

Medicare Blue PPO Copay Plan

Prepared for Lewis County

Effective: 01/01/2025

PPO Plan 1

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	In-Network	Out-of-Network
Annual deductible	None	\$0
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	\$0 combined in network and out-of-network	\$0 combined in network and out-of-network
Out-of-network benefits	N/A	Benefits are available, but additional costs may apply
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 office	\$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	<p>FitOn® is an Exercise Program that offers the following at no cost (\$0 copayment):</p> <ul style="list-style-type: none"> - Membership in a participating fitness facility - Access to online digital fitness classes - Home fitness accessories and equipment - Access to nonparticipating fitness facilities if needed. <p>Blue365: Exclusive discounts on health-related products and services</p>	
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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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.	
Inpatient hospital benefits		
Hospital benefits	\$0 copay per admission for unlimited days	\$0 copay per admission, 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

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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	\$0 copay	\$0 copay
Outpatient mental health care	\$0 copay, unlimited visits	\$0 copay, unlimited visits
Partial hospitalization	\$0 copay, unlimited visits	\$0 copay, unlimited visits
Outpatient chemical dependence care	\$0 copay, unlimited visits	\$0 copay, unlimited visits
Other services		
Rehabilitative therapy (physical, occupational and speech)	\$0 copay	\$0 copay
Cardiac rehabilitation	\$0 copay	\$0 copay
Telehealth	MDLive Provider: \$0 copay Behavioral Health Provider:\$0 copay Additional Telehealth Services: follows in-person copay	Not Covered Additional Telehealth Services: follows in-person copay

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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	\$0 copay
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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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: \$0/\$5/\$20</p> <p>90 day supply: Subject to 1 times the copay</p> <p>Annual out-of-pocket costs will be capped at \$2,000 for Medicare Part D drugs.</p> <p><u>Catastrophic Coverage:</u></p> <p>The member pays \$0 copay for all drugs.</p> <p><u>Out of Network:</u></p> <p>Covered at in network cost sharing in emergency situations only.</p>	<p>Covered at in-network cost sharing in emergency situations only.</p>

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