

**Medicare Blue PPO Copay Plan**  
 Prepared for Chemung County  
 Effective: 01/01/2016

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
	In-Network	Out-of-Network
<b>Type of Care/Plan Benefits</b>		
<b>Annual deductible</b>	None	\$250
<b>Annual out-of-pocket maximum (medical services only, does not include prescription drugs)</b>	\$1,250 in network	\$8,000 combined in network and out-of-network annual out-of-pocket maximum
<b>Out-of-network benefits</b>	N/A	Benefits are available, but additional costs may apply
<b>Lifetime maximum</b>	None	
<b>Physician office services</b>		
<b>Office visit copay (PCP)</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Office visit copay (Specialist)</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Chiropractor office visit (manual manipulation to correct subluxation)</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Podiatrist office visit (for medically necessary foot care)</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Allergy tests/injections</b>	\$15 copay per visit to a specialist	\$25 copay, subject to the deductible
<b>Lifestyle and wellness benefits</b>		
<b>Ways to help you and your family live healthier every day</b>	Silver&Fit® is an Exercise Program that gives you the choice of: <ul style="list-style-type: none"> <li>- Membership in a fitness club/exercise center (\$25 annual fee)</li> <li>- Home Fitness Program (\$10 annual fee)</li> <li>- \$150 annual reimbursement toward paid membership at non-participating fitness clubs/exercise centers</li> </ul>	
	Blue365: Exclusive discounts on health-related products and services	
<b>Preventive health care services (office visit copay may apply)</b>		
<b>Annual wellness exam</b>	Covered in full, limited to one per year	\$25 copay subject to the deductible, limited to one per year
<b>Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)</b>	Covered in full	20% coinsurance, subject to the deductible, flu and pneumonia vaccines covered in full

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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, subject to the deductible, limited to one per year
Prostate cancer screening	Covered in full, limited to one per year	\$25 copay, subject to the deductible, limited to one per year
Bone density screening	Covered in full, limited to one per year	\$25 copay, subject to the deductible, limited to one per year
Colorectal screening	Covered in full for preventive colonoscopies, limited to one per year	\$25 copay, subject to the deductible limited to one per year
Smoking cessation	Covered in full	\$25 copay, subject to the deductible
Routine hearing exam	\$15 copay per visit, limited to one exam per year	\$25 copay, subject to the deductible, limited to one exam per year
Hearing aid allowance	\$300 allowance available once every 3 calendar years.	
Routine vision exam	\$15 copay per visit, limited to one exam per year	\$25 copay, subject to the deductible, 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
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		

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<b>Skilled nursing facility (3 day inpatient stay is not required)</b>	\$0 copay per day, days 1-20. 50% coinsurance per day, days 21-100. Not covered, days 100 and beyond	50% coinsurance, subject to the deductible, days 1-100. Not covered, days 100 and beyond
<b>Emergency care</b>		
<b>Emergency room care (covered worldwide)</b>	\$65 copay per visit; unless admitted within 23 hours	\$65 copay per visit; unless admitted within 23 hours
<b>Urgent care (covered nationwide)</b>	\$15 copay	\$15 copay
<b>Ambulance</b>	\$65 copay	\$65 copay
<b>Outpatient benefits</b>		
<b>Surgical care</b>	\$50 copay	20% coinsurance, subject to the deductible
<b>Ambulatory surgical center</b>	\$50 copay	20% coinsurance, subject to the deductible
<b>Hospital Observation Stay</b>	\$50 copay	20% coinsurance up to a maximum of \$8,000
<b>Office surgery</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Diagnostic tests and laboratory services</b>	Covered in full	20% coinsurance, subject to the deductible
<b>X-rays (film) and radiation therapy</b>	\$15 copay	20% coinsurance, subject to the deductible
<b>Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)</b>	\$15 copay	20% coinsurance up to a maximum of \$8,000
<b>Chemotherapy</b>	\$15 copay	20% coinsurance, subject to the deductible
<b>Outpatient mental health care</b>	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
<b>Partial hospitalization</b>	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
<b>Outpatient chemical dependence care</b>	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
<b>Other services</b>		
<b>Rehabilitative therapy (physical, occupational and speech)</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Cardiac rehabilitation</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Pulmonary rehabilitation</b>	\$15 copay	\$25 copay, subject to the deductible
<b>Acupuncture</b>	50% coinsurance, up to 10 visits per year	50% coinsurance, up to 10 visits per year

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Medicare Part B drugs including chemotherapy drugs	20% coinsurance	20% coinsurance, subject to the deductible
Diabetic education	Covered in full	20% coinsurance, subject to the deductible
Diabetic supplies	Meters and test strips: \$10 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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<b>Prescription drugs</b> <b>Prescription drug coverage</b>	Prior Authorization and Step Therapy do not apply. Quantity Limits Apply. <u>Deductible: \$0</u> <u>Initial Coverage:</u> up to \$3,310 in covered drugs 30 day supply: \$10/\$25/\$40 90 day supply: Subject to 1 times the copay <u>Coverage Gap:</u> up to \$4,850 out-of-pocket 30 day supply: \$10/\$25/\$40 90 day supply: Subject to 1 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 \$2.95 copay for generic and a \$7.40 copay for all other drugs, or 5% coinsurance.	Covered at in-network cost sharing in emergency situations only.

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