Medicare Blue PPO Copay Plan
Prepared for Genesee Area Healthcare Plan
Effective: 01/01/2021

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

This is not a contract. It is intended to highlight the coverage of this plan. Benefits are determined by the terms of the Evidence of Coverage (contract). All benefits are subject to medical necessity.

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
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 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.	
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

This is not a contract. It is intended to highlight the coverage of this plan. Benefits are determined by the terms of the Evidence of Coverage (contract). All benefits are subject to medical necessity.

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
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		
Rehabilitative therapy (physical, occupational and speech)	$15 copay	$25 copay

This is not a contract. It is intended to highlight the coverage of this plan. Benefits are determined by the terms of the Evidence of Coverage (contract). All benefits are subject to medical necessity.

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
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

This is not a contract. It is intended to highlight the coverage of this plan. Benefits are determined by the terms of the Evidence of Coverage (contract). All benefits are subject to medical necessity.

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Prescription drugs		
Prescription drug coverage	Prior Authorization and Step Therapy apply. Quantity Limits Apply. Deductible: $0 Initial Coverage: up to $4,130 in covered drugs 30 day supply: $10/$30/$50 90 day supply: Subject to 3 times the copay Coverage Gap: 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. Catastrophic Coverage: 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.