

Prepared for: St. John Fisher University  
Effective: 01/01/2027

Plan Name: **Small Group Medicare Blue Choice Plan 2**

| Plan Feature Highlights                                                                      | Medicare Blue Choice 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)    | \$3,400 in network                                                                                                                                                                                                                                                                                | N/A                                                                                        |
| Out-of-network benefits                                                                      | N/A                                                                                                                                                                                                                                                                                               | 20% coinsurance up to a maximum of \$5,000                                                 |
| Lifetime maximum                                                                             | None                                                                                                                                                                                                                                                                                              |                                                                                            |
| Physician office services                                                                    |                                                                                                                                                                                                                                                                                                   |                                                                                            |
| Office visit copay (PCP)                                                                     | \$20 copay                                                                                                                                                                                                                                                                                        | 20% coinsurance up to a maximum of \$5,000                                                 |
| Office visit copay (Specialist)                                                              | \$20 copay                                                                                                                                                                                                                                                                                        | 20% coinsurance up to a maximum of \$5,000                                                 |
| Chiropractor office visit (manual manipulation to correct subluxation)                       | \$20 copay                                                                                                                                                                                                                                                                                        | 20% coinsurance up to a maximum of \$5,000                                                 |
| Podiatrist office visit (for medically necessary foot care)                                  | \$20 copay                                                                                                                                                                                                                                                                                        | 20% coinsurance up to a maximum of \$5,000                                                 |
| Allergy tests/injections                                                                     | \$20 copay if performed in PCP office, \$20 copay if performed in a specialist office                                                                                                                                                                                                             | 20% coinsurance up to a maximum of \$5,000                                                 |
| 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:<br>- Membership in a fitness club/exercise center (\$0 annual fee)<br>- You can also participate in the Silver&Fit Home Fitness Program (\$0 annual fee)<br>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                                                                                                                                                                                                                                                          | 20% coinsurance up to a maximum of \$5,000, limited to one per year                        |
| Immunizations (flu, pneumonia, COVID, Hepatitis B, and other vaccines if patient is at risk) | Covered in full                                                                                                                                                                                                                                                                                   | 20% coinsurance, subject to the deductible, flu and pneumonia vaccines are covered in full |

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| Plan Feature Highlights    | Medicare Blue Choice 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                                                                                                                                                                        | 20% coinsurance up to a maximum of \$5,000, limited to one per year      |
| Pap smear/pelvic exam      | Covered in full, limited to one every 24 months                                                                                                                                                                                            | 20% coinsurance up to a maximum of \$5,000, limited to one per 24 months |
| Routine GYN exam           | Covered in full, limited to one per year                                                                                                                                                                                                   | 20% coinsurance up to a maximum of \$5,000, limited to one per year      |
| Prostate cancer screening  | Covered in full, limited to one per year                                                                                                                                                                                                   | 20% coinsurance up to a maximum of \$5,000, limited to one per year      |
| Bone density screening     | Covered in full, limited to one per year                                                                                                                                                                                                   | 20% coinsurance up to a maximum of \$5,000, limited to one per year      |
| Colorectal screening       | Covered in full for preventive colonoscopies, limited to one per year                                                                                                                                                                      | 20% coinsurance up to a maximum of \$5,000, limited to one per year      |
| Smoking cessation          | Covered in full                                                                                                                                                                                                                            | 20% coinsurance up to a maximum of \$5,000                               |
| Routine hearing exam       | \$0 copay, limited to one exam per year. Must use a TruHearing Provider.                                                                                                                                                                   | Not covered                                                              |
| 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. | Not Covered                                                              |
| Routine vision exam        | \$20 copay per visit, limited to one exam per year                                                                                                                                                                                         | 20% coinsurance up to a maximum of \$5,000, limited to one exam per year |
| Eyewear allowance          | \$100 allowance available once every calendar year.                                                                                                                                                                                        |                                                                          |

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| <b>Plan Feature Highlights</b>                                         |  | <b>Medicare Blue Choice Copay Plan</b>                                                           |                                                                       |
|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <b>Type of Care/Plan Benefits</b>                                      |  | <b>In-Network</b>                                                                                | <b>Out-of-Network</b>                                                 |
| <b>Inpatient hospital benefits</b>                                     |  |                                                                                                  |                                                                       |
| <b>Hospital benefits</b>                                               |  | \$250 copay per admission for unlimited days (maximum 3 copays per year)                         | 20% coinsurance up to a maximum of \$5,000                            |
| <b>In-Hospital Physician Visits</b>                                    |  | Covered in full                                                                                  | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Anesthesia</b>                                                      |  | Covered in full                                                                                  | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Inpatient chemical dependence</b>                                   |  | \$250 copay per admission (maximum 3 copays per year)                                            | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Inpatient mental health care</b>                                    |  | \$250 copay per admission (maximum 3 copays per year)                                            | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Skilled nursing facility</b>                                        |  |                                                                                                  |                                                                       |
| <b>Skilled nursing facility (3 day inpatient stay is not required)</b> |  | \$0 copay per day, days 1-20. \$221 copay per day, days 21-100. Not covered, days 101 and beyond | 20% coinsurance per day, days 1-100. Not covered, days 101 and beyond |
| <b>Emergency care</b>                                                  |  |                                                                                                  |                                                                       |
| <b>Emergency room care (covered worldwide)</b>                         |  | \$65 copay per visit; unless admitted within 23 hours                                            | \$65 copay per visit; unless admitted within 23 hours                 |
| <b>Urgent care (covered worldwide)</b>                                 |  | \$20 copay                                                                                       | \$20 copay                                                            |
| <b>Ambulance</b>                                                       |  | \$65 copay                                                                                       | \$65 copay                                                            |
| <b>Outpatient benefits</b>                                             |  |                                                                                                  |                                                                       |
| <b>Surgical care</b>                                                   |  | \$50 copay                                                                                       | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Ambulatory surgical center</b>                                      |  | \$50 copay                                                                                       | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Hospital Observation Stay</b>                                       |  | \$50 copay                                                                                       | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Office surgery</b>                                                  |  | \$20 copay if performed in PCP office, \$20 copay if performed in specialist office              | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Diagnostic tests and laboratory services</b>                        |  | Covered in full                                                                                  | 20% coinsurance up to a maximum of \$5,000                            |
| <b>X-rays (film) and radiation therapy</b>                             |  | \$20 copay                                                                                       | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)</b>            |  | \$20 copay                                                                                       | 20% coinsurance up to a maximum of \$5,000                            |
| <b>Chemotherapy (office visit)</b>                                     |  | \$20 copay; Additional cost share may apply for Medicare Part B drugs                            | 20% coinsurance up to a maximum of \$5,000                            |

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| <b>Plan Feature Highlights</b>                                    | <b>Medicare Blue Choice Copay Plan</b>                                                                                 |                                               |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Type of Care/Plan Benefits</b>                                 | <b>In-Network</b>                                                                                                      | <b>Out-of-Network</b>                         |
| <b>Outpatient mental health care</b>                              | 20% coinsurance, unlimited visits                                                                                      | 20% coinsurance up to a maximum of \$5,000    |
| <b>Partial hospitalization</b>                                    | 20% coinsurance, unlimited visits                                                                                      | 20% coinsurance up to a maximum of \$5,000    |
| <b>Outpatient chemical dependence care</b>                        | 20% coinsurance, unlimited visits                                                                                      | 20% coinsurance up to a maximum of \$5,000    |
| <b>Other services</b>                                             |                                                                                                                        |                                               |
| <b>Rehabilitative therapy (physical, occupational and speech)</b> | \$20 copay                                                                                                             | 20% coinsurance up to a maximum of \$5,000    |
| <b>Cardiac rehabilitation</b>                                     | Covered in full                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>MDLIVE Telehealth</b>                                          | MDLive Provider: \$20 copay<br>Behavioral Health Provider: \$20 copay                                                  | Not Covered                                   |
| <b>Telehealth</b>                                                 | Covered – follows base benefit                                                                                         | Covered – follows out-of-network base benefit |
| <b>Acupuncture</b>                                                | 50% coinsurance, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis | Not Covered                                   |
| <b>Medicare Part B drugs including chemotherapy drugs</b>         | 20% coinsurance                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>Diabetic education</b>                                         | Covered in full                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>Diabetic supplies</b>                                          | Meters and test strips: \$5 copay per 30 day supply, from a preferred manufacturer                                     | 20% coinsurance up to a maximum of \$5,000    |
| <b>Insulin used in a traditional insulin pump</b>                 | \$35 copayment                                                                                                         | \$35 copayment                                |
| <b>Durable medical equipment</b>                                  | 20% coinsurance                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>Prosthetic devices</b>                                         | 20% coinsurance                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>Home care</b>                                                  | Covered in full                                                                                                        | 20% coinsurance up to a maximum of \$5,000    |
| <b>Hospice</b>                                                    | Covered by Original Medicare                                                                                           | Covered by Original Medicare                  |
| <b>Kidney dialysis</b>                                            | Covered in full                                                                                                        | Covered in full                               |

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|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Type of Care/Plan Benefits        | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Out-of-Network                                                          |
| <b>Prescription drugs</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                         |
| <b>Prescription drug coverage</b> | <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:<br/>\$10/\$30/\$50</p> <p>90 day supply:</p> <p>Subject to 3 times the copay</p> <p>Annual Out-Of-Pocket costs will be capped at \$2,400 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 \$2,400 Annual Out-Of-Pocket is reached.</p> | <p>Covered at in-network cost sharing in emergency situations only.</p> |

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