

**Medicare Blue Choice Copay Plan**

Prepared for New York State

Effective: 01/01/2025

<b>Plan Feature Highlights</b>	<b>Medicare Blue Choice Copay Plan</b>	
<b>Type of Care/Plan Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Annual deductible</b>	None	None
<b>Annual out-of-pocket maximum (medical services only, does not include prescription drugs)</b>	\$3,400 in network	N/A
<b>Out-of-network benefits</b>	N/A	20% coinsurance up to a maximum of \$5,000
<b>Lifetime maximum</b>	None	
<b>Physician Office Services</b>		
<b>Office visit copay (PCP)</b>	\$5 copay	20% coinsurance up to a maximum of \$5,000
<b>Office visit copay (Specialist)</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Chiropractor office visit (manual manipulation to correct subluxation)</b>	\$5 copay	20% coinsurance up to a maximum of \$5,000
<b>Podiatrist office visit (for medically necessary foot care)</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Allergy tests/injections</b>	\$5 copay for PCP \$20 copay for a specialist	20% coinsurance up to a maximum of \$5,000
<b>Lifestyle and Wellness benefits</b>		
<b>Ways to help you and your family live healthier every day</b>	<p>Silver&amp;Fit® is an Exercise Program that gives you the choice of:</p> <ul style="list-style-type: none"> <li>- Membership in a fitness club/exercise center (\$0 annual fee)</li> <li>- \$150 annual reimbursement toward paid membership at non-participating fitness clubs/exercise centers</li> </ul> <p>You can also participate in the Silver&amp;Fit Home Fitness Program (\$0 annual fee)</p> <p>Blue 365: Exclusive online discounts to health related products and services</p>	
<b>Preventive health care services (office visit copay may apply)</b>		
<b>Annual wellness exam</b>	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)</b>	Covered in full	Covered in full for flu/pneumonia; 20% coinsurance up to a maximum of \$5,000 for all other vaccines

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<b>Preventive mammography</b>	Covered in full for preventive mammography, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Pap smear/pelvic exam</b>	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Routine GYN exam</b>	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Prostate cancer screening</b>	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Bone density screening</b>	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Colorectal screening</b>	Covered in full for preventive colonoscopies, limited to one per year	20% coinsurance up to a maximum of \$5,000
<b>Smoking cessation</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Routine hearing exam</b>	\$0 copay, one exam per year, must use TruHearing providers	Not covered.
<b>TruHearing® Hearing aid</b>	\$499 or \$799 copay per hearing aid. Covers 2 per year. \$50 additional cost per aid for hearing aid rechargeability	
<b>Routine vision exam</b>	\$20 copay per visit, limited to one exam per year	20% coinsurance up to a maximum of \$5,000
<b>Eyewear allowance</b>	\$120 allowance available once every calendar year.	
<b>Preventive dental</b>	\$0 copay for 2 oral exams, 2 cleanings and 2 dental X-rays per year. The plan will pay up to a maximum allowable benefit for each service covered. If your dentist does not participate in the health plan's network and charges more than the maximum allowable benefit, you will be responsible for the additional costs.	
<b>Inpatient hospital benefits</b>		
<b>Hospital benefits</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>In-Hospital Physician Visits</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Anesthesia</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Inpatient chemical dependence</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Inpatient mental health care</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Skilled Nursing Facility</b>		

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<b>Skilled nursing facility (3 day inpatient stay is not required)</b>	\$0 copay per day, days 1-20 \$25 copay per day, days 21-100. Not covered, days 100 and beyond	20% coinsurance up to a maximum of \$5,000
<b>Emergency care</b>		
<b>Emergency room care (covered worldwide)</b>	\$50 copay per visit unless admitted within 23 hours	\$50 copay per visit unless admitted within 23 hours
<b>Urgent care (covered worldwide)</b>	\$20 copay- Physician Billed \$50 copay- Free Standing Facility	\$20 copay- Physician Billed \$50 copay- Free Standing Facility
<b>Ambulance</b>	\$35 copay	\$35 copay
<b>Outpatient benefits</b>		
<b>Surgical care</b>	\$50 copay	20% coinsurance up to a maximum of \$5,000
<b>Ambulatory surgical center</b>	\$50 copay	20% coinsurance up to a maximum of \$5,000
<b>Office surgery</b>	\$5 copay to a PCP \$20 copay to a specialist	20% coinsurance up to a maximum of \$5,000
<b>Oral surgery</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Diagnostic tests and laboratory services</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>X-rays and radiation therapy</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Chemotherapy</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Outpatient mental health care</b>	20% coinsurance, unlimited visits	20% coinsurance up to a maximum of \$5,000
<b>Partial hospitalization</b>	20% coinsurance, unlimited visits	20% coinsurance up to a maximum of \$5,000
<b>Outpatient chemical dependence care</b>	20% coinsurance unlimited visits	20% coinsurance up to a maximum of \$5,000
<b>Telehealth- network providers Telemedicine- MD Live</b>	Follows the base benefit MD Live Providers: \$5 copayment and \$20 Behavioral Health visits	Follows the base benefit MD Live Providers not covered out of network
<b>Other services</b>		
<b>Rehabilitation therapy (physical, occupational and speech)</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Cardiac rehabilitation</b>	\$0 copay	20% coinsurance up to a maximum of \$5,000
<b>Pulmonary rehabilitation</b>	\$20 copay	20% coinsurance up to a maximum of \$5,000
<b>Acupuncture</b>	50% coinsurance, up to 20 visits per year for chronic low back pain and 10 visits per year for all other diagnosis	Not covered

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<b>Medicare Part B drugs including chemotherapy drugs</b>	\$50 copay	20% coinsurance up to a maximum of \$5,000
<b>Diabetic education</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Diabetic supplies</b>	\$5 copay per item for a 30 day supply from preferred supplier	20% coinsurance up to a maximum of \$5,000
<b>Durable medical equipment</b>	20% coinsurance	20% coinsurance up to a maximum of \$5,000
<b>Prosthetic devices</b>	20% coinsurance	20% coinsurance up to a maximum of \$5,000
<b>Home care</b>	Covered in full	20% coinsurance up to a maximum of \$5,000
<b>Hospice</b>	Covered by Original Medicare	Covered by Original Medicare
<b>Kidney dialysis</b>	Covered in full	Covered in full

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<b>Prescription drugs</b> <b>Prescription drug coverage</b>	Prior Authorization, Step Therapy and Quantity Limits apply <u>Deductible:</u> \$0 <u>Initial Coverage:</u> up to \$2,000 out-of-pocket 30 day supply: \$10/\$25/\$40 90 day supply: Subject to 2 times the copay  <u>Catastrophic Coverage:</u> The member pays \$0 when entering the catastrophic phase.	Covered at in-network cost sharing in emergency situations only.

Out-of-network/non-contracted providers are under no obligation to treat Excellus BlueCross BlueShield members, except for emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Excellus BlueCross BlueShield contracts with the Federal Government and is an HMO/PPO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

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