Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

2021 SUMMARY OF BENEFITS
January 1, 2021 – December 31, 2021

Medicare Blue Choice® Optimum (HMO-POS) (H3351-006)
Medicare Blue Choice® Platinum (HMO-POS) (H3351-007)
Medicare Blue Choice® Value Plus (HMO-POS) (H3351-013)

This is a summary of drug and health services covered by Excellus BlueCross BlueShield.

Excellus BlueCross BlueShield contracts with the Federal Government and is an HMO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling us at the telephone numbers on the next page.

To join **Medicare Blue Choice® Value Plus (HMO-POS), Medicare Blue Choice® Optimum (HMO-POS) and Medicare Blue Choice® Platinum (HMO-POS),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New York: Livingston, Monroe, Ontario, Seneca, Wayne, and Yates.

Medicare Blue Choice® Value Plus (HMO-POS), Medicare Blue Choice® Optimum (HMO-POS) and Medicare Blue Choice® Platinum (HMO-POS) have a network of doctors, hospitals, and other providers. In general, if you use providers that are not in our network, the plan may not pay for these services. However, the Point-of-Service (POS) benefit does allow you to use providers that are not in our network for some services. Check this document and the Evidence of Coverage for more information.

Medicare Blue Choice® Optimum (HMO-POS) and Medicare Blue Choice® Value Plus (HMO-POS), also have a network of pharmacies. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print.

This information is not a complete description of benefits. Call us at one of the phone numbers listed below for more information.

If you are a member of one of these plans: Call toll-free at 1-877-883-9577 (TTY users call 1-800-662-1220).
From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

If you are not a member of one of these plans: Call toll-free at 1-800-659-1986 (TTY users call 1-800-662-1220).
From October 1 to December 30, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
From January 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

You can also visit us at ExcellusMedicare.com.

You can see our plan's provider and/or pharmacy directory at our website at ExcellusMedicare.com/Providers. Or, call us and we will send you a copy of the directory.

Medicare Blue Choice® Platinum (HMO-POS): We cover Part B drugs such as chemotherapy and some drugs administered by your provider.

Medicare Blue Choice® Value Plus (HMO-POS) and Medicare Blue Choice® Optimum (HMO-POS) : We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs), and any restrictions on our website at ExcellusMedicare.com/Formulary. Or, call us and we will send you a copy of our formulary.

This information is not a complete description of benefits. Call 1-800-659-1986 (TTY users call 1-800-662-1220) for more information.

Out-of-network/non-contracted providers are under no obligation to treat Excellus BlueCross BlueShield members, except in emergency situations. Please call our Customer Care number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Excellus BlueCross BlueShield's pharmacy network includes limited lower-cost, preferred pharmacies. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-877-883-9577 (TTY: 1-800-662-1220) or consult the online pharmacy directory at ExcellusMedicare.com/Providers.

The Silver&Fit Program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). ASH is an independent company.

TruHearing is an independent company offering a network of audiologists and hearing aid providers.

MDLive is an independent company offering telehealth services in the Excellus BlueCross BlueShield service area.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Monthly Plan Premium	You pay $158 per month.	You pay $256 per month.	You pay $117 per month.	You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$6,700 for medical services you receive from In-Network providers.	$6,700 for medical services you receive from In-Network providers.	$4,500 for medical services you receive from In-Network providers.	The most you pay for copayments and coinsurance for medical services for the year.
Inpatient Hospital Coverage	**In-Network:** You pay $310 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission.	**In-Network:** You pay $285 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission.	**In-Network:** You pay $260 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission.	Prior Authorization is required. Our plan covers an unlimited number of days for an inpatient hospital stay. Benefit applied per admission.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Inpatient Hospital Coverage *(Continued)*	**Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Ambulatory Surgery Center	**In-Network:** You pay $400 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required.
Outpatient Hospital Coverage	**In-Network:** You pay $400 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Doctor Visits				
Primary	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $15 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Specialists	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Preventive Care	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	See the Evidence of Coverage for a list of covered preventive services. If you are treated for a new or existing medical condition during a visit where a preventive screening is performed, an office visit copayment or coinsurance will apply to the care received for the new or existing medical condition. Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Emergency Care	You pay $90 copayment.	You pay $90 copayment.	You pay $90 copayment.	If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	You pay $40 copayment.	You pay $40 copayment.	You pay $50 copayment.	
Diagnostic Services/Labs/ Imaging Diagnostic Radiology Service *(e.g., MRI, CT scans)*	**In-Network:** You pay $175 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $150 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $150 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required for some services. Contact us for more information.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Diagnostic Services/Labs/ Imaging *(Continued)*				
Lab Services - Diagnostics	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Diagnostic Tests and Procedures	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Diagnostic Services/Labs/ Imaging *(Continued)* X-Rays	**In-Network:** You pay $50 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Therapeutic Radiology (such as radiation treatment for cancer)	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Hearing Services Diagnostic/ Treatment Exam	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Routine Hearing Exam	**In-Network:** You pay $45 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $45 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $45 copayment. **Out-of-Network:** Not covered.	One routine hearing exam each year. You must see a TruHearing® provider to receive in-network benefits. This copayment not included in the Out-of-Pocket Maximum.
Hearing Aid	$699 copay per aid for Advanced Aids. $999 copay per aid for Premium Aids. $50 per aid for optional hearing aid rechargeability.	$699 copay per aid for Advanced Aids. $999 copay per aid for Premium Aids. $50 per aid for optional hearing aid rechargeability.	$699 copay per aid for Advanced Aids. $999 copay per aid for Premium Aids. $50 per aid for optional hearing aid rechargeability.	From TruHearing Providers only. This copayment not included in the Out-of-Pocket Maximum.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Dental Services	**Medicare covered limited dental services** (this does not include routine services in connection with care, treatment, filling, removal, or replacement of teeth): **In-Network:** You pay $45 copayment **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. **Preventive dental services:** **Cleaning, Dental xray(s), and Oral Exam(s):** (For up to 2 every year): You pay $0 copayment.	**Medicare covered limited dental services** (this does not include routine services in connection with care, treatment, filling, removal, or replacement of teeth): **In-Network:** You pay $40 copayment **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. **Preventive dental services:** **Cleaning, Dental xray(s), and Oral Exam(s):** (For up to 2 every year): You pay $0 copayment.	**Medicare covered limited dental services** (this does not include routine services in connection with care, treatment, filling, removal, or replacement of teeth): **In-Network:** You pay $40 copayment **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. **Preventive dental services not covered**	Medicare only covers certain limited dental procedures under specific conditions. The Plan will pay up to the maximum allowable benefit for each service covered.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Optional Supplemental Dental Coverage	**Complementary Dental** Premium: **$29 per month** *This is in addition to the plan premium*. **Preventive dental services:** Included with your plan. No additional coverage needed.	**Complementary Dental** Premium: **$29 per month** *This is in addition to the plan premium*. **Preventive dental services:** Included with your plan. No additional coverage needed.	**Full Comprehensive Dental** Premium: **$39 per month** *This is in addition to the plan premium*. **Preventive dental services:** **Cleaning, Dental x-ray(s), and Oral Exam(s)** (per calendar year in and out of network.)**:** (For up to 2 every year): You pay $0 copayment.	If your provider does not participate in the Plan's network and charges more than the maximum allowable benefit, you will be responsible for the additional cost. See the Evidence of Coverage for more information.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Optional Supplemental Dental Coverage *(Continued)*	**Deductible:** $100 deductible before coverage begins, per calendar year for in and out of network benefits. **Annual Maximum Plan Benefit Coverage Amount:** $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	**Deductible:** $100 deductible before coverage begins, per calendar year for in and out of network benefits. **Annual Maximum Plan Benefit Coverage Amount:** $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	**Deductible:** $100 deductible before coverage begins, per calendar year for in and out of network benefits. **Annual Maximum Plan Benefit Coverage Amount:** $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	**The deductible and maximum plan benefit do not apply to preventive services.**

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Optional Supplemental Dental Coverage *(Continued)* Restorative (e.g., restorations) Periodontics (e.g., scaling) Oral Surgery (e.g., extractions) Endodontics (e.g., root canal) Prosthodontics (e.g., crowns, dentures, and bridges) Prosthetic Maintenance (e.g., denture or bridge repairs)	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance **In-Network:** 50% coinsurance **Out-of-Network:** 55% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance **In-Network:** 50% coinsurance **Out-of-Network:** 55% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance **In-Network:** 50% coinsurance **Out-of-Network:** 55% coinsurance	If your provider does not participate in the Plan's network and charges more than the maximum allowable benefit, you will be responsible for the additional cost. See the Evidence of Coverage for more information. Limited to specific dental codes (exclusions apply).

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Vision Services Diagnostic / Treatment Exam	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Routine Eye Exam	**In-Network:** You pay $45 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $40 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $40 copayment. **Out-of-Network:** Not covered.	One routine eye exam each year.
Eyeglasses or Contacts after Cataract Surgery	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Vision Services *(continued)* Routine Eyewear Allowance	$75 Allowance every year towards purchase of contact lenses and eyeglasses (frames and lenses).	$120 Allowance every year towards purchase of contact lenses and eyeglasses (frames and lenses).	$120 Allowance every year towards purchase of contact lenses and eyeglasses (frames and lenses).	
Mental Health Services Inpatient Visit	**In-Network:** You pay $310 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $285 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $260 copayment per day for days 1 to 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	For Inpatient Mental Health Services, prior authorization is required. Benefit is applied per admission. Covers up to 190 days in a lifetime for inpatient mental health care at a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. See the Evidence of Coverage for more information.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Mental Health Services *(Continued)* Individual and Group Outpatient Therapy Visit	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required for some services.
Skilled Nursing Facility	**In-Network:** You pay $0 copayment for days 1 to 20. You pay a $184 copayment per day for days 21 to 100. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment for days 1 to 20. You pay a $184 copayment per day for days 21 to 100. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment for days 1 to 20. You pay a $184 copayment per day for days 21 to 100. **Out-of-Network:** You pay 30% coinsurance per stay. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required. We cover up to 100 days in a Skilled Nursing Facility.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Physical Therapy	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required.
Ambulance	You pay $200 copayment.	You pay $150 copayment.	You pay $150 copayment.	Prior Authorization may be required.
Transportation	Not Covered.	Not Covered.	Not Covered.	
Medicare Part B Drugs	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required. Part B drugs may be subject to step therapy requirements.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Medicare Part D Prescription Drugs				
Phase 1: Initial Coverage (After you pay your deductible, if applicable).	This plan does not have a deductible.	This plan does not have a deductible.	Not Covered.	Cost-sharing may vary depending on the pharmacy you choose and what phase of the Part D benefit you are in. For more information please call us or access our Evidence of Coverage online.
Tier 1: Preferred Generic	**Preferred Pharmacy** 30-day supply: You pay $0 **Standard Pharmacy** 30-day supply: You pay $5 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $0 **Standard Pharmacy** 90-day supply: You pay $10	**Preferred Pharmacy** 30-day supply: You pay $0 **Standard Pharmacy** 30-day supply: You pay $5 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $0 **Standard Pharmacy** 90-day supply: You pay $10	Not Covered.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Phase 1: Initial Coverage *(Continued)* **Tier 2:** Generic	**Preferred Pharmacy** 30-day supply: You pay $15 **Standard Pharmacy** 30-day supply: You pay $20 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $30 **Standard Pharmacy** 90-day supply: You pay $40	**Preferred Pharmacy** 30-day supply: You pay $12 **Standard Pharmacy** 30-day supply: You pay $17 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $24 **Standard Pharmacy** 90-day supply: You pay $34	Not Covered.	
Tier 3: Preferred Brand	**Preferred Pharmacy** 30-day supply: You pay $42 **Standard Pharmacy** 30-day supply: You pay $47 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $84 **Standard Pharmacy** 90-day supply: You pay $94	**Preferred Pharmacy** 30-day supply: You pay $42 **Standard Pharmacy** 30-day supply: You pay $47 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $84 **Standard Pharmacy** 90-day supply: You pay $94	Not Covered.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Phase 1: Initial Coverage *(Continued)* **Tier 4:** Non-Preferred Drug	**Preferred Pharmacy** 30-day supply: You pay $95 **Standard Pharmacy** 30-day supply: You pay $100 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $190 **Standard Pharmacy** 90-day supply: You pay $200	**Preferred Pharmacy** 30-day supply: You pay $95 **Standard Pharmacy** 30-day supply: You pay $100 **Preferred Pharmacy Or Mail Order** 90-day supply: You pay $190 **Standard Pharmacy** 90-day supply: You pay $200	Not Covered.	
Tier 5: Specialty	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-day supply: You pay 33% **Preferred Pharmacy Or Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33%	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-day supply: You pay 33% **Preferred Pharmacy Or Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33%	Not Covered.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Phase 2: Coverage Gap	Once you and your plan's total spending adds up to **$4,130**, you enter the coverage gap. You pay **25%** of the total cost for generic and brand medications covered under your plan.	Once you and your plan's total spending adds up to **$4,130**, you enter the coverage gap. You pay **25%** of the total cost for generic and brand medications covered under your plan.	Not Covered.	
Phase 3: Catastrophic Coverage	Once you have paid **$6,550** during the year, which includes your deductible, copayments and coinsurances, you enter the catastrophic coverage stage. You pay whatever is greater: **5%** coinsurance or **$3.70** for generics **$9.20** for brand drugs	Once you have paid **$6,550** during the year, which includes your deductible, copayments and coinsurances, you enter the catastrophic coverage stage. You pay whatever is greater: **5%** coinsurance or **$3.70** for generics **$9.20** for brand drugs	Not Covered.	You will remain in the catastrophic coverage stage for the rest of the calendar year. On January 1 of the following year, you will begin again in the deductible phase.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Insulin	The cost of a 30-day supply of select insulin will be $25 at a preferred pharmacy and $30 at a standard pharmacy.	The cost of a 30-day supply of select insulin will be $25 at a preferred pharmacy and $30 at a standard pharmacy.	Not Included.	Costs will remain the same through the deductible, initial and coverage gap phases of the Part D benefit.
Additional Benefits				
Acupuncture	You pay 50% coinsurance.	You pay 50% coinsurance.	You pay 50% coinsurance.	For up to 10 visits per calendar year or up to 20 visits per calendar year for chronic lower back pain.
Rehabilitation Services Occupational Therapy Visit	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Rehabilitation Services *(Continued)* Speech and Language Therapy Visit	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required.
Cardiac rehabilitation Services	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Foot Care (Podiatry Services) Diagnostic Exams and Treatment	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Foot exams and treatment are covered if you have Diabetes-related nerve damage and/or meet certain conditions.
Routine Foot Care	**In-Network:** You pay $45 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Medical Equipment/ Supplies Durable Medical Equipment (e.g., Wheelchairs, Oxygen)	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required for Durable Medical Equipment.
Prosthetics (e.g., Braces, Artificial Limbs and related supplies)	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required for Prosthetics.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Medical Equipment/ Supplies *(Continued)* Diabetes monitoring supplies	**In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Abbott Diabetes Care is the contracted supplier for Diabetic Monitoring supplies. Your provider must get an approval from the plan before we'll pay for supplies from a non-preferred manufacturer.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Medical Equipment/ Supplies *(Continued)*				
Diabetes self-management training	**In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	
Therapeutic shoes or inserts	**In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	For people with Diabetes who have severe diabetic foot disease. See the Evidence of Coverage for more information.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Wellness Programs (e.g., Fitness)	Silver&Fit® participating fitness clubs and exercise centers: You pay a $25 annual non-refundable fee. Silver&Fit Home Fitness Program: You pay a $10 annual non-refundable fee. Silver&Fit non-participating fitness clubs and exercise centers: You will be reimbursed up to an annual allowance of $150.	Silver&Fit participating fitness clubs and exercise centers: You pay a $25 annual non-refundable fee. Silver&Fit Home Fitness Program: You pay a $10 annual non-refundable fee. Silver&Fit non-participating fitness clubs and exercise centers: You will be reimbursed up to an annual allowance of $150.	Silver&Fit participating fitness clubs and exercise centers: You pay a $25 annual non-refundable fee. Silver&Fit Home Fitness Program: You pay a $10 annual non-refundable fee. Silver&Fit non-participating fitness clubs and exercise centers: You will be reimbursed up to an annual allowance of $150.	You cannot enroll in a participating facility and a non-participating facility at the same time. You pay the annual non-refundable fee over-the-phone or online using a debit or credit card. These copayments are not included in the Out-of-Pocket Maximum.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Routine Annual Physical Exam	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered.	One annual routine physical exam each calendar year.
Telehealth Primary Specialists Behavior Health visit MDLive® visit MDLive® Behavior Health visit Out-of-Network	 You pay $10 copayment. You pay $45 copayment. 20% coinsurance You pay $10 copayment. You pay a $45 copayment Not covered	 You pay $10 copayment. You pay $40 copayment. 20% coinsurance You pay $10 copayment. You pay a $40 copayment Not covered	 You pay $15 copayment. You pay $40 copayment. 20% coinsurance You pay $15 copayment. You pay a $40 copayment Not covered	For non-emergency medical issues only. Contact a network doctor by phone or secure video using your computer or mobile device. Telehealth doctors can diagnose symptoms, prescribe medication and send prescriptions to select pharmacies. Services from MDLive® available 24 hour a day, 7 days a week.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Chiropractic	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $10 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $15 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	We only cover manual manipulation of the spine to correct a subluxation (when 1 or more of the bones in your spine move out of position).
Home Health Care	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required.
Outpatient Dialysis Services	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 20% coinsurance.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 20% coinsurance.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 20% coinsurance.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Platinum (HMO-POS)	What You Should Know
Outpatient Substance Abuse Services Individual and Group therapy visit	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization may be required for some services.

Discrimination is Against the Law

Our Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact our dedicated Medicare Customer Care representatives at 1-877-883-9577, (TTY: 1-800-662-1220). Monday - Friday, 8 a.m. - 8 p.m.
From October 1 - March 31, 8 a.m. - 8 p.m., 7 days a week.

If you believe that our Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone Number: 1-800-614-6575 (TTY: 1-800-662-1220)
Fax Number: 315-671-6656

You can file a grievance in person, or by mail or fax. If you need help filing a grievance, our Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Y0028_5016d_C
B-5608 (Rev. 07/2019)

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-662-1220).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-662-1220).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-883-9577 (TTY：1-800-662-1220）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-883-9577 (телетайп: 1-800-662-1220).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-883-9577 (TTY: 1-800-662-1220).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-883-9577 (TTY: 1-800-662-1220)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-883-9577 (TTY: 1-800-662-1220).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-877-883-9577 (TTY: ১-800-662-1220)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-883-9577 (TTY: 1-800-662-1220).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-883-9577 (رقم هاتف الصم والبكم: 1-800-662-1220).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-883-9577 (ATS : 1-800-662-1220).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-883-9577 (TTY: 1-800-662-1220).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-883-9577 (TTY: 1-800-662-1220).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-883-9577 (TTY: 1-800-662-1220).

Y0028_2971e_C
B-5606

A11y 08/20/2019

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Care representative at 1-800-659-1986.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit ExcellusMedicare.com or call 1-800-659-1986 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory). However, the Point-of-Service (POS) benefit does allow you to use providers that are not in our network for some services. Check the EOC for more information.

Excellus BlueCross BlueShield contracts with the Federal Government and is an HMO plan with a Medicare contract. Enrollment in Excellus BlueCross BlueShield depends on contract renewal.