Medicare Blue PPO Copay Plan
Prepared for Broome County Purchasing Alliance
Effective: 01/01/2027

MAPD PPO Plan 12

Plan Feature Highlights	Medicare Blue 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)	$1,250 in-network	$1,250 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)	$20 copay	$20 copay
Office visit copay (Specialist)	$20 copay	$20 copay
Chiropractor office visit (manual manipulation to correct subluxation)	$20 copay	$20 copay
Podiatrist office visit (for medically necessary foot care)	$20 copay	$20 copay
Allergy tests/injections	$20 copay if performed in PCP office, $20 copay if performed in a specialist office	$20 copay if performed in PCP office, $20 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 the 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) - $150 allowance for non-participating fitness clubs/exercise center 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	Covered in full, limited to one per year
Immunizations (flu, pneumonia, COVID, Hepatitis B, and other vaccines if patient is at risk)	Covered in full	Covered in full

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Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
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.	$75 copayment, limited to one exam per year
Hearing Aid(s)	$299 Copay for Standard Hearing Aid, $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. $75 allowance for non-TruHearing in-network providers	$75 allowance, combined in-network and out-of-network
Routine vision exam	$20 copay, limited to one exam per year	$20 copay, limited to one exam per year
Eyewear allowance	$100 allowance available once every calendar year.	
Inpatient hospital benefits		
Hospital benefits	$100 copay per admission, unlimited days (maximum 3 copays per year)	$100 copay per admission, unlimited days (maximum 3 copays per year)
In-Hospital Physician Visits	Covered in full	Covered in full
Anesthesia	Covered in full	Covered in full
Inpatient chemical dependence	$100 copay per admission (maximum 3 copays per year)	$100 copay per admission (maximum 3 copays per year)

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Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Inpatient mental health care	$100 copay per admission (maximum 3 copays per year)	$100 copay per admission (maximum 3 copays per year)
Skilled Nursing Facility		
Skilled nursing facility (3 day inpatient stay is not required)	$0 copay per day, days 1-20. $221 copay per day, days 21-100. Not covered, days 101 and beyond	$0 copay per day, days 1-20. $221 copay per day, days 21-100. 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)	$20 copay	$20 copay
Ambulance	$65 copay	$65 copay
Outpatient benefits		
Surgical care	$50 copay	$50 copay
Ambulatory surgical center	$50 copay	$50 copay
Hospital Observation Stay	$50 copay	$50 copay
Office surgery	$20 copay if performed in PCP office, $20 copay if performed in specialist office	$20 copay if performed in PCP office, $20 copay if performed in specialist office
Diagnostic tests and laboratory services	$0 copay	$0 copay
X-rays (film) and radiation therapy	$20 copay	$20 copay
Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)	$20 copay	$20 copay
Chemotherapy (office visit)	$20 copay	$20 copay
Outpatient mental health care	20% coinsurance	20% coinsurance
Partial hospitalization	20% coinsurance	20% coinsurance
Outpatient chemical dependence care	20% coinsurance	20% coinsurance
Other services		
Rehabilitative therapy (physical, occupational and speech)	$20 copay	$20 copay
Cardiac rehabilitation	$0 copay	$0 copay
MDLIVE Telehealth	MDLive Provider: $20 copay Including teledermatology Behavioral Health Provider: $20 copay	Not Covered
Telehealth	Covered - follows base benefit	Covered - follows out-of-network base benefit

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Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Acupuncture	$20 copay, up to 20 visits per year for chronic lower back pain and 10 additional visits for any diagnosis	$20 copay, up to 20 visits per year for chronic lower back pain and 10 additional visits for any diagnosis
Medicare Part B drugs including chemotherapy drugs	20% coinsurance	20% coinsurance
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	$35 copay	$35 copay
Durable medical equipment	20% coinsurance	20% coinsurance
Prosthetic devices	20% coinsurance	20% coinsurance
Home care	Covered in full	Covered in full
Hospice	Covered by Original Medicare	Covered by Original Medicare
Kidney dialysis	Covered in full	Covered in full

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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: 30 day supply: $10/$25/$40 90 day supply: Subject to 1 times the copay Annual out-of-pocket costs will be capped at $2,400 for Medicare Part D drugs. Catastrophic Coverage: The member pays $0 copay for all Medicare Part D Drugs once the $2,400 annual out-of-pocket is reached.	Covered at in-network cost sharing in emergency situations only.

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Prepared for Broome County Purchasing Alliance

Medicare Blue PPO Copay Plan

Quote Effective: 01/01/2027	Rating Region: Syracuse
Plan Cycle: Calendar Year	Rate Type: Large Group

Plan Feature Highlights	Medicare Blue Choice Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Office visit copay (PCP)	$20 copay	$20 copay
Office visit copay (Specialist)	$20 copay	$20 copay
Hospital benefits	$100 copay per admission for unlimited days (maximum 3 copays per year)	$100 copay per admission for unlimited days (maximum 3 copays per year)
Prescription drugs	$10/$25/$40 Subject to 1 times the copay for a 90 day supply	Covered at in-network cost sharing in emergency situations only.
Emergency room care	$65 copay per visit; unless admitted within 23 hours	
Urgent care	$20 copay. Covered worldwide.	
Eyewear allowance	$100 allowance available once every calendar year.	
Annual deductible	None	None
Annual out-of-pocket maximum (medical services only)	$1,250 combined in network and out-of-network	
Lifestyle and wellness benefits	Silver&Fit® fitness program, Blue 365: Exclusive discounts on health-related products and services	

Proposed Rate	
1 Tier	$391.26

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: _____ Title: _____ Date: _____
(Group Representative)

Quote Effective Date: 01/01/2027