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 (not including the Medicare Part A deductible) 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.

Blood: First three pints of blood each year.

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.

Outline of Health New England Medicare Supplement Plus coverage

Medicare Pays	Medicare Supplement Plus Pays	You Pay
Ambulance Services		
Full benefits, except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Blood Services – Inpatient		
First 3 pints of blood per Calendar Year – Medicare pays nothing	• 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: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 Copay per visit
Diabetic Supplies		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Diabetic Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 Copay per visit (screenings and diabetic management training)
Diagnostic Tests: Laboratory and Radiology		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Durable Medical Equipment and Prosthetic Devices		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Dialysis Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Emergency Room Care		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $50 Copay per visit (waived if admitted)
Eye Care (Routine)		
When not covered by Medicare: • Nothing	When not covered by Medicare: • Allowed amount charged less member copayment. Covered for 1 routine eye exam every 24 months.	• $15 Copay per visit

Medicare Pays	Medicare Supplement Plus Pays	You Pay
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%	• 20% Coinsurance after the first $500 and all charges in excess of the benefit limit
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: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
When not covered by Medicare: • Nothing	**When not covered by Medicare:** • Covered Services paid in full	• Nothing
Hospice Services		
When covered by Medicare: Full benefits for most services	**When Medicare does not provide full benefits:** • The difference between the amount Medicare pays and the Allowed Charge	**When covered by Medicare:** • Nothing
When not covered by Medicare: • Nothing	**When not covered by Medicare:** • Covered Services paid in full	**When not covered by Medicare:** Nothing
Inpatient Hospital Admissions in a General Hospital – Medical and Surgical Care		
Hospital charges per Benefit Period – full semi-private benefits except: • Day 1–60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	Per Benefit Period: • Day 1-60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	Per Benefit Period • Day 1-60: Nothing • Day 61-90: Nothing • 60 Lifetime Reserve Days: Nothing • After the above, you pay all charges
Inpatient Hospital Admissions in a General Hospital – Physician and Professional Provider Services		
Physician and other professional Provider services – full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Inpatient Behavioral Health Services		
Inpatient stay in a general or behavioral health hospital, per Benefit Period – full benefits except: • Day 1–60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance **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: • Day 1-60: Part A Deductible • Day 61-90: Part A Coinsurance • 60 Lifetime Reserve Days: Part A Coinsurance	Inpatient stay in a general or behavioral health hospital Per Benefit Period: • Day 1-60: Nothing • Day 61-90: Nothing • 60 Lifetime Reserve Days: Nothing • After the above, you pay all charges

Medicare Pays	Medicare Supplement Plus Pays	You Pay
Inpatient Behavioral Health Admissions in a Behavioral Health Hospital - Physician & Professional Provider Services		
Inpatient physician and other covered professional behavioral health Provider services for as many days as Medically Necessary – full benefits except: • Part B Deductible • 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: • Part B Deductible • Part B Coinsurance • 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: • Nothing for as many days as Medically Necessary
Medical Care – Specialist, Clinic, Office and Home Visits (Applies to Medical and Behavioral Health Care)		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • 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: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Oxygen and Equipment		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Podiatry Services		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 Copay per visit
Prescription Drugs		
Outpatient Drug Coverage under Medicare Part B When covered by Medicare, full benefits except: • Part B Deductible • Part B Coinsurance	When covered by Medicare: • Part B Deductible • Part B Coinsurance	When covered by Medicare: • Nothing
Outpatient Drug Coverage for drugs *not* covered under Medicare Part B • 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 †
Bone mass density testing, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • 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.

Medicare Pays	Medicare Supplement Plus Pays	You Pay
Cardiovascular screening (routine), full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Colorectal Screening (routine), full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Diabetes self-management training, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Family planning, counseling & treatment • Nothing	• Benefits as required by Massachusetts state mandate	• Nothing
Glaucoma testing, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • 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: • 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: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Medicare approved smoking cessation program, full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing (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: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Scalp Hair Prosthesis (Wigs) for hair loss due to treatment of any form of cancer or leukemia		
• Nothing	• Up to $350 per benefit year	• All charges after $350 per benefit year
Second Opinions		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • 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: • Part B Deductible • Part B Coinsurance	For services covered by Medicare: • Part B Deductible • Part B Coinsurance	• $15 Copay per visit

Medicare Pays	Medicare Supplement Plus Pays	You Pay
Skilled Nursing Facility Services		
In a **Skilled Nursing Facility that participates with Medicare**, per Benefit Period: • Day 1-20: full benefits • Day 21-100: full benefits except the Part A Coinsurance • Day 101-365: Nothing • Beyond day 365: Nothing	In a **Skilled Nursing Facility that participates with Medicare**, per Benefit Period: • Day 1-20: Nothing • Day 21-100: Part A Coinsurance • Day 101-365: $10 a day • Beyond day 365: Nothing	In a **Skilled Nursing Facility that participates with Medicare,** per Benefit Period: • Day 1-20: Nothing • Day 21-100: Nothing • Day 101-365: All charges after $10 a day • Beyond day 365: All charges
In a Skilled Nursing Facility that **does not participate with Medicare,** per Benefit Period: • Day 1-365: Nothing • Beyond day 365: Nothing	In a Skilled Nursing Facility that **does not participate with Medicare**, per Benefit Period: • Day 1-365: $8 a day • Beyond day 365: Nothing	In a Skilled Nursing Facility that **does not participate with Medicare**, per Benefit Period: • Day 1-365: All charges after $8 a day • Beyond day 365: All charges
Surgery as an Outpatient		
Full benefits except: • Part B Deductible • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• Nothing
Urgent care		
Full benefits except: • Part B Coinsurance • Part B Coinsurance	• Part B Deductible • Part B Coinsurance	• $15 Copay per visit

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

Medicare Pays	Medicare Supplement Plus Pays	You Pay
Autism Spectrum Disorder		
• Not covered by Medicare	• All costs less any applicable Copay per visit	• $15 Copay per visit (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: • Part B Deductible • Part B Coinsurance	When covered by Medicare: • Part B Deductible • Part B Coinsurance	When covered by Medicare: • Nothing
When not covered by Medicare: • Nothing	When not covered by Medicare, benefits in full for: • Certain enteral formulas • Low protein food products up to $5,000 per Calendar Year.	When not covered by Medicare: • Nothing for certain enteral formulas • All charges for low protein food products after the Plan pays $5,000 in a benefit year