

Medicare Blue Choice Copay Plan

Prepared for New York State

Effective: 01/01/2026

Plan Feature Highlights	Medicare Blue Choice Copay Plan	
Type of Care/Plan Benefits	In-Network	Out-of-Network
Annual deductible	None	None
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	\$3,400 in network	N/A
Out-of-network benefits	N/A	20% coinsurance up to a maximum of \$5,000
Lifetime maximum	None	
Physician Office Services		
Office visit copay (PCP)	\$5 copay	20% coinsurance up to a maximum of \$5,000
Office visit copay (Specialist)	\$20 copay	20% coinsurance up to a maximum of \$5,000
Chiropractor office visit (manual manipulation to correct subluxation)	\$5 copay	20% coinsurance up to a maximum of \$5,000
Podiatrist office visit (for medically necessary foot care)	\$20 copay	20% coinsurance up to a maximum of \$5,000
Allergy tests/injections	\$5 copay for PCP \$20 copay for a specialist	20% coinsurance up to a maximum of \$5,000
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) Blue 365: Exclusive online discounts to 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	20% coinsurance up to a maximum of \$5,000
Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)	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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Preventive mammography	Covered in full for preventive mammography, limited to one per year	20% coinsurance up to a maximum of \$5,000
Pap smear/pelvic exam	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
Routine GYN exam	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
Prostate cancer screening	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
Bone density screening	Covered in full, limited to one per year	20% coinsurance up to a maximum of \$5,000
Colorectal screening	Covered in full for preventive colonoscopies, limited to one per year	20% coinsurance up to a maximum of \$5,000
Smoking cessation	Covered in full	20% coinsurance up to a maximum of \$5,000
Routine hearing exam	\$0 copay, one exam per year, must use TruHearing providers	Not covered.
TruHearing@Hearing aid	\$499 or \$799 copay per hearing aid. Covers 2 per year. \$50 additional cost per aid for nearing aid rechargeability	
Routine vision exam	\$20 copay per visit, limited to one exam per year	20% coinsurance up to a maximum of \$5,000
Eyewear allowance	\$120 allowance available once every calendar year.	
Preventive dental	\$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.	
Inpatient hospital benefits		
Hospital benefits	Covered in full	20% coinsurance up to a maximum of \$5,000
In-Hospital Physician Visits	Covered in full	20% coinsurance up to a maximum of \$5,000
Anesthesia	Covered in full	20% coinsurance up to a maximum of \$5,000
Inpatient chemical dependence	Covered in full	20% coinsurance up to a maximum of \$5,000
Inpatient mental health care	Covered in full	20% coinsurance up to a maximum of \$5,000
Skilled Nursing Facility		

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Skilled nursing facility (3 day inpatient stay is not required)		\$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
Emergency care			
Emergency room care (covered worldwide)		\$50 copay per visit unless admitted within 23 hours	\$50 copay per visit unless admitted within 23 hours
Urgent care (covered worldwide)		\$20 copay- Physician Billed \$50 copay- Free Standing Facility	\$20 copay- Physician Billed \$50 copay- Free Standing Facility
Ambulance		\$35 copay	\$35 copay
Outpatient benefits			
Surgical care		\$50 copay	20% coinsurance up to a maximum of \$5,000
Ambulatory surgical center		\$50 copay	20% coinsurance up to a maximum of \$5,000
Office surgery		\$5 copay to a PCP \$20 copay to a specialist	20% coinsurance up to a maximum of \$5,000
Oral surgery		\$20 copay	20% coinsurance up to a maximum of \$5,000
Diagnostic tests and laboratory services		Covered in full	20% coinsurance up to a maximum of \$5,000
X-rays and radiation therapy		\$20 copay	20% coinsurance up to a maximum of \$5,000
Chemotherapy		\$20 copay	20% coinsurance up to a maximum of \$5,000
Outpatient mental health care		20% coinsurance, unlimited visits	20% coinsurance up to a maximum of \$5,000
Partial hospitalization		20% coinsurance, unlimited visits	20% coinsurance up to a maximum of \$5,000
Outpatient chemical dependence care		20% coinsurance unlimited visits	20% coinsurance up to a maximum of \$5,000
Telehealth- network providers Telemedicine- MD Live		Follows the base benefit MD Live Providers: \$5 copayment and \$20 Behavioral Health visits consult	Follows the base benefit MD Live Providers not covered out of network
Other services			
Rehabilitation therapy (physical, occupational and speech)		\$20 copay	20% coinsurance up to a maximum of \$5,000
Cardiac rehabilitation		\$0 copay	20% coinsurance up to a maximum of \$5,000
Pulmonary rehabilitation		\$20 copay	20% coinsurance up to a maximum of \$5,000
Acupuncture		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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Medicare Part B drugs including chemotherapy drugs	\$50 copay	20% coinsurance up to a maximum of \$5,000	
Diabetic education	Covered in full	20% coinsurance up to a maximum of \$5,000	
Diabetic supplies	\$5 copay per item for a 30 day supply from preferred supplier	20% coinsurance up to a maximum of \$5,000	
Durable medical equipment	20% coinsurance	20% coinsurance up to a maximum of \$5,000	
Prosthetic devices	20% coinsurance	20% coinsurance up to a maximum of \$5,000	
Home care	Covered in full	20% coinsurance up to a maximum of \$5,000	
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	Prior Authorization, Step Therapy and Quantity Limits apply <u>Deductible:</u> \$0 <u>Initial Coverage:</u> up to \$2,100 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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