

Medicare Blue PPO Copay Plan

Prepared for Genesee Area Healthcare Plan

Effective: 01/01/2021

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
	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	<p>The Silver&Fit® Program offers:</p> <ul style="list-style-type: none"> - Up to 2 Home Fitness kits per year (\$10 annual fee) <p>And your choice of:</p> <ul style="list-style-type: none"> - 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. <p>Blue365: Exclusive discounts on health-related products and services</p>	
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 for 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 per year	\$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.	\$75 Copay for a non-TruHearing provider, limited to one exam per year.
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.	
Preventive dental	\$0 copay for up to 2 oral exams, 2 cleanings and 2 dental X-rays per year. There is no provider network. We will pay 100% of our Schedule of Allowances or the dentist's charges, whichever is less.	
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

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In-Hospital Physician Visits	Covered in full	20% coinsurance, subject to the deductible
Anesthesia	Covered in full	20% coinsurance, subject to the deductible
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. \$184 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		

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Rehabilitative therapy (physical, occupational and speech)	\$15 copay	\$25 copay
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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Prescription drugs Prescription drug coverage	Prior Authorization and Step Therapy apply. Quantity Limits Apply. <u>Deductible:</u> \$0 <u>Initial Coverage:</u> up to \$4,130 in covered drugs 30 day supply: \$10/\$30/\$50 90 day supply: Subject to 3 times the copay <u>Coverage Gap:</u> up to \$6,550 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. <u>Catastrophic Coverage:</u> The member pays the greater of \$3.70 copay for generic and a \$9.20 copay for all other drugs, or 5% coinsurance.	Covered at in-network cost sharing in emergency situations only.

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