

SCHOOLCARE

2027 Retiree Plan Options Comparison Chart



	Advantage	Traditional With Rx	Traditional No Rx
Description	You Pay	You Pay	You Pay
Carrier	UnitedHealthcare	United American	United American
Medicare Part A Deductible	\$0	\$0	\$0
Medicare Part A Services			
Hospitalization (up to 515 consecutive days)	\$0	\$0	\$0
Skilled Nursing Facility (up to 100 days)	\$0	\$0	\$0
Skilled Nursing Prior Hospital Stay Req.	Waived	3 Days	3 Days
Medicare Part B Deductible	\$0	\$292**	\$292**
Medicare Part B Services			
Medical Expenses, Lab Services	\$0	\$292**	\$292**
Part A & B Services			
Home Health Care	\$0	\$0	\$0
Durable Medical Equipment	\$0	\$292*	\$292*
Podiatry	\$0, 6 visits	\$292*	\$292*
Physical Therapy	\$0	\$292*	\$292*
Hearing Aids	\$500 allowance	Not covered	Not covered
Foreign Travel	Emergency or Urgent Care Unlimited benefit \$0	Emergency Only \$50,000 lifetime max benefit \$250 deductible plus 20%	Emergency Only \$50,000 lifetime max benefit \$250 deductible plus 20%
Prescriptions (Part D)	Included, see Summary of Benefits	With Express Scripts See Summary of Benefits	Not included
Prescription Benefits			
Tier 1: Preferred Generic Retail 30-day/ Mail 90-day	\$10/ \$15	\$10/ \$15	
Tier 2: Preferred Brand Retail 30-day/ Mail 90-day	\$30/ \$45	\$30/ \$45	
Tier 3: Non-preferred Brand Retail 30-day/ Mail 90-day	\$40/ \$60	\$40/ \$60	N/A
Tier 4: Specialty Drug	12% Coinsurance	12% Coinsurance	
Out of pocket maximum	\$2,400	\$2,400	
<i>Prescription Benefits Continued:</i>			

Once you have been billed \$292 of Medicare-approved amounts for covered services, your Medicare Part B deductible will have been met for the calendar year.

Catastrophic coverage stage: Once you reach this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the year.			
Additional Benefits and Programs Routine Physical Exam Routine Hearing Exam Routine Eye Exam Vision Eyewear Healthy at Home Let's Move Renew Active® Fitness Program	\$0; 1 per plan year \$0; 1 per plan year \$0; 1 every 12 months Plan pays \$100 for eyeglasses or contacts every 12 months \$0 for 28 meals, 12 rides and 6 hours of in-home personal care up to 30 days following inpatient stay. Referral required. \$0 \$0 for standard gym membership at participating locations	Not covered	Not covered
Monthly Cost (per person)	\$631.00	\$500.00	\$225.00

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