City of Rochester

2027 Medicare Retiree Benefit Comparison

	Preferred Gold HMO-POS Medicare Advantage	USA Care PPO Medicare Advantage In-Network
Physician Services		
Primary Care Physician Office Visit for Adults	$10	$10
Specialist Office Visit	$15	$15
Preventive Care Services		
Periodic Physical Exams (age 19 and up)	No Charge	No Charge
Periodic Mammogram Screenings	No Charge	No Charge
Emergency and Urgent Care Services		
Ambulance Services	$75 per use	$35 per use
Emergency Room (copay waived if admitted to hospital; not waived for observation stay)	$65	$65
Urgent Care at an Urgent Care Center	$15	$15
Outpatient Hospital and Skilled Nursing Services		
Outpatient Procedures in Facility ~Facility Charges (per procedure)	No Charge	No Charge
Skilled Nursing Facility (360 day lifetime)	No Charge days 1-20; $140 per day days 21-100	No Charge days 1-100
Inpatient Hospital		
Hospital Admisson	No Charge	No Charge
Anesthesiology	No Charge	No Charge
Mental Health		
Inpatient (up to 190 days in a psychiatric hospital per lifetime)	No Charge	No Charge
Outpatient	$15	$15
Chemical Abuse		
Inpatient Detoxification	No Charge	No Charge
Outpatient	$15	$15
Additional Services		
Chiropractic Care	$15	$15
Physical, Occupational, and Speech Therapy	$15 Medicare Therapy Caps Apply	$15 Medicare Therapy Caps Apply

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Chemotherapy	$15	$15
Radiation Therapy	No Charge	No Charge
Dialysis	No Charge	No Charge
Diagnostic lab tests (outside hospital)	No Charge	No Charge
Diagnostic x-ray services (per visit)	$15, Advanced Radiology $30	$15, Advanced Radiology $35
Physician administered medications (per day)	$15	$15
Home health care (per day)	No Charge	No Charge
Out-of-Network Coverage		
	30% member coinsurance. $5000 annual coverage limit	Out-of-network benefits same as In network
Routine Eye and Hearing Services		
Eye exam for glasses or contacts	$15	$15
Vision wear	Balance after $100 credit every two years	Balance after $100 credit every two years
Hearing aids	TruHearing Advanced $699 /TruHearing Premium $999 copay per ear. 2 per year or $600 allowance per ear, 2 per year through TruHearing catalog	TruHearing Advanced $699 /TruHearing Premium $999 copay per ear. 2 per year or $600 allowance per ear, 2 per year through TruHearing catalog
Prescription Coverage		
Not Covered: Non-standard/unevaluated medications and cosmetic drugs	**The following copays apply for covered prescriptions**	**The following copays apply for covered prescriptions**

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Deductible	None	None
Retail, up to 30-day supply		
Tier 1 Preferred Generics	$0	$0
Tier 2 Non-Preferred Generics	$10	$5
Tier 3 Preferred Brand	$35	$5
Tier 4 Non-Preferred Drugs	50%	$5
Tier 5 Specialty Drugs	33%	$5
Mail Order, up to 90-day supply		
Tier 1 Preferred Generics	$0	$0
Tier 2 Non-Preferred Generics	$20	$10
Tier 3 Preferred Brand	$70	$10
Tier 4 Non-Preferred Drugs	50%	$10
Tier 5 Specialty Drugs	Not available	Not available
Catastrophic Coverage	When you have paid $2,400 out-of-pocket, your cost for covered Part D drugs is reduced to $0.	When you have paid $2,400 out-of-pocket, your cost for covered Part D drugs is reduced to $0.

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Prescription Drug Plan Notes	Tier 1 drugs are available up to a 100-day supply Weight loss medications excluded	Tier 1 drugs are available up to a 100-day supply Weight loss medications excluded
Diabetic oral agents/insulin/supplies, 30-day supply retail	10% for Diabetic supplies purchased with Non-Preferred Vendors, 0% with Preferred Vendors (Accu-Chek, FreeStyle and Prodigy). Non-preferred strips are not covered without prior authorization. Appropriate Tier Copay for pharmacy. Diabetic DME 20% coinsurance	10% for Diabetic supplies purchased with Non-Preferred Vendors, 0% with Preferred Vendors (Accu-Chek, FreeStyle and Prodigy). Non-preferred strips are not covered without prior authorization. Appropriate Tier Copay for pharmacy. Diabetic DME 20% coinsurance
Diabetic 90-day supply mail-order	10% for Diabetic supplies.	10% for Diabetic supplies.
Durable Medical Equipment		
Durable Medical Equipment	You pay 20%	You pay 20%
External Prosthetics	You pay 20%	You pay 20%
Diabetic DME education (per visit)	No Charge	No Charge

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Health and Wellness Program		
Health and Wellness Program	24 Hour Nurse Line. The **SilverSneakers Fitness Program-**free fitness center membership at participating locations. **$100 Gift Card for completing an annual an Annual Wellness Visit**	24 Hour Nurse Line. The **SilverSneakers Fitness Program-**free fitness center membership at participating locations. **$100 Gift Card for completing an annual an Annual Wellness Visit**
Annual Deductible		
	No Deductible	No deductible
Annual Out of Pocket Maximum		
	$4,000	$4,000 Combined In & Out

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