Medicare Blue PPO Copay Plan
Prepared for Marion Central School
Effective: 01/01/2023

MB PPO LG 2 - $5/$20/$35 3x Rx - Dental

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	Silver&Fit® is an Exercise Program that gives you the choice of: - Membership in a fitness club/exercise center ($0 annual fee) - Home Fitness Program ($0 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
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

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Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
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 every 24 months	$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 every 24 months	20% coinsurance, subject to the deductible, limited to one per year
Colorectal screening	Covered in full for preventive colonoscopies, limited to one every 24 months	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.	$0 copay, limited to one exam per year. Must use a TruHearing Provider.
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.	
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.	
Preventive dental	The plan will pay up to a maximum allowable benefit for each service covered. If your dentist does not participate in the health plan's network and charges more than the maxmium allowable benefit, you will be responsible for the additional costs.	
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

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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. $196 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 the 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

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Cardiac rehabilitation	Covered in full	$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

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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 $4,660 in covered drugs 30 day supply: $5/$20/$35 90 day supply: Subject to 3 times the copay Coverage Gap: up to $7,400 out-of-pocket 30 day supply: $5/$20/$35 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 $4.15 copay for generic and a $10.35 copay for all other drugs, or 5% coinsurance.	Covered at in-network cost sharing in emergency situations only.

Excellus

Quote Prepared for: Marion Central School

Medicare Blue PPO Copay Plan	
Quote Effective: 01/01/2023	Rating Region: Rochester
Plan Cycle: Calendar Year	Rate Type: Large Group

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Office visit copay (PCP)	$15 copay	$25 copay
Office visit copay (Specialist)	$15 copay	$25 copay
Hospital benefits	$250 copay per admission for unlimited days (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission, unlimited days
Emergency room care	$65 copay per visit unless admitted within 23 hours. Covered worldwide.	
Urgent care	$15 copay In-Network. Covered worldwide.	
Out-of-network benefits	Benefits are available, but additional costs may apply	
Prescription drugs	$5/$20/$35 Subject to 3 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	
Preventive dental	The plan will pay up to a maximum allowable benefit for each service covered. If your dentist does not participate in the health plan's network and charges more than the maxmium allowable benefit, you will be responsible for the additional costs.	
Annual deductible	None	$250
Annual out-of-pocket maximum (medical services only)	$1,250 in network	$8,000 combined in-network and out-of-network annual out-of-pocket maximum
Lifestyle and wellness benefits	Silver&Fit® fitness program, Blue365: Exclusive discounts on health-related products and services	

Proposed Rate	

1 Tier	$187.31

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: 01/01/2023