Medicare Blue PPO Copay Plan
Prepared for Genesee Area Healthcare Plan
Effective: 01/01/2022

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Annual deductible	None	$250
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	$1,250 in network	$8,000 combined in network and out-of-network annual out-of-pocket maximum
Out-of-network benefits	N/A	Benefits are available, but additional costs may apply
Lifetime maximum	None	
Physician office services		
Office visit copay (PCP)	$15 copay	$25 copay
Office visit copay (Specialist)	$15 copay	$25 copay
Chiropractor office visit (manual manipulation to correct subluxation)	$15 copay	$25 copay
Podiatrist office visit (for medically necessary foot care)	$15 copay	$25 copay
Allergy tests/injections	$15 copay if performed in PCP office, $15 copay if performed in a specialist office	$25 copay if performed in PCP office, $25 copay if performed in specialist office
Lifestyle and wellness benefits		
Ways to help you and your family live healthier every day	The Silver&Fit® Program offers: - Up to 2 Home Fitness kits per year ($10 annual fee) And your choice of: - Membership in a fitness club/exercise center ($25 annual fee) - $150 annual reimbursement toward paid membership at non-participating fitness clubs/exercise centers - Silver&Fit® copays will not be included in the Annual Out-Of-Pocket Maximum. Blue365: Exclusive discounts on health-related products and services	
Preventive health care services (office visit copay may apply)		
Annual wellness exam	Covered in full, limited to one per year	$25 copay, limited to one per year

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Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)	Covered in full flu, pneumonia and Hepatitis B. All other vaccines 20% coinsurance	Covered in full for Flu and pneumonia. Hepatitis B and other vaccines 20% coinsurance subject to the deductible
Preventive mammography	Covered in full for preventive mammography, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Pap smear/pelvic exam	Covered in full, limited to one every 24 months	20% coinsurance, subject to the deductible, limited to one per year
Routine GYN exam	Covered in full, limited to one every 24 months	$25 copay, limited to one per year
Prostate cancer screening	Covered in full, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Bone density screening	Covered in full, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Colorectal screening	Covered in full for preventive colonoscopies, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Smoking cessation	Covered in full	$25 copay
Routine hearing exam	$0 copay, limited to one exam per year. Must use a TruHearing Provider.	$0 copay, limited to one exam per year. Must use a TruHearing Provider.
Hearing Aid(s)	$699 Copay for Advanced Hearing Aids or $999 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.	
Routine vision exam	$15 copay per visit, limited to one exam per year	$25 copay, limited to one exam per year
Eyewear allowance	$100 allowance available once every calendar year.	
Inpatient hospital benefits		
Hospital benefits	$250 copay per admission for unlimited days (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission, unlimited days
In-Hospital Physician Visits	Covered in full	20% coinsurance, subject to the deductible
Anesthesia	Covered in full	20% coinsurance, subject to the deductible

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Inpatient chemical dependence	$250 copay per admission (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission
Inpatient mental health care	$250 copay per admission (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission
Skilled nursing facility		
Skilled nursing facility (3 day inpatient stay is not required)	$0 copay per day, days 1-20. $188 copay per day, days 21-100. Not covered, days 101 and beyond	50% coinsurance, subject to the deductible, days 1-100. Not covered, days 101 and beyond
Emergency care		
Emergency room care (covered worldwide)	$65 copay per visit; unless admitted within 23 hours	$65 copay per visit; unless admitted within 23 hours
Urgent care (covered worldwide)	$15 copay	$15 copay
Ambulance	$65 copay	$65 copay
Outpatient benefits		
Surgical care	$50 copay	20% coinsurance, subject to the deductible
Ambulatory surgical center	$50 copay	20% coinsurance, subject to the deductible
Hospital Observation Stay	$50 copay	20% coinsurance, subject to deductible
Office surgery	$15 copay if performed in PCP office, $15 copay if performed in specialist office	$25 copay if performed in PCP office, $25 copay if performed in specialist office
Diagnostic tests and laboratory services	Covered in full	20% coinsurance, subject to the deductible
X-rays (film) and radiation therapy	$15 copay	20% coinsurance, subject to the deductible
Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)	$15 copay	20% coinsurance, subject to the deductible
Chemotherapy	$15 copay	20% coinsurance, subject to the deductible
Outpatient mental health care	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Partial hospitalization	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Outpatient chemical dependence care	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Other services		
Rehabilitative therapy (physical, occupational and speech)	$15 copay	$25 copay

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Cardiac rehabilitation	$15 copay	$25 copay
Telehealth	MDLive Provider: $15 copay Behavioral Health Provider:$15 copay Additional Telehealth Services: follows in-person copay	Not Covered
Acupuncture	50% coinsurance, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis	50% coinsurance, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis
Medicare Part B drugs including chemotherapy drugs	20% coinsurance	20% coinsurance, subject to the deductible
Diabetic education	Covered in full	$25 copay
Diabetic supplies	Meters and test strips: $5 copay per 30 day supply, from a preferred manufacturer	20% coinsurance, subject to the deductible
Durable medical equipment	20% coinsurance	20% coinsurance, subject to the deductible
Prosthetic devices	20% coinsurance	20% coinsurance, subject to the deductible
Home care	Covered in full	20% coinsurance, subject to the deductible
Hospice	Covered by Original Medicare	Covered by Original Medicare
Kidney dialysis	Covered in full	Covered in full

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Type of Care/Plan Benefits	**In-Network**	
Prescription drugs		
Prescription drug coverage	Prior Authorization and Step Therapy apply. Quantity Limits Apply. Deductible: $0 Initial Coverage: up to $4,430 in covered drugs 30 day supply: $10/$30/$50 90 day supply: Subject to 3 times the copay Coverage Gap: up to $7,050 out-of-pocket 30 day supply: $10/$30/$50 90 day supply: Subject to 3 times the copay Coverage for generic drugs is provided by the Part D plan. Coverage for brand name drugs is provided by a wraparound group health plan. Catastrophic Coverage: The member pays the greater of $3.95 copay for generic and a $9.85 copay for all other drugs, or 5% coinsurance.	Covered at in-network cost sharing in emergency situations only.

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Excellus

Quote Prepared for: Genesee Area Healthcare Plan

Medicare Blue PPO Copay Plan	
Quote Effective: 01/01/2022	Rating Region: Rochester
Plan Cycle: Calendar Year	Rate Type: Large Group

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Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Office visit copay (PCP)	$15 copay	$25 copay
Office visit copay (Specialist)	$15 copay	$25 copay
Hospital benefits	$250 copay per admission for unlimited days (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission, unlimited days
Emergency room care	$65 copay per visit unless admitted within 23 hours. Covered worldwide.	
Urgent care	$15 copay In-Network. Covered worldwide.	
Out-of-network benefits	Benefits are available, but additional costs may apply	
Prescription drugs	$10/$30/$50 Subject to 3 times the copay for a 90 day supply	Covered at in-network cost sharing in emergency situations only.
Eyewear allowance	$100 eyewear allowance available once every calendar year	
Annual deductible	None	$250
Annual out-of-pocket maximum (medical services only)	$1,250 in network	$8,000 combined in-network and out-of-network annual out-of-pocket maximum
Lifestyle and wellness benefits	Silver&Fit® fitness program, Blue365: Exclusive discounts on health-related products and services	