drug Coverage for drugs not covered under Medicare Part B<br>• Nothing | Benefits are administered through SilverScript®. For questions about your prescription drug coverage, please contact SilverScript® at (877) 876-7214. TTY user should call 711. | |
| **Preventive Care** | | |
| **"**Welcome to Medicare" preventive visit within 12 months after Part B coverage begins, full benefits | • Nothing † | • Nothing |
| Yearly "Wellness" visit, full benefits | • Nothing † | • Nothing |
| Annual physical exam:<br>• Nothing | • Covered for one exam per calendar year † | • Nothing |
| Bone mass density testing, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |

† If your provider orders services not covered under this preventive benefit, Part B Deductible and Part B Coinsurance may apply. The Plan will cover the Part B Coinsurance and the Part B Deductible.

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| Cardiovascular screening (routine), full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| Colorectal Screening (routine), full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| Diabetes self-management training, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| Family planning, counseling & treatment<br>• Nothing | • Benefits as required by Massachusetts state mandate | • Nothing |
| Glaucoma testing, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| GYN exams (routine) and Pap smear tests (routine) covered by Medicare, full benefits | • Nothing | • Nothing |
| Pap smear tests (routine) not covered by Medicare:<br>• Nothing | • Full coverage for one routine PAP smear test each Calendar Year | • Nothing |
| Mammograms (routine), full benefits | • Nothing | • Nothing |
| Prostate cancer screening (routine), full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| Medicare approved smoking cessation program, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing<br>(For information about coverage for prescription drugs, please contact SilverScript® at (877) 876-7214. TTY user should call 711.) |
| **Radiation and X-Ray Therapy** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |

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| **Scalp Hair Prosthesis (Wigs) for hair loss due to treatment of any form of cancer or** | | |
| • Nothing | • Up to $350 per benefit year | • All charges after $350 per benefit year |
| **Second Opinions** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |
| **Short-Term Rehabilitation Therapy: Physical, Occupational and Speech/Language Therapy** | | |
| For services covered by Medicare, full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | For services covered by Medicare:<br>• Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |
| **Skilled Nursing Facility Services** | | |
| In a Skilled Nursing Facility that participates with Medicare, per Benefit Period:<br>• Day 1-20: full benefits<br>• Day 21-100: full benefits except the Part A Coinsurance<br>• Day 101-365: Nothing<br>• Beyond day 365: Nothing | In a Skilled Nursing Facility that participates with Medicare, per Benefit Period:<br>• Day 1-20: Nothing<br>• Day 21-100: Part A Coinsurance<br>• Day 101-365: $10 a day<br>• Beyond day 365: Nothing | In a Skilled Nursing Facility that participates with Medicare, per Benefit Period:<br>• Day 1-20: Nothing<br>• Day 21-100: Nothing<br>• Day 101-365: All charges after $10 a day<br>• Beyond day 365: All charges |
| In a Skilled Nursing Facility that does not participate with Medicare, per Benefit Period:<br>• Day 1-365: Nothing<br>• Beyond day 365: Nothing | In a Skilled Nursing Facility that does not participate with Medicare, per Benefit Period:<br>• Day 1-365: $8 a day<br>• Beyond day 365: Nothing | In a Skilled Nursing Facility that does not participate with Medicare, per Benefit Period:<br>• Day 1-365: All charges after $8 a day<br>• Beyond day 365: All charges |
| **Surgery as an Outpatient** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • Nothing |
| **Urgent care** | | |
| Full benefits except:<br>• Part B Deductible<br>• Part B Coinsurance | • Part B Deductible<br>• Part B Coinsurance | • $15 Copay per visit |

(For benefits not covered under Medicare Parts A and B)

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| **Autism Spectrum Disorder** | | |
| • Not covered by Medicare | • All costs less any applicable Copay per visit | • $15 Copay per visit<br><br>(Neuropsychological evaluation, psychological care, therapeutic care when services provided by licensed or certified speech therapist, occupational therapist or physical therapist) |
| **Enteral Formulas, Low Protein Food Products** | | |
| When covered by Medicare: Full benefits except:<br><br>• Part B Deductible<br>• Part B Coinsurance | When covered by Medicare:<br><br>• Part B Deductible<br>• Part B Coinsurance | When covered by Medicare:<br><br>• Nothing |
| When not covered by Medicare:<br><br>• Nothing | When not covered by Medicare, benefits in full for:<br><br>• Certain enteral formulas<br>• Low protein food products up to $5,000 per Calendar Year. | When not covered by Medicare:<br><br>• Nothing for certain enteral formulas<br>• All charges for low protein food products after the Plan pays $5,000 in a benefit year |