Rochester City School District
2023 Survivor Over 65 Health Insurance Comparison Summary
All Plans Require Enrollment in Medicare Parts A & B

Services	Basic Blue Cross Blue Shield $258.95	Retiree+ Enhanced EPO (Monthly Premium of $773.83)	Medicare Blue Choice HMO-POS (Monthly Premium of $79.06)	MVP Preferred Buy Up Plan (Monthly Premium of $228.75)	MVP Preferred Gold Standard Plan (Monthly Premium of $180.66)
SERVICE AREA			Livingston, Monroe, Ontario, Seneca, Wayne, Yates, Steuben, Schuyler, Chemung, Cayuga, Thompkins, Tioga, Oswego, Onondaga, Cortland, Broome, Jefferson, St. Lawrence, Franklin, Clinton, Essex, Hamilton, Fulton, Montgomery, Herkimer, Oneida, Lewis, Madison, Otsego, Chenango and Delaware counties	Any county within the State of New York (with the exception of counties in New York City & Long Island)	Any county within the State of New York (with the exception of counties in New York City & Long Island)
HOSPITAL INPATIENT SERVICES					
Hospital Services	Covers Medicare Part A inpatient deductible, hospital coinsurance for days 61-90 and full coverage for days 91-120. Private room covered when medically necessary.	Covered in full for unlimited days, precertification applies	$250 copayment per admission unlimited days (3 maximum per year annual $750)	Unlimited days of semiprivate accommodations and all medically necessary services for acute care covered in full.	Unlimited days of semiprivate accommodations and all medically necessary services for acute care covered in full after $250 copayment per stay, $750 annual maximum.
Skilled Nursing Facility	Covers Medicare SNF coinsurance for days 21-100 and full coverage for days 101-120. Custodial care is not covered.	Covered in full for up to 120 days per calendar year, 360 day lifetime max, precertification applies	$0/day for days 1-20; $196/day for days 21-100	Covered in Full days 1-20, $135 per day for days 21-100.	$0/day for days 1-20; $160 per day for days 21-100
Hospice	Covered in full for the same number of approved Medicare days	Covered in full	Covered in full	Covered by Medicare	Covered by Medicare
HOSPITAL OUTPATIENT SERVICES					
Diagnostic X-Ray	No coverage	$15 copay per visit, precertification applies to MRI, PET and CAT scans	$15 copay per visit	$15 copayment per visit	$30 copayment, $60 copayment for MRI, CT or PET Scan.
Diagnostic Laboratory and Pathology	No coverage	Covered in full	Covered in full	Covered in full.	Covered in full with routine physical, $10 copayment other
Chemotherapy	Covers Medicare Part B deductible and 20% coinsurance	Covered in full	$15 copay per visit, 20% coinsurance for Part B infused drugs.	Covered in full in inpatient setting. Drugs picked up at pharmacy are subject to part B or part D cost-sharing. IV/injectable chemotherapy covered with a $15 provider administered drug copayment.	Covered in full in inpatient setting. Drugs picked up at pharmacy are subject to part B or part D cost-sharing. IV/injectable chemotherapy covered with a 20% coinsurance.
Radiation Therapy	Covers Medicare Part B deductible and 20% coinsurance	Covered in full	$15 copay per visit	Covered in full	Covered in full
Surgical Care	Covers Medicare Part B deductible and 20% coinsurance	$15 copay per visit	$50 copay per visit. Office surgery $15 copay per visit.	Covered in full	$60 hospital/$30 Surgical Center
EMERGENCY SERVICES					
Emergency and Urgent Care	Emergency Room Care for Emergency Medical Conditions - Balance after Medicare is covered in full	Emergency room - $50 copay – waived if admitted within 24 hours Freestanding Urgent Care Center - $25 copay	Emergency room $65 copay – waived if admitted within 23 hours, worldwide coverage; Urgent Care $15 copay	Emergency Room - $65 copayment in not followed by hospital admission. Urgently Need Care - $15 copayment per visit. Worldwide coverage.	Emergency Room - $75 copayment if not followed by hospital admission. Worldwide coverage. Urgently Needed Care - $30 copayment per visit. Worldwide coverage.
PHYSICIAN SERVICES					
Hospital Inpatient					
Physician Visits	Covers Medicare Part B deductible, 20% coinsurance and additional amounts for covered services up to the Blue Shield Schedule of Allowances.	Covered in full	Covered in full; copayment applies after surgery	Covered in full.	Covered in full; copayment applies after surgery.

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Surgery	Covers Medicare Part B deductible, 20% coinsurance and additional amounts for covered services up to the Blue Shield Schedule of Allowances.	Covered in full	Covered in full	Covered in full.	Covered in full
Anesthesia	Covers Medicare Part B deductible, 20% coinsurance and additional amounts for covered services up to the Blue Shield Schedule of Allowances.	Covered in full	Covered in full	Covered in full.	Covered in full.
Physician's Office					
Diagnostic Office Visits	No coverage	$15 copay per visit	$15 copay per visit	$10 copayment per visit, $15 specialist	$15 copay per visit PCP, $30 specialist
Routine Physical Exam	No coverage	Covered in full – one per year	Covered in full – one per year	Covered in full	Covered in full.
Pap Smear	Periodic routine pap smears - Balance after Medicare is covered in full	Covered in full	Covered in full	Covered in full.	Covered in full
Mammograms	Periodic routine mammograms - Covers Medicare Part B deductible and 80% of the difference between the Medicare payment and the Blue Shield Schedule of Allowances.	Covered in full	Covered in full	Covered in full	Covered in full
Prostate cancer screening	No coverage	$15 copay per visit	Covered in full	Covered in full	Covered in full.
Bone Density Testing	No coverage	$15 copay per visit	Covered in full	Covered in full	Covered in full.
Colorectal Screening	No coverage	$15 copay per visit	Covered in full	Covered in full	Covered in full.
Allergy Tests and Injections	No coverage	$15 copay per visit	$15 copay per visit	$10 copayment per visit PCP. Serum covered in full. $15 copayment per visit to a specialist.	$15 copayment per visit PCP. Serum covered in full. $30 copayment per visit to a specialist.
Adult Immunizations	No coverage	Covered in full	Covered in full	Pneumonia and Flu Shots covered in full. Office Visit copayment may apply.	Pneumonia and Flu shots covered in full. Office visit copayment may apply.
Eye Exams	No coverage for eye exams. No coverage for eyeglasses.	$15 copay for one routine exam per calendar year; $100 eyewear allowance available per calendar year.	$15 copay for one routine exam per calendar year; $100 eyewear allowance available annually	$15 charge per visit. Routine allowed once every year. Unlimited visits for disease or injury. $100 credit toward the purchase of glasses (frames and lenses) every two years. Covered at 80% for corrective lenses following cataract surgery	$30 charge per visit. Routine allowed once per year. Unlimited visits for disease or injury; $100 allowance toward the purchase of glasses (frames and lenses) every two years. Covered at 80% for corrective lenses following cataract surgery.
Hearing Evaluations	No coverage for hearing Evaluations. Hearing aids are not covered.	$15 copay for diagnostic exam, no coverage for routine exam, hearing aids covered up to $600 for up to 2 hearing aids every 3 years for children to age 19.	$0 copay for annual hearing exam (through a TruHearing provider). $499 copay for Advanced hearing Aids or $799 copay for Premium Hearing Aids. Limit of 2 per year. Must use a TruHearing provider. TruHearing copays are not included in the Out of Pocket Maximum.	$0 copay for exam. $699 copay for TruHearing Advanced hearing Aids or $999 copay for Premium Hearing Aids with rechargeability, maximum of 2 aids per year. Or $600 Hearing Aid allowance (and TruHearing discounts) through 6 manufacturers when purchased from TruHearing, maximum 2 per year. Includes a 3-year supply of batteries on non-rechargeable hearing aids. Hearing aid copyament and allowance cannot be combined.	$0 copay for exam. $699 copay for TruHearing Advanced hearing Aids or $999 copay for Premium Hearing Aids with rechargeability, maximum of 2 aids per year. Or $600 Hearing Aid allowance (and TruHearing discounts) through 6 manufacturers when purchased from TruHearing, maximum 2 per year. Includes a 3-year supply of batteries on non-rechargeable hearing aids. Hearing aid copyament and allowance cannot be combined.

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Chemotherapy	Covers Medicare Part B deductible, 20% coinsurance and additional amounts for covered services up to the Blue Shield Schedule of Allowances.	Covered in full	$15 copay per visit, 20% coinsurance for Part B infused drugs.	Covered in full in inpatient setting. Drugs picked up at pharmacy are subject to part B or part D cost-sharing. IV/injectable chemotherapy covered with a $15 administered drug copayment	Covered in full in inpatient setting. Drugs picked up at pharmacy are subject to part B or part D cost-sharing. IV/injectable chemotherapy covered with a 20% coinsurance
Radiation Therapy	Covers Medicare Part B deductible, 20% coinsurance and additional amounts for covered services up to the Blue Shield Schedule of Allowances.	Covered in full	$15 copay	Covered in full.	Covered in full
Diagnostic Laboratory and Pathology	No coverage	Covered in full	Covered in full	Covered in full.	Covered in full with routine physical, $10 copayment other
Diagnostic X-Ray	Covers Medicare Part B deductible and 80% of the difference between the Medicare payment and the Blue Shield Schedule of Allowances.	$15 copay per visit, precertification applies to MRI, PET and CAT scans	$15 copay	$15 copayment	$30 copayment. $60 CT, PET, MRI scans
Podiatry	No coverage	No coverage	$15 copay when medically necessary	$15 copayment per visit. Routine foot care, for diabetic patients only	$30 copayment per visit. Routine foot care, for diabetic patients only
PSYCHIATRIC AND CHEMICAL DEPENDENCE					
Inpatient					
Acute Psychiatric	Covers Medicare Part A inpatient deductible, hospital coinsurance days 61-90 and full coverage for days 91-120.	Covered in full, precertification applies	$250 copayment / 3 max (up to $750 annually)	Unlimited days of acute hospital and physician care covered in full. There is a 190 day lifetime limit for inpatient services in a psychiatric hospital.	Unlimited days of acute hospital and physician care covered in full after $250 copayment per stay, $750 annual maximum. There is a 190 day lifetime limit for inpatient services in a psychiatric hospital.
Chemical Dependence	Covers Medicare Part A inpatient deductible, hospital coinsurance days 61-90 and full coverage for days 91-120.	Covered in full, precertification applies	$250 copayment / 3 max (up to $750 annually)	Detoxification only-covered in full if medically necessary.	Detoxification only - covered in full if medically necessary after $250 copayment per stay, $750 annual maximum.
Outpatient					
Acute Psychiatric	Covered in full for 20 visits per calendar year	$15 copay per visits, services can be provided in an outpatient facility or in a provider office	20% coinsurance	$15 copayment	$30 copayment per visit
Chemical Dependence	Balance after Medicare is covered in full for up to 60 outpatient facility visits per member per calendar year.	$15 copay per visits, services can be provided in an outpatient facility or in a provider office	20% coinsurance	$15 copayment per visit.	$30 copayment per visit
OTHER SERVICES					
Home Care	Covered in full for the same number of approved Medicare days.	Covered in full for unlimited visits, precertification applies	Covered in full when approved by Medicare Blue Choice	Covered in full	Covered in full
Private Duty Nursing	No coverage	Covered in full inpatient and at home	Covered in full when approved by Medicare Blue Choice	No coverage	No coverage
Physical, Speech, Occupational Therapy	No coverage	$15 copay for up to a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy	$15 copay	$15 copayment per visit. Therapy caps apply	$30 copayment per visit. Therapy caps apply

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Diabetic Supplies	No coverage	$15 copay	$5 copay - Meters and Test Strips from preferred vendor (Abbott)	Covered at 90%, 10% member coinsurance. Preferred vendor Glucose Strips covered with $0 copay (OneTouch, Precision, FreeStyle). Non-preferred strips are not covered without prior authorization.	Covered at 90%, 10% member coinsurance. Preferred vendor Glucose Strips covered with $0 copay (OneTouch, Precision, FreeStyle). Non-preferred strips are not covered without prior authorization
Durable Medical Equipment	No coverage	Covered at 80%, up to $15,000 maximum per calendar year combined with external prosthetics, precertification applies	20% coinsurance	When purchased through a participating vendor, covered at 80%; no deductible, following Medicare guidelines. Member has 20% coinsurance	When purchased through a participating vendor, covered at 80%; no deductible, following Medicare guidelines. Member has 20% coinsurance
Internal Prosthetics	Balance after Medicare is covered in full	Covered in full	Covered in full	Covered in full	Covered in full
External Prosthetics	No coverage	Covered at 80%, up to $15,000 per calendar year combined with DME	20% coinsurance when approved by Medicare Blue Choice	Covered, following Medicare guidelines at 80%. Member has 20% coinsurance.	Covered, following Medicare guidelines at 80%. Member has 20% coinsurance
Orthopedic Braces and Supports	No coverage	Covered at 80%, up to $15,000 per calendar year combined with DME	20% coinsurance when approved by Medicare Blue Choice	Covered, following Medicare guidelines at 80%. Member has 20% coinsurance	Covered, following Medicare guidelines at 80%. Member has 20% coinsurance
Chiropractic Services	No coverage	$15 copay per visit	$15 copay per visit for manual manipulation to correct alignment	Coverage provided for manipulation of spine to correct a subluxation only. $15 copayment. No referral needed	Coverage provided for manipulation of spine to correct a subluxation only. $20 copayment. No referral needed
Fitness Benefit	None	None	Silver and Fit-$0 annual fee for fitness facilities /gyms. $0 fee for 1 fitness kit or $150 reimbursement for all out of network facilities. Go to Silver and Fit.com for more information	SilverSneakers-a Free fitness center membership exclusively for MVP Medicare members. SilverSneakers is available nationwide and also includes: Fun, group exercise classes. Full use of strengthening equipment, heated pools and more (depending on which fitness center you choose)	SilverSneakers-a Free fitness center membership exclusively for MVP Medicare members. SilverSneakers is available nationwide and also includes: Fun, group exercise classes Full use of strengthening equipment, heated pools and more (depending on which fitness center you choose)
Ambulance	No coverage	$15 copay	$65 copay	Ambulance transportation covered when medical support required during transport. $50 copayment.	Ambulance transportation covered when medical support required during transport. $100 copayment.
Dental	Balance after Medicare covered according to the Blue Shield Schedule of Allowances when related to an accidental injury to sound, natural teeth and services are within 12 months of the accident.	Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Not covered	Not Covered.	Not covered

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Prescription Drugs	No coverage	$5/$20/$35 for retail and mail order. Retail 1 copay for 30 day supply or 3 copays for 90 day supply. Mail order 1 copay for 90 day supply	25% coinsurance for **brand and/or generic** for 30-day and/or 90-day supply. After total yearly out-of-pocket drug costs paid by both the member and the plan for Part D-eligible drugs reaches $4,660, the member pays 25% of the total cost for generic drugs and 25% of the total cost for brad drugs, until your total out-of-pocket costs reach $7,400. Under Catastrophic coverage, the member will then pay the greater of a $4.15 copayment for generic or a $10.35 copayment for all other drugs, or 5% coinsurance, whichever is greater.	Up to a 30-day supply of outpatient prescription drugs is covered. (Until $4,660 in total drug costs is met) Tier 1 Preferred Generic drugs: $0 Tier 2 Non-preferred Generic drugs: $10.00 Tier 3 Preferred Brand name drugs: $35.00 Tier 4 Non-preferred drugs: 50% coinsurance Tier 5: Specialty drugs: 33% coinsurance <u>Mail Order Program</u>: Up to a 90-day supply of approved drugs is covered (until $4,660 in total drug costs is met). Tier 1: $0 Tier 2: $20.00 Tier 3: $70.00 Tier 4: 50% coinsurance Tier 5: Not available Once your total drug expenses reach $4,660, you will pay 25% for generic drugs, 25% for Medicare-contracted brands, 100% for non-Medicare contracted brands and $0 for Tier 1 drugs. When you have paid $7,400 out of pocket your cost for prescriptions is reduced to the greater of 5% or $4.15 for generics and $10.35 for brand-name drugs in Tiers 2-5. If you are taking Tier 1 medication, it will be $0 in the initial coverage phase, coverage gap or "donut hole" and catastrophic phase.	Up to a 30-day supply of outpatient prescription drugs is covered. (Until $4,660 in total drug costs is met) Tier 1 Preferred Generic drugs: $0 Tier 2 Non-preferred Generic drugs: $10.00 Tier 3 Preferred Brand name drugs: $35.00 Tier 4 Non-preferred drugs: 50% coinsurance Tier 5: Specialty drugs: 33% coinsurance <u>Mail Order Program</u>: Up to a 90-day supply of approved drugs is covered (until $4,660 in total drug costs is met). Tier 1: $0 Tier 2: $20.00 Tier 3: $70.00 Tier 4: 50% coinsurance Tier 5: Not available Once your total drug expenses reach $4,660, you will pay 25% for generic drugs, 25% for Medicare-contracted brands, 100% for non-Medicare contracted brands and $0 for Tier 1 drugs. When you have paid $7,400 out of pocket your cost for prescriptions is reduced to the greater of 5% or $4.15 for generics and $10.35 for brand-name drugs in Tiers 2-5. If you are taking Tier 1 medication, it will be $0 in the initial coverage phase, coverage gap or "donut hole" and catastrophic phase.
Out of Area Coverage	Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide for emergency care. $65 copayment for emergency room if not followed by hospital admission. **<u>Out-Of-Network and Travel Coverage (POS):</u>** Each member will receive up to $5,000 of coverage. A 20% coinsurance will apply for non-emergency and non-urgent services such as office visits, mammograms, chiropractic services, x-rays and lab services.	Coverage provided worldwide for urgent and emergency care. $65 copayment for urgent and emergency care if not followed by hospital admission. **<u>Out-Of-Network and Travel Coverage (POS):</u>** Each member will receive up to $5,000 of coverage. A 30% coinsurance will apply for non-emergency and non-urgent services such as office visits, mammograms, chiropractic services, x-rays and lab services.	Coverage provided worldwide for urgent and emergency care. $75 copayment for urgent and emergency care if not followed by hospital admission. **<u>Out-Of-Network and Travel Coverage (POS):</u>** Each member will receive up to $5,000 of coverage. A 30% coinsurance will apply for non-emergency and non-urgent services such as office visits, mammograms, chiropractic services, x-rays and lab services.
Lifetime Benefit Maximum	None	None	None	None	None
Out of Pocket Max			$3400 for all Medical Services	$4000 - Excludes Part D costs, acupuncture, eyewear, hearing aids and dental if applicable.	$4000 - Excludes Part D costs, acupuncture, eyewear, hearing aids and dental if applicable.
	Non-participating physician charges are covered at 50% of the Schedule of Allowances			**Mom's Meals Meal Delivery Service-14 meals delivered post-hospitalization (inpatient only)**	**Mom's Meals Meal Delivery Service-14 meals delivered post-hospitalization (inpatient only)**

This comparison is not a contract. It is intended to highlight coverage of each program. Benefits are determined by the terms of the contract.