

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
Type of Care/Plan Benefits		
Annual deductible	None	\$500
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	\$2,500 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)	\$20 copay	\$25 copay, subject to the deductible
Office visit copay (Specialist)	\$20 copay	\$25 copay, subject to the deductible
Chiropractor office visit (manual manipulation to correct subluxation)	\$20 copay	\$25 copay, subject to the deductible
Podiatrist office visit (for medically necessary foot care)	\$20 copay	\$25 copay, subject to the deductible
Allergy tests/injections	\$20 copay per visit to a specialist	\$25 copay, subject to the deductible
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: <ul style="list-style-type: none"> - Membership in a fitness club/exercise center (\$25 annual fee) - Home Fitness Program (\$10 annual fee) - \$150 annual reimbursement toward paid membership at non-participating fitness clubs/exercise centers 	
	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 subject to the deductible, limited to one per year
Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)	Covered in full	30% 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	30% coinsurance, subject to the deductible, limited to one per year
Pap smear/pelvic exam	Covered in full, limited to one every 24 months	30% 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	\$20 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	\$20 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	\$500 copay per admission for unlimited days (maximum 3 copays per year)	30% coinsurance, subject to the deductible per admission, unlimited days
In-Hospital Physician Visits	Covered in full	30% coinsurance, subject to the deductible
Anesthesia	Covered in full	30% coinsurance, subject to the deductible
Inpatient chemical dependence	\$500 copay per admission (maximum 3 copays per year)	30% coinsurance, subject to the deductible per admission
Inpatient mental health care	\$500 copay per admission (maximum 3 copays per year)	30% coinsurance, subject to the deductible per admission
Skilled-nursing-facility		

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Skilled nursing facility (3 day inpatient stay is not required)	\$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
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 nationwide)	\$20 copay	\$20 copay
Ambulance	\$65 copay	\$65 copay
Outpatient benefits		
Surgical care	\$50 copay	30% coinsurance, subject to the deductible
Ambulatory surgical center	\$50 copay	30% coinsurance, subject to the deductible
Hospital Observation Stay	\$50 copay	30% coinsurance up to a maximum of \$8,000
Office surgery	\$20 copay	\$25 copay, subject to the deductible
Diagnostic tests and laboratory services	Covered in full	30% coinsurance, subject to the deductible
X-rays (film) and radiation therapy	\$20 copay	30% coinsurance, subject to the deductible
Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)	\$20 copay	30% coinsurance up to a maximum of \$8,000
Chemotherapy	\$20 copay	30% coinsurance, subject to the deductible
Outpatient mental health care	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
Partial hospitalization	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
Outpatient chemical dependence care	20% coinsurance, unlimited visits	35% coinsurance, subject to the deductible
Other services		
Rehabilitative therapy (physical, occupational and speech)	\$20 copay	\$25 copay, subject to the deductible
Cardiac rehabilitation	\$20 copay	\$25 copay, subject to the deductible
Pulmonary rehabilitation	\$20 copay	\$25 copay, subject to the deductible
Acupuncture	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	30% coinsurance, subject to the deductible
Diabetic education	Covered in full	30% coinsurance, subject to the deductible
Diabetic supplies	Meters and test strips: \$10 copay per 30 day supply, from a preferred manufacturer	30% coinsurance, subject to the deductible
Durable medical equipment	20% coinsurance	30% coinsurance, subject to the deductible
Prosthetic devices	20% coinsurance	30% coinsurance, subject to the deductible
Home care	Covered in full	30% 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> up to \$3,310 in covered drugs 30 day supply: \$10/\$25/\$40 90 day supply: Subject to 2 times the copay</p> <p><u>Coverage Gap:</u> up to \$4,850 out-of-pocket 30 day supply: \$10/\$25/\$40 90 day supply: Subject to 2 times the copay</p> <p>Coverage for generic drugs is provided by the Part D plan. Coverage for brand name drugs is provided by a wraparound group health plan.</p> <p><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.</p>	<p>Covered at in-network cost sharing in emergency situations only.</p>

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