



Medicare Blue PPO Copay Plan

Prepared for Genesee Area Healthcare Plan

Effective: 01/01/2026

MBPPO LG 5 - \$10/\$45/\$90 3x Rx

Plan Feature Highlights			Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	In-Network	Out-of-Network		
Annual deductible	None	\$650		
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	\$6,700 in network	\$10,000 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)	\$25 copay	\$30 copay		
Office visit copay (Specialist)	\$45 copay	\$50 copay		
Chiropractor office visit (manual manipulation to correct subluxation)	\$15 copay	\$30 copay		
Podiatrist office visit (for medically necessary foot care)	\$45 copay	\$50 copay		
Allergy tests/injections	\$25 copay if performed in PCP office, \$45 copay if performed in a specialist office	\$30 copay if performed in PCP office, \$50 copay if performed in specialist office		
Lifestyle and wellness benefits				
Ways to help you and your family live healthier every day	Silver&Fit® is an Exercise Program that gives you the choice of: - Membership in a fitness club/exercise center (\$0 annual fee) - You can also participate in the Silver&Fit Home Fitness Program (\$0 annual fee)			
	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	\$30 copay, limited to one per year		
Immunizations (flu, pneumonia, COVID, Hepatitis B, and other vaccines if patient is at risk)	Covered in full for Flu, COVID and pneumonia. Hepatitis B and other vaccines 40% coinsurance, subject to the deductible	Covered in full for Flu, COVID and pneumonia. Hepatitis B and other vaccines 40% coinsurance, subject to the deductible		
Preventive mammography	Covered in full for preventive mammography, limited to one per year	40% coinsurance, subject to the deductible, limited to one per year		

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Pap smear/pelvic exam	Covered in full, limited to one every 24 months, if high risk covered once every 12 months	40% coinsurance, subject to the deductible, limited to one every 24 months, if high risk covered once every 12 months	
Routine GYN exam	Covered in full, limited to one every 24 months, if high risk covered once every 12 months	\$30 copay, limited to one every 24 months, if high risk covered once every 12 months	
Prostate cancer screening	Covered in full, limited to one per year	40% coinsurance, subject to the deductible, limited to one per year	
Bone density screening	Covered in full, limited to one every 24 months	40% coinsurance, subject to the deductible, limited to one every 24 months	
Colorectal screening	Covered in full for preventive colonoscopies, limited to one every 24 months	40% coinsurance, subject to the deductible, limited to one every 24 months	
Smoking cessation	Covered in full	\$30 copay	
Routine hearing exam	\$0 copay, limited to one exam per year. Must use a TruHearing Provider.	Not covered	
Hearing Aid(s)	\$499 Copay for Advanced Hearing Aids or \$799 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.	Not covered	
Routine vision exam	\$45 copay per visit, limited to one exam per year	\$50 copay, limited to one exam per year	
Eyewear allowance	\$100 allowance available once every calendar year.		
Inpatient hospital benefits			
Hospital benefits	\$700 copay per admission for unlimited days (maximum 3 copays per year)	40% coinsurance, subject to the deductible per admission, unlimited days	
In-Hospital Physician Visits	Covered in full	40% coinsurance, subject to the deductible	
Anesthesia	Covered in full	40% coinsurance, subject to the deductible	
Inpatient chemical dependence	\$700 copay per admission (maximum 3 copays per year)	40% coinsurance, subject to the deductible per admission	

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Inpatient mental health care	\$700 copay per admission (maximum 3 copays per year)	40% 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. \$218 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)	\$45 copay	\$45 copay	
Ambulance	\$65 copay	\$65 copay	
Outpatient benefits			
Surgical care	\$150 copay	40% coinsurance, subject to the deductible	
Ambulatory surgical center	\$150 copay	40% coinsurance, subject to the deductible	
Hospital Observation Stay	\$150 copay	40% coinsurance, subject to the deductible	
Office surgery	\$25 copay if performed in PCP office, \$45 copay if performed in specialist office	\$30 copay if performed in PCP office, \$50 copay if performed in specialist office	
Diagnostic tests and laboratory services	Covered in full	40% coinsurance, subject to the deductible	
X-rays (film) and radiation therapy	\$45 copay	40% coinsurance, subject to the deductible	
Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)	\$150 copay	40% coinsurance, subject to the deductible	
Chemotherapy (office visit)	\$45 copay; Additional cost share may apply for Medicare Part B drugs	40% coinsurance, subject to the deductible	
Outpatient mental health care	20% coinsurance, unlimited visits	40% coinsurance, subject to the deductible	
Partial hospitalization	20% coinsurance, unlimited visits	40% coinsurance, subject to the deductible	
Outpatient chemical dependence care	20% coinsurance, unlimited visits	40% coinsurance, subject to the deductible	
Other services			
Rehabilitative therapy (physical, occupational and speech)	\$40 copay	\$50 copay	
Cardiac rehabilitation	Covered in full	\$50 copay	

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MDLIVE Telehealth	MDLive Provider: \$25 copay Including teledermatology Behavioral Health Provider:\$45 copay	Not Covered	
Telehealth	Covered – follows base benefit	Covered – follows out-of-network base benefit	
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	40% coinsurance, subject to the deductible	
Diabetic education	Covered in full	\$30 copay	
Diabetic supplies	Meters and test strips: \$5 copay per 30 day supply, from a preferred manufacturer	40% coinsurance, subject to the deductible	
Insulin used in a traditional insulin pump	\$35 copayment	\$35 copayment	
Durable medical equipment	20% coinsurance	40% coinsurance, subject to the deductible	
Prosthetic devices	20% coinsurance	40% coinsurance, subject to the deductible	
Home care	Covered in full	40% 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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Prescription drugs		
Prescription drug coverage	<p>Prior Authorization and Step Therapy apply. Quantity Limits Apply.</p> <p><u>Deductible:</u> \$0</p> <p><u>Initial Coverage:</u></p> <p>30 day supply: \$10/\$45/\$90</p> <p>90 day supply: Subject to 3 times the copay</p> <p>Annual Out-Of-Pocket costs will be capped at \$2,100 for Medicare Part D Drugs.</p> <p><u>Catastrophic Coverage:</u></p> <p>The member pays \$0 copays for all Medicare Part D Drugs once the \$2,100 Annual Out-Of-Pocket is reached.</p>	Covered at in-network cost sharing in emergency situations only.

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