



Univera Medicare PPO Copay Plan

Prepared for Broome County Purchasing Alliance

Effective: 01/01/2026

MAPD PPO Plan 3

| Plan Feature Highlights | Univera Medicare PPO 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) | \$0 in-network | \$0 combined in-network and out-of-network |
| Out-of-network benefits | N/A | Benefits are available |
| Lifetime maximum | None | |
| Physician office services | | |
| Office visit copay (PCP) | \$0 copay | \$0 copay |
| Office visit copay (Specialist) | \$0 copay | \$0 copay |
| Chiropractor office visit (manual manipulation to correct subluxation) | \$0 copay | \$0 copay |
| Podiatrist office visit (for medically necessary foot care) | \$0 copay | \$0 copay |
| Allergy tests/injections | \$0 copay if performed in PCP office, \$0 copay if performed in a specialist | \$0 copay if performed in PCP office, \$0 copay if performed in specialist office |
| Lifestyle and wellness benefits | | |
| Ways to help you and your family live healthier every day | Silver&Fit® is an Exercise Program that gives you 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) Access to Health Coaching and other tools to be active and stay healthy | |
| Preventive health care services (office visit copay may apply) | | |
| Annual wellness exam | Covered in full, limited to one per year | Covered in full, limited to one per year |

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| Plan Feature Highlights | | Univera Medicare PPO Copay Plan | |
|---|--|--|--|
| Type of Care/Plan Benefits | | In-Network | Out-of-Network |
| Immunizations (flu, pneumonia, COVID, Hepatitis B, and other vaccines if patient is at risk) | | Covered in full | Covered in full |
| Preventive mammography | | Covered in full for preventive mammography, limited to one per year | Covered in full for preventive mammography, limited to one per year |
| Pap smear/pelvic exam | | Covered in full, limited to one every 24 months, if high risk covered once every 12 months | Covered in full, limited to one every 24 months, if high risk covered once every 12 months |
| Routine GYN exam | | Covered in full, limited to one every 24 months, if high risk covered once every 12 months | Covered in full, limited to one every 24 months, if high risk covered once every 12 months |
| Prostate cancer screening | | Covered in full, limited to one per year | Covered in full, limited to one per year |
| Bone density screening | | Covered in full, limited to one every 24 months | Covered in full, limited to one every 24 months |
| Colorectal screening | | Covered in full for preventive colonoscopies, limited to one every 24 months | Covered in full for preventive colonoscopies, limited to one every 24 months |
| Smoking cessation | | Covered in full | Covered in full |
| Routine hearing exam | | Covered in full, limited to one exam per year. Must use a TruHearing Provider. | Not covered |
| Hearing Aid(s) | | \$499 Copay for Advanced Hearing Aids or \$799 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. | Not covered |
| Routine vision exam | | Covered in full per visit, limited to one exam per year | Covered in full, limited to one exam per year |
| Eyewear allowance | | \$100 allowance available once every calendar year. | |

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|--|---|---|
| Type of Care/Plan Benefits | In-Network | Out-of-Network |
| Inpatient hospital benefits | | |
| Hospital benefits | \$0 copay per admission for unlimited days | \$0 copay per admission for unlimited days |
| In-Hospital Physician Visits | \$0 copay | \$0 copay |
| Anesthesia | \$0 copay | \$0 copay |
| Inpatient chemical dependence | \$0 copay per admission | \$0 copay per admission |
| Inpatient mental health care | \$0 copay per admission | \$0 copay per admission |
| Skilled nursing facility | | |
| Skilled nursing facility (3 day inpatient stay is not required) | \$0 copay per day, days 1-100. Not covered, days 101 and beyond | \$0 copay per day, days 1-100. Not covered, days 101 and beyond |
| Emergency care | | |
| Emergency room care (covered worldwide) | \$0 copay per visit; unless admitted within 23 hours | \$0 copay per visit; unless admitted within 23 hours |
| Urgent care (covered worldwide) | \$0 copay | \$0 copay |
| Ambulance | \$0 copay | \$0 copay |
| Outpatient benefits | | |
| Surgical care | \$0 copay | \$0 copay |
| Ambulatory surgical center | \$0 copay | \$0 copay |
| Hospital Observation Stay | \$0 copay | \$0 copay |
| Office surgery | \$0 copay if performed in PCP office, \$0 copay if performed in specialist office | \$0 copay if performed in PCP office, \$0 copay if performed in specialist office |
| Diagnostic tests and laboratory services | \$0 copay | \$0 copay |
| X-rays (film) and radiation therapy | \$0 copay | \$0 copay |
| Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc) | \$0 copay | \$0 copay |
| Chemotherapy (office visit) | \$0 copay | \$0 copay |
| Outpatient mental health care | \$0 copay, unlimited visits | \$0 copay, unlimited visits |

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|---|--|--|
| Type of Care/Plan Benefits | In-Network | Out-of-Network |
| Partial hospitalization | \$0 copay, unlimited visits | \$0 copay, unlimited visits |
| Outpatient chemical dependence care | \$0 copay, unlimited visits | \$0 copay, unlimited visits |
| Other services | | |
| Rehabilitation therapy (physical, occupational and speech) | \$0 copay | \$0 copay |
| Cardiac rehabilitation | \$0 copay | \$0 copay |
| MDLIVE Telehealth | MDLive Provider: \$0 copay Behavioral Health Provider: \$0 copay | Not Covered |
| Telehealth | Covered – follows base benefit | Covered – follows out-of-network base benefit |
| Acupuncture | \$0 copay, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis | \$0 copay, 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 | \$0 copay | \$0 copay |
| Diabetic education | \$0 copay | \$0 copay |
| Diabetic supplies | Meters and test strips: \$0 copay per 30 day supply, from a preferred manufacturer | Meters and test strips: \$0 copay per 30 day supply, from a preferred manufacturer |
| Insulin used in a traditional insulin pump | \$0 copay | \$0 copay |
| Durable medical equipment | \$0 copay | \$0 copay |
| Prosthetic devices | \$0 copay | \$0 copay |
| Home care | \$0 copay | \$0 copay |
| Hospice | Covered by Original Medicare | Covered by Original Medicare |
| Kidney dialysis | \$0 copay | \$0 copay |

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|----------------------------|--|--|---|
| Type of Care/Plan Benefits | | In-Network | Out-of-Network |
| 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></p> <p>30 day supply: \$10/\$20/\$35</p> <p>90 day supply:</p> <p>Subject to 2 times the copay</p> <p>Annual Out-Of-Pocket costs will be capped at \$2,100 for Medicare Part D Drugs.</p> <p><u>Catastrophic Coverage:</u></p> <p>The member pays \$0 copays for all Medicare Part D Drugs once the \$2,100 Annual Out-Of-Pocket is reached.</p> | <p>Covered at in-network cost sharing in emergency situations only.</p> |

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Prepared for: Broome County Purchasing Alliance

Univera Medicare PPO Copay Plan

Quote Effective: 01/01/2026

Rating Region: Western New York

Plan Cycle: Calendar Year

Rate Type: Large Group

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| Type of Care/Plan Benefits | In-Network | Out-of-Network |
| Office visit copay (PCP) | \$0 copay | \$0 copay |
| Office visit copay (Specialist) | \$0 copay | \$0 copay |
| Hospital benefits | \$0 copay per admission for unlimited days | \$0 copay per admission for unlimited days |
| Emergency room care | \$0 copay per visit unless admitted within 23 hours. Covered worldwide. | |
| Urgent care | \$0 copay in-Network. Covered worldwide. | |
| Out-of-network benefits | Benefits are available | |
| Prescription drugs | \$10/\$20/\$35 Subject to 2 times the copay for a 90 day supply | Covered at in-network cost sharing in emergency situations only. |
| Eyewear allowance | \$100 eyewear allowance available once every calendar year | |
| Annual deductible | None | None |
| Annual out-of-pocket maximum (medical services only) | \$0 combined in-network and out-of-network | |
| Lifestyle and Wellness benefits | Silver&Fit® fitness program and Health Coaching | |

| Proposed Rate | |
|---------------|----------|
| 1 Tier | \$613.00 |

NOTE: Rate is subject to New York State Department of Financial Services approval of employer group prescription drug plans.

By signing this rate quote, the employer group agrees to the following:

Compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for Uniform Premium waivers in relation to premiums charged to our group plan participants. The employer group plan sponsor cannot charge participants covered under this plan an amount greater than the standard Medicare Part D beneficiary premium plus up to 100% of the value of any supplement prescription drug coverage.

Administration of any Low Income Subsidy (LIS) premium payments received for plan participants in accordance with CMS regulations (any LIS premium payments we receive from CMS for plan participants will be passed through to the employer group).

Compliance with alternative disclosure requirements under ERISA, including Summary Plan descriptions of benefit offerings to participants covered under this plan.

Qualification as an employer group under standard underwriting guidelines. The employer group plan sponsor must operate in the plan service area, offer active employees a benefit offering (no retiree only groups), have 2 or more employees, contribute to the premium and not be a Chamber, Trust or Association.

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Quoted premium rates contain a factor for broker commissions included in the overall retention load. The Sales Representative providing this quote is a New York State licensed insurance producer. The individual will be compensated in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.

Signature: _____
(Group Representative)

Title: _____ Date: _____

Quote Effective Date: 01/01/2026