

# Employer Group Waiver Plan Overview Chart—Calendar Year 2024



## Medicare Secure Freedom (HMO-POS)

In Network

Out of Network<sup>6</sup>

### MONTHLY PLAN PREMIUM

Check with your Account Executive

Medical Deductible	\$0	\$0
Annual Preventive Exam	\$0	\$0
Office Visits	\$15	\$55
Specialist Office Visits	\$15	\$55
Lab Work/X-rays	\$0	\$0
Diagnostic Imaging (MRI, PET, CT Scans) <sup>1</sup>	\$50	\$200 <sup>PA</sup>
Durable Medical Equipment/Prosthetics <sup>1</sup>	\$0	20% coinsurance <sup>PA</sup>
Teladoc <sup>4</sup>	\$0	N/A
Worldwide Emergency Room (ER)	\$65	\$65
Inpatient Hospital	\$300 per admission	\$900 per admission <sup>PA</sup>
Outpatient Surgery <sup>1</sup>	\$150	\$450
Medical Out-of-Pocket Maximum	\$3,400	No maximum

### ADDITIONAL BENEFITS

Over-the-Counter (OTC) Items Allowance <sup>5</sup>	\$40 per quarter	
Preventive Hearing Exam <sup>2</sup>	\$15	\$55
Hearing Aid Benefit—TruHearing <sup>® 3</sup>	\$699 copay per aid for Advanced Aids \$999 copay per aid for Premium Aids	N/A
Preventive Vision Exam—EyeMed <sup>® 2†</sup>	\$0	N/A
Vision Eyewear Allowance—EyeMed <sup>® 2†</sup>	\$200 every two years	N/A
Dental Services Allowance <sup>2</sup>	\$250 allowance per year via Additional Benefits Card	
Fitness Center/ Weight Management Programs/Acupuncture/Activity Tracker <sup>2</sup>	\$150 allowance per year via Additional Benefits Card	

### PRESCRIPTION DRUG (PART D) COVERAGE

The Medicare Secure Freedom (HMO-POS) plan offers additional donut-hole (gap) coverage. Catastrophic cost sharing still applies.

Initial Coverage: Up to \$5,030 in Drug Costs	<b>Preferred Generic:</b> \$0 preferred pharmacy/\$4 standard pharmacy; <b>Generic:</b> \$5 preferred pharmacy/\$10 standard pharmacy; <b>Preferred Brand:</b> \$20 preferred pharmacy/\$25 standard pharmacy; <b>Non-Preferred Drug:</b> \$40 preferred pharmacy/\$45 standard pharmacy; <b>Specialty Tier:</b> \$45 preferred pharmacy/\$50 standard pharmacy
Coverage Gap: Over \$5,030 in Drug Costs; Up to \$8,000 in Out-of-Pocket Costs	
Catastrophic Coverage: Over \$8,000 in Out-of-Pocket Costs	If you reach the Catastrophic Coverage stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.
Mail Order (three-month supply)	\$8 Preferred Generic   \$20 Generic   \$50 Preferred Brand   \$135 Non-Preferred Drug

## Disclaimers

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Health New England Medicare Advantage is an HMO, HMO-POS, and PPO Plan with a Medicare contract. Enrollment in Health New England Medicare Advantage depends on contract renewal.

<sup>1</sup>Some services require prior authorization (PA). Our network providers know what we cover under your benefit plan. They also know what requires prior authorization and will request approval from Health New England on your behalf. For a complete list of services that require prior authorization, refer to the summary of benefits.

<sup>2</sup>Health New England additional benefits include allowances that must be used within the one or two calendar year period, as well as other additional benefits. Refer to the Summary of Benefits or call Member Services if you have questions about what items and services are covered.

<sup>3</sup>You must see a TruHearing<sup>®</sup> provider to use this benefit. Please note, hearing aids purchased through other providers are not covered. Other providers are available in our network.

<sup>4</sup>You must use Teladoc<sup>®</sup> service to receive this benefit.

<sup>5</sup>The OTC benefit can only be redeemed through Optum<sup>®</sup> Personal Care Benefits. Quarterly credits expire every three months and do not accumulate.

<sup>6</sup>Out-of-network/non-contracted providers are under no obligation to treat Health New England Medicare Advantage members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services

<sup>†</sup>You must use an EyeMed<sup>®</sup> provider.

<sup>PA</sup> Members of the Health New England Medicare Secure Freedom (HMO-POS) plan who choose to get these services out-of-network are responsible for getting prior authorization from Health New England. Please tell your out-of-network provider that prior authorization is required. The provider may be willing to contact Health New England Member Services for you to get prior authorization. Call Member Services to confirm prior authorization. For a complete list of services that require prior authorization, refer to the Summary of Benefits.

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.

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