# 2027 Summary of Benefits

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

## *Health New England Medicare Compass (PPO)*

**January 1, 2027 – December 31, 2027**

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 covered services, please visit www.healthnewengland.org/medicare to view the *Evidence of Coverage*. You can also request a printed copy by calling Member Services at 1-877-443-3314 (TTY: 711), 8:00 a.m. – 8:00 p.m. ET, 7 days a week from October 1st to March 31st and Monday-Friday from April 1st to September 30th.

**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 Medicare Compass (PPO)).

**Tips for comparing your Medicare choices**

This *Summary of Benefits* booklet gives you a summary of what Health New England Medicare Compass (PPO) covers and what you pay.

- If you want to compare our plan with other Medicare health plans, the Medicare Plan Finder on http://www.medicare.gov is the official, searchable tool that allows users to shop and compare Medicare health and drug plans.
- 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**

- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Inpatient and Outpatient Care and Services
- Prescription Drug Benefits
- Additional Services

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including braille, in large print, or other alternate formats that's accessible and appropriate for you.

For additional information, call us at 1-877-443-3314 (TTY: 711).

**Things to Know About Health New England Medicare Compass (PPO)**

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 Medicare Compass (PPO) Phone Numbers and Website**

- Questions, call us at (413)787-0010, toll free (877)443-3314 or TTY: 711.
- Our website: www.healthnewengland.org/medicare

**Who can join?**

To join **Health New England Medicare Compass (PPO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. The service area for the plan described in this document includes the following counties in Massachusetts: **Franklin, Hampden and Hampshire**

**Which doctors, hospitals, and pharmacies can I use?**

Health New England Medicare Compass (PPO) plan uses a network of doctors, hospitals, pharmacies, and other providers. **If you use the providers that are not in our network, you may pay more. You must use a network pharmacy to fill your covered prescription(s) unless you aren't able to or fill your prescription through our plan's mail-order service.** You can check which providers, and pharmacies are in-network by

visiting: www.healthnewengland.org/medicare

Or, call the plan to **request a printed directory.**

**What do we cover?**

We cover everything that Original Medicare covers – and *more*.

- Our plan members get all the benefits covered by Original Medicare. For some of these benefits, you may pay less in our plans than you would in Original Medicare. For others, you may pay more.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.healthnewengland.org/medicare.
- Or, call the plan to request a printed formulary

**How will I determine my drug costs?**

Our plan has a List of Covered Drugs (formulary) - **we call it the Drug List.**

Every drug on our plan's Drug List is in one of the five cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug. To find out which cost-sharing tier your drug is in, you can look it up in our plan's Drug List at https://healthnewengland.org/medicare/find-drug.

**If you have any questions about this plan's benefits or costs, please contact Health New England Medicare Advantage for details at (413)787-0010, toll free (877)443-3314 or TTY: 711.**

| SUMMARY OF BENEFITS | Health New England Medicare Compass (PPO) |
|---|---|
| **Monthly Plan Premium** | $64 per month.<br>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:<br>• $8,150 for services you receive from in-network providers.<br>• $11,000 for services you receive from in and out-of-network providers combined.<br>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.<br>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** | In-network:<br>• $375 copay per day for Days 1 through 7.<br>• $0 copay per day for Days 8 through 90.<br>Out-of-network:<br>• 50% coinsurance |
| **Outpatient Hospital Coverage**[1] | In-network: $0-$450 copay, depending on the service.<br>The copay range for Outpatient Hospital Services describes the varying cost share based on the services provided. The minimum copay applies to services related to the monitoring of Coumadin treatment. The maximum copay applies to all other outpatient hospital services.<br>Out-of-network: 50% coinsurance |
| **Ambulatory Surgical Center (ASC)**[1] | In-network:<br>• $225 copay<br>Out-of-network:<br>• 50% coinsurance |
| **Doctor Visits** | Primary Care Providers:<br>• In-network: $25 copay<br>• Out-of-network: $30 copay<br>Specialists:<br>• In-network: $50 copay |

| SUMMARY OF BENEFITS | Health New England Medicare Compass (PPO) |
|---|---|
| | • Out-of-network: $70 copay<br>No referral required for network doctors, specialists, and hospitals. |
| **Preventive Care** | • In-network: You pay nothing for preventive services covered under Original Medicare at zero cost-sharing. Any additional preventive services approved by Medicare during the contract year will be covered.<br>• Out-of-network: You pay 50% coinsurance for all preventive services covered under Original Medicare.<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | • In-network: $115 copay<br>• Out-of-network: $115 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Includes worldwide coverage. |
| **Urgently Needed Services** | • In-network: $40 copay<br>• Out-of-network: $40 copay<br>Includes worldwide coverage. |
| **Diagnostic Services/Labs/Imaging**[1]<br><br>***(Costs for these services may be different if received in an outpatient surgery setting)*** | Diagnostic tests and procedures:<br>• In-network: $25 copay<br>• Out-of-network: 50% coinsurance<br>Lab services:<br>• In-network: $0-$25 copay<br>The minimum copay applies to hemoglobin A1C, prothrombin (protime), and fecal immunochemical test (FIT) lab services, and the maximum copay applies to all other lab services.<br>• Out-of-network: 50% coinsurance<br>Outpatient x-rays:<br>• In-network: $35 copay<br>• Out-of-network: 50% coinsurance<br>Diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology):<br>• In-network: $0-$375 copay<br>The minimum copay applies to ultrasounds, and the maximum copay applies to all other high cost imaging including CT, MRI, PET scans and Nuclear Cardiology. |

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|---|---|
| | • Out-of-network: 50% coinsurance |
| **Hearing Services**<br><br>**Hearing Aids - NationsHearing®** | Exam to diagnose and treat hearing and balance issues:<br>• In-network: $50 copay<br>• Out-of-network: $70 copay<br>One routine hearing exam every year:<br>• In-network: You pay nothing<br>• Out-of-network: 50% coinsurance<br>$499 copay per aid for Standard Aids<br>$699 copay per aid for Advanced Aids<br>$999 copay per aid for Premium Aids<br>Up to two hearing aids every year (one per ear, per year). For more information on how to use your NationsHearing® benefit, please visit hne.nationsbenefits.com/hearing or refer to your plan materials and Evidence of Coverage (EOC) for more details. |
| **Dental Services[1]** | Limited dental services (dental care required to treat illness or injury):<br>• In-network: $50-$450 copay, depending on the service.<br>The minimum copay is for a Specialist visit, and the maximum is for Outpatient Surgery.<br>• Out-of-network: $70 copay, 50% coinsurance<br>The copay is for a Specialist visit and coinsurance is for Outpatient Hospital Services.<br>Our plan has a $500 allowance for Dental Benefits through NationsBenefits®. See the *"Additional Services – Additional Benefits Card"* section below for more information. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>• In-network: $50 copay<br>• Out-of-network: $70 copay<br>Routine eye exam (for up to 1 every year):<br>• In-network: You pay nothing.<br>• Out-of-network: 50% coinsurance<br>Our plan pays up to $250 every two years for prescription eyewear. For more information on how to use your EyeMed® benefit, visit |

| SUMMARY OF BENEFITS | Health New England Medicare Compass (PPO) |
|---|---|
| | eyemedvisioncare.com/hne or refer to your plan materials and Evidence of Coverage (EOC) for more details. |
| **Mental Health Care** | Inpatient visit:<br>In-network:<br>• $345 copay per day for Days 1 through 6.<br>• $0 copay per day for Days 7 through 90.<br>Out-of-network:<br>• You pay 50% coinsurance<br>Outpatient group therapy visit:<br>• In-network: $50 copay<br>• Out-of-network: 50% coinsurance<br>Outpatient individual therapy visit:<br>• In-network: $50 copay<br>• Out-of-network: 50% coinsurance<br>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. |
| **PRESCRIPTION DRUG BENEFITS[2]** | |
| There are **three drug payment stages**:<br>• **Yearly Deductible Stage** – You pay the full cost of your covered drugs until you reach your deductible, if applicable.<br>• **Initial Coverage Stage** – After you meet your deductible, you pay your share of the cost for covered drugs according to the plan's copays or coinsurance.<br>• **Catastrophic Coverage Stage** – Once your annual out-of-pocket costs reach the Medicare Part D limit, you pay nothing for covered Part D drugs for the remainder of the calendar year. | |
| Drug costs may vary based on pharmacy type or status (such as preferred, standard, mail order, long-term care, or home infusion pharmacies) and the days' supply dispensed. | |
| **Deductible** | $490 for Tier 3, Tier 4 and Tier 5 drugs. |
| **Initial Coverage**<br>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Once you have paid $2,400 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). You may get your drugs at network retail pharmacies and mail order pharmacies. | |

| **Preferred Retail Cost Sharing[2]** | | | |
|---|---|---|---|
| Drug Tier | 1-Month Supply | 2-Month Supply | 3-Month Supply |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay |
| Tier 2 (Generic) | $10 copay | $20 copay | $30 copay |
| Tier 3 (Preferred Brand) | 15% | 15% | 15% |
| Tier 4 (Non-Preferred Drug) | 31% | 31% | 31% |
| Tier 5 (Specialty Tier) | 28% | N/A | N/A |

| **Preferred Mail Order[2]** | |
|---|---|
| Drug Tier | 3-Month Supply |
| Tier 1 (Preferred Generic) | $0 copay |
| Tier 2 (Generic) | $20 copay |
| Tier 3 (Preferred Brand) | 15% |
| Tier 4 (Non-Preferred Drug) | 31% |
| Tier 5 (Specialty Tier) | N/A |

| **Standard Retail Cost Sharing** | | | |
|---|---|---|---|
| Drug Tier | 1-Month Supply | 2-Month Supply | 3-Month Supply |
| Tier 1 (Preferred Generic) | $5 copay | $10 copay | $15 copay |
| Tier 2 (Generic) | $20 copay | $40 copay | $60 copay |
| Tier 3 (Preferred Brand) | 15% | 15% | 15% |
| Tier 4 (Non-Preferred Drug) | 31% | 31% | 31% |
| Tier 5 (Specialty Tier) | 28% | N/A | N/A |

| **Standard Mail Order** | |
|---|---|
| Drug Tier | 3-Month Supply |
| Tier 1 (Preferred Generic) | $10 copay |
| Tier 2 (Generic) | $40 copay |
| Tier 3 (Preferred Brand) | 15% |
| Tier 4 (Non-Preferred Drug) | 31% |
| Tier 5 (Specialty Tier) | N/A |

- If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
- Costs may differ based on pharmacy type or status, when applicable.
- If you request and the plan approves a formulary exception, you will pay Tier 4: Non-Preferred Brand cost sharing.

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|---|---|
| **Catastrophic Coverage** | In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out- |

| SUMMARY OF BENEFITS | Health New England Medicare Compass (PPO) |
|---|---|
| | of-pocket costs reach the $2,400 limit for the calendar year. During this payment stage, you pay nothing for your covered Part D drugs, and excluded drugs covered under our enhanced benefits. |
| **Part D Insulins** | You will pay no more than $35 per month, 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, you pay no 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 2027 Formulary. |
| **ADDITIONAL SERVICES** | |
| **Additional Benefits Card** | Our plan gives you access to a variety of additional benefits designed to support your overall well-being, through NationsBenefits®. You will receive a Benefits Mastercard® Prepaid Card from NationsBenefits® pre-loaded with your annual Dental allowance, and Wellness allowance. Use this card for dental services, fitness activities, weight management programs, acupuncture, an activity tracker, and plan-approved health-related transportation.<br>For over-the-counter (OTC) care items, funds are uploaded quarterly, and expire at the end of each quarter (see *Over-the-Counter (OTC) Care* below for more information). Please refer to your plan materials and Evidence of Coverage (EOC) for more details.<br>Allowance amounts for this plan are:<br>$150 annually for Wellness<br>$500 annually for the Dental Services |
| **Ambulance[1]**<br>**(Ground & Air)** | • In-network: $310 copay<br>• Out-of-network: 50% coinsurance<br>Ambulance transportation limited to Medicare-covered medically necessary ambulance services. Chair vans are not covered. Authorization required for non-emergency Medicare services. |
| **Chiropractic Care** | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):<br>• In-network: $15 copay<br>• Out-of-network: 50% coinsurance |
| **Home Health Care[1]** | • In-network: You pay nothing |

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|---|---|
| | • Out-of-network: 50% coinsurance |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice.<br>You may have to pay part of the cost for drugs and respite care.<br>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 - Mom's Meals** | If you are discharged from an inpatient hospital, skilled nursing facility, rehab stay, or have undergone outpatient joint replacement surgery, you may qualify to receive up to 28 fully-prepared, nutritious home-delivered meals (2 meals per day for 14 days) from our plan-approved vendor at no cost. |
| **Medicare Part B Drugs[1]** | For Part B drugs such as chemotherapy drugs:<br>• In-network: You pay up to 20% of the cost<br>• Out-of-network: 50% of the cost<br>Other Part B drugs:<br>• In-network: You pay up to 20% of the cost<br>• Out-of-network: 50% of the cost |
| **Outpatient Substance Abuse** | Group therapy visit:<br>• In-network: $50 copay<br>• Out-of-network: 50% coinsurance<br>Individual therapy visit:<br>• In-network: $50 copay<br>• Out-of-network: 50% coinsurance |
| **Over-the-Counter (OTC) Care - NationsBenefits®** | $45 allowance every three months on your Additional Benefits Card. The allowance can be used for specific OTC products from certain retail locations or by mail from the NationsBenefits® website, app or catalog. Allowance expires at the end of each quarter and does not carry over. |
| **Renal Dialysis** | • In-network: 20% coinsurance<br>• Out-of-network: 50% coinsurance |
| **Skilled Nursing Facility (SNF)[1]** | In-network:<br>Our plan covers up to 100 days in a SNF.<br>• You pay nothing per day for Days 1 through 20.<br>• $221 copay per day for Days 21 through 100.<br>Out-of-network: |

| SUMMARY OF BENEFITS | Health New England Medicare Compass (PPO) |
|---|---|
| | 50% coinsurance |
| **Telehealth Services** | Primary Care Provider:<br>• $25 copay<br>Specialist:<br>• $50 copay |
| **Therapy**[1] | Occupational therapy visit:<br>• In-network: $35 copay<br>• Out-of-network: 50% coinsurance<br>Physical therapy:<br>• In-network: $45 copay<br>• Out-of-network: 50% coinsurance<br>Speech and Language therapy visit:<br>• In-network: $45 copay<br>• Out-of-network: 50% coinsurance |

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

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

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.