City of Rochester

2027 Medicare Retiree Benefit Comparison (Out of Area)

	Enhanced PPO with Medicare Primary	
	In-Network	**Out-of-Network**
Physician Services		
Primary Care Physician Office Visit for Adults	$5	You pay 30%
Specialist Office Visit	$10	You pay 30%
Preventive Care Services*		
Routine GYN exam (one every six months)	No Charge	You pay 30%
Periodic Physical Exams (age 19 and up)	No Charge	You pay 30%
Periodic Mammogram Screenings	No Charge	You pay 30%
Emergency and Urgent Care Services		
Ambulance Services	$15	$15
Emergency Room (copay waived if admitted to hospital; not waived for observation stay)	$50	$50
Urgent Care at an Urgent Care Center	$25	$25
Outpatient Hospital and Skilled Nursing Services		
Outpatient Procedures in Facility Facility Charges (per procedure)	$10	You pay 30%
Skilled Nursing Facility (360 day lifetime)	No Charge	You pay 30%
Inpatient Hospital		
Hospital Admisson	No Charge	You pay 30%
Anesthesiology	No Charge	You pay 30%
Maternity & Family Planning Services		
Prenatal and postnatal care in the doctor's office (per pregnancy)	$50	You pay 30%
Maternity Radiology & Tests (e.g., ultrasound & Amniocentesis)	$10	You pay 30%
Hospital Delivery and Newborn Nursery (per delivery)	No Charge	You pay 30%

City of Rochester

2027 Medicare Retiree Benefit Comparison (Out of Area)

MVP HEALTH CARE

	Enhanced PPO with Medicare Primary	
	In-Network	**Out-of-Network**
Mental Health		
Inpatient	No Charge	You pay 30%
Outpatient	$5	You pay 30%
Extended Mental Health Coverage	Biologically Based Mental Illness Coverage is provided for the diagnosis and treatment of mental, nervous or emotional conditions that are caused by a biological disorder of the brain and result in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Emotionally Disturbed Children Coverage is provided for the diagnosis and treatment of children (under the age of 18) with serious emotional disturbances.	Biologically Based Mental Illness Coverage is provided for the diagnosis and treatment of mental, nervous or emotional conditions that are caused by a biological disorder of the brain and result in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Emotionally Disturbed Children Coverage is provided for the diagnosis and treatment of children (under the age of 18) with serious emotional disturbances.
Chemical Abuse		
Inpatient Detoxification	No Charge	You pay 30%
Outpatient	$5	You pay 30%
Additional Services		
Chiropractic Care	$10	You pay 30%
Physical, Occupational, and Speech Therapy	$10	You pay 30%
Chemotherapy	No Charge	You pay 30%
Radiation Therapy	No Charge	You pay 30%
Dialysis	No Charge	You pay 30%
Diagnostic lab tests (outside hospital)	No Charge	You pay 30%
Diagnostic x-ray services (per visit)	$10	You pay 30%
Physician administered medications (per day)	$5	You pay 30%
Home health care (per day)	No Charge (200 visits per member per year)	You pay 30% (200 visits per member per year)

City of Rochester

2027 Medicare Retiree Benefit Comparison (Out of Area)

	Enhanced PPO with Medicare Primary	
	In-Network	**Out-of-Network**
Out-of-Network Coverage		
Worldwide coverage for emergency care.	National Cigna Network and Emergency Coverage Worldwide	National Cigna Network and Emergency Coverage Worldwide
Routine Eye and Hearing Services		
Eye exam for glasses or contacts	$15	You pay 30%
Vision wear	$60 credit every 2 years and 20% discount at participating providers	$60 credit every 2 years and 20% discount at participating providers
Prescription Coverage		
Not Covered: Non-standard/unevaluated, Weight Loss medications and cosmetic drugs	• $0 copayment for Tier 1 Preferred Generics • $5 copayment for Tier 2 Non-Preferred Generics • $5 copayment for Tier 3 Preferred Brands • $5 copayment for Tier 4 Non-Preferred Drugs • $5 copayment for Tier 5 Specialty Drugs Catastrophic Coverage: When you have paid $2,400 out-of-pocket, your cost for covered Part D drugs is reduced to $0. Mail Order pharmacy: 90-day supply available at 2 times the retail cost of a 30-day supply	
Deductible	None	
Prescription Drug Plan Notes	Administered by CVS/Caremark. You may incur additional expenses if you use a non-participating pharmacy.	

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	In-Network	**Out-of-Network**
Diabetic Testing supplies including lancets, testing strips and re-agents	$10	
Diabetic oral agents, insulin and insulin administration supplies	Prescription Drug Copay - $5	N/A
Diabetic 90-day supply mail-order	$10.00	N/A
Durable Medical Equipment		
Durable Medical Equipment	50% coverage	You pay 30%
External Prosthetics	No copay	You pay 30%
Diabetic DME education (per visit)	$10	You pay 30%
Dependent Coverage		
	Dependent to 26	Dependent to 26
Health and Wellness Program		
Health and Wellness Program	WellBeing Rewards - up to $600 in rewards and reimbursements per contract per calendar year	
Annual Deductible*		
	No deductible	Single - $500
	No deductible	Two Person - $1500
	No deductible	Family - $1500
Annual Out of Pocket Maximum		
	No out-of-pocket max	Single - $1500
	No out-of-pocket max	Two Person - $3000
	No out-of-pocket max	Family - $3000

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	Enhanced PPO with Medicare Primary	
	In-Network	**Out-of-Network**
Additional Information		
This comparison is not a contract. It is intended to highlight coverage of each program. Benefits are determined by the terms of the contract.		^Services are covered as noted after satisfaction of the annual deductible. Adult physicals, routine gynecological examinations, well child visits, immunizations, vaccinations, routine eye examinations, mammography, prostate screening, laboratory services, diabetic services and diabetic supplies are not subject to the deductible.