2024 Summary of Benefits

Health New England Medicare Advantage HMO Plans with Part D Prescription Drug Coverage:

Health New England Baystate Health Preferred (HMO)

January 1, 2024 – December 31, 2024

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SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at (413)787-0010, toll free (877)443-3314 or TTY: 711 to request the **"Evidence of Coverage"** or visit www.healthnewengland.org/medicare.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Health New England Baystate Health Preferred (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health New England Baystate Health Preferred (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE
  (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Health New England Baystate Health Preferred (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at (877)443-3314 (TTY: 711).

Things to Know About Health New England Baystate Health Preferred (HMO)

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Health New England Baystate Health Preferred (HMO) Phone Numbers and Website

- If you are a member of this plan, call us at (413)787-0010, toll free (877)443-3314 or TTY: 711.
- If you are not a member of this plan, call us at (413)787-0010, toll free (877)443-3314 or TTY: 711.
- Our website: www.healthnewengland.org/medicare

SUMMARY OF BENEFITS

Who can join?

To join **Health New England Baystate Health Preferred (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Massachusetts: Hampden and Hampshire.

Which doctors, hospitals, and pharmacies can I use?

Health New England Baystate Health Preferred (HMO), has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website www.healthnewengland.org/medicare.

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Health New England Medicare Advantage Plans for details.

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Monthly Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan does not have a medical deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: • $6,500 for services you receive from in-network providers. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
INPATIENT AND OUTPATIENT CARE AND SERVICES	
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $370 copay per day for Days 1 through 5 per admission. • You pay nothing per day for Days 6 through 90 per admission. • There is a $5,550 out-of-pocket limit every year.
Outpatient Hospital Coverage[1]	$0-400 copay, depending on the service. The copayment range for Outpatient Hospital Services describes the varying cost share based on the services provided. The minimum copayment applies to services related to the monitoring of Coumadin treatment. The maximum copayment applies to all other outpatient clinic services.
Ambulatory Surgical Center (ASC)	$250 Copay.
Doctor Visits	Primary Care Provider: You pay nothing. Specialists: $30 copay. No referral required for network doctors, specialists, and hospitals.
Preventive Care	You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$90 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Includes worldwide coverage.
Urgently Needed Services	$35 copay. Includes worldwide coverage.

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Diagnostic Services/Labs/Imaging[1] ***(Costs for these services may be different if received in an outpatient surgery setting)***	Diagnostic tests and procedures: $25 copay. Lab services: $25 copay. Outpatient x-rays: $25 copay. Diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology)[1]: $275 copay.
Hearing Services **Hearing Aids**	Exam to diagnose and treat hearing and balance issues: $30 copay. One routine hearing exam every year: $30 copay. $499 copay per aid for Standard Aids $699 copay per aid for Advanced Aids $999 copay per aid for Premium Aids Up to two Hearing Aids per year. Must use a TruHearing provider to use this benefit.
Dental Services[1]	Limited dental services (dental care required to treat illness or injury): $30-400 copay depending on the services. Our plan has a $1,225 allowance for Dental Benefits. See the – *"Additional Services – Additional Benefit Card"* section for more information.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $30 copay, depending on the service. One routine eye exam every year: You pay nothing. You must use an EyeMed vision provider for this benefit. Our plan pays up to $200 every two years for eyewear. You must use an EyeMed vision provider for this benefit.
Mental Health Care[1]	Inpatient visit: • $370 copay per day for Days 1 through 5 per admission. • You pay nothing per day for Days 6 through 90 per admission. Outpatient group therapy visit: $30 copay. Outpatient individual therapy visit: $30 copay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

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Health New England Baystate Health Preferred (HMO)

PRESCRIPTION DRUG BENEFITS[2]

Cost may differ based on pharmacy type or status. Our plan has preferred pharmacies which offer lower copays for drugs compared to a standard pharmacy.

Deductible	$270 for Tier 3, Tier 4, Tier 5

Initial Coverage

After you pay your yearly deductible you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Preferred Retail Cost-Sharing[2]

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$15 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$120 copay
Tier 4 (Non-Preferred Drug)	$90 copay	$180 copay	$270 copay
Tier 5 (Specialty Tier)	26% coinsurance	Not Applicable	Not Applicable

Preferred Mail Order[2]

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$80 copay
Tier 4 (Non-Preferred Drug)	$270 copay
Tier 5 (Specialty Tier)	Not Applicable

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$4 copay	$8 copay	$12 copay
Tier 2 (Generic)	$10 copay	$20 copay	$30 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$285 copay
Tier 5 (Specialty Tier)	26% coinsurance	Not Applicable	Not Applicable

Standard Mail Order

Tier	Three-month supply
Tier 1 (Preferred Generic)	$8 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$90 copay
Tier 4 (Non-Preferred Drug)	$285 copay
Tier 5 (Specialty Tier)	Not Applicable

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• If you reside in a long-term care facility, you pay the same as at a retail pharmacy. • If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Brand cost sharing.	
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000 which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000 you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit. You will remain in this payment stage until the end of the calendar year.
Part D Insulins	You will pay $35 or less for a 30-day supply of a covered insulin product at any in-network Pharmacy. This applies across all phases of prescription drug coverage. If you received a 90-day supply of a covered insulin product your costs cannot be more than $105 (or $35 for each month's supply). The cost of a 90-day supply through mail order may differ based on the pharmacy type or status. Please refer to your 2024 Formulary.
ADDITIONAL SERVICES	
Additional Benefits Card	The Additional Benefits Card is preloaded with funds that can be used for supplemental benefits such as fitness, acupuncture, weight management programs, activity tracker, eyewear, hearing aid, and dental care. Use the card to pay a portion, or the full cost, of a service or an item. Allowance amounts are $800 for the Fitness Benefit and $1,225 for the Dental Benefit.
Ambulance[1]	$250 copay. Ambulance transportation limited to Medicare covered medically necessary ambulance services. Chair Vans are not covered.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay.
Home Health Care[1]	You pay nothing.

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Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit[1]: You pay nothing.
Meal Benefit	If you are discharged from an inpatient hospital or skilled nursing stay you may qualify to receive up to 14 fully-prepared, nutritious home-delivered meals (2 meals per day for 7 days) by a plan approved vendor at no cost.
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs[1]: 20% coinsurance. Other Part B drugs[1]: 20% coinsurance.
Nutritional Grocery Store Program	The Nutritional Grocery Store Program is designed to engage and empower members who have at least two chronic conditions (diabetes, cardiovascular disease or congestive heart failure) to improve their health by focusing on nutrition. Health New England is partnering with Big Y® Supermarkets and their consulting registered dietitians to offer eligible members a grocery store tour (in-person or virtual) to help you develop a better understanding of healthy shopping and healthy eating. After completion of the grocery store tour with a registered dietitian, you will receive a $100 reward for health-related food purchases at Big Y.** **The Nutritional Grocery Store Program benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify. The $100 reward will be applied to your Big Y member card account for health-related food purchases.
Outpatient Substance Abuse	Group therapy visit: $40 copay. Individual therapy visit: $40 copay.
Over-the-Counter Items	Limited to $65 every three months for specific over-the-counter drugs and other health-related pharmacy products, as listed in the OTC catalog.
Physical Therapy[1]	Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay.
Renal Dialysis	20% coinsurance.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for Days 1 through 20 per day. • $180 copay per day for Days 21 through 50 per day. • You pay nothing per day for Days 51 through 100 per day. No prior hospital stay is required.

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Telehealth Services	Teladoc: You pay nothing Primary Care Provider: You pay nothing Specialists: You pay nothing
Transportation	Not covered.

[1]Prior authorization may be required for certain covered medical and hospital benefits

[2]Health New England Preferred Mail Order Pharmacies: OptumRX® and WelldyneRX®

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.