Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

2024 SUMMARY OF BENEFITS
January 1, 2024 – December 31, 2024

Medicare Blue Choice® Optimum (HMO-POS) (H3351-006)
Medicare Blue Choice® Freedom (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® Freedom (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® Freedom (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 on the next page 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 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.

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® Freedom (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.

Convey is an independent company offering OTC benefits in the Excellus BlueCross BlueShield service area.

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.

Mom's Meals® is an independent company that provides home delivered meals and nutritional services to Excellus BlueCross BlueShield members.

Reach Kidney Care is an independent company offering services to help members with chronic kidney disease.

SafeRide® is an independent company, offering transportation services in the Excellus BlueCross BlueShield service area.

Vori Health is an independent company offering services to help members with muscular skeletal conditions.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Monthly Plan Premium	You pay $66.40 per month.	You pay $203.40 per month.	You pay $0 per month.	You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	Not applicable	Not applicable.	$35 reduction of the monthly premium you pay to the Social Security Administration.	
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a medical deductible. Part D drugs not covered.	
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 in copayments/ coinsurance for medical services for the year.
Inpatient Hospital Coverage	**In-Network:** You pay $310 copayment per day, days 1 to 5. You pay $0 copay for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $285 copayment per day, days 1 to 5. You pay $0 copay for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $260 copayment per day, days 1 to 5. You pay $0 copay for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	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® Freedom (HMO-POS)	What You Should Know
Outpatient Hospital Coverage	**In-Network:** You pay $300 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required.
Ambulatory Surgery Center	**In-Network:** You pay $300 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $250 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	Prior Authorization is required.
Doctor Visits Primary	**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 $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.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Doctor Visits Specialists	**In-Network:** You pay $30 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 $30 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 $35 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.	
Preventive 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.	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 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® Freedom (HMO-POS)	What You Should Know
Emergency Care	You pay $100 copayment.	You pay $100 copayment.	You pay $100 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.
Lab Services - Diagnostics	**In-Network:** You pay $4 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® Freedom (HMO-POS)	What You Should Know
Diagnostic Services/Labs/ Imaging (continued) Diagnostic Tests and Procedures	**In-Network:** You pay $4 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.	
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® Freedom (HMO-POS)	What You Should Know
Hearing Services Diagnostic Hearing Exam	**In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $35 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	
Routine Hearing 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 routine hearing exam each year. You must see a TruHearing provider. This copayment not included in the Out-of-Pocket Maximum.
Hearing Aids	**In-Network:** $499 copay per aid for Advanced Aids. $799 copay per aid for Premium Aids. $50 additional cost per aid for optional hearing aid rechargeability. **Out-of-Network:** Not covered.	**In-Network:** $499 copay per aid for Advanced Aids. $799 copay per aid for Premium Aids. $50 additional cost per aid for optional hearing aid rechargeability. **Out-of-Network:** Not covered.	**In-Network:** $499 copay per aid for Advanced Aids. $799 copay per aid for Premium Aids. $50 additional cost per aid for optional hearing aid rechargeability. **Out-of-Network:** Not covered.	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® Freedom (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 $30 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $30 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $35 copayment **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	This does not include routine services in connection with care, treatment, filling, removal, or replacement of teeth. Medicare only covers certain limited dental procedures under specific conditions.
Preventive dental services	You pay $0 copayment per service.	You pay $0 copayment per service.	You pay $0 copayment per service.	Includes up to 2 cleaning(s), dental x-ray(s), and oral exam(s) per year
Annual Allowance	$1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	$1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	$1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility).	The Plan will pay up to the annual allowance for each service covered. For in and out of network benefits. Services above the limit are your responsibility.
Restorative (e.g., restorations) Periodontics (e.g., scaling) Oral Surgery (e.g., extractions) Endodontics (e.g., root canal)	**In-Network:** You pay $0 copayment per service. **Out-of-Network:** You pay $0 copayment per service.	**In-Network:** You pay $0 copayment per service. **Out-of-Network:** You pay $0 copayment per service.	**In-Network:** You pay $0 copayment per service. **Out-of-Network:** You pay $0 copayment per service.	If your provider does not participate in the Plan's network and charges more than the annual allowance, you will be responsible for the additional cost.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Dental Services (continued) Prosthodontics (e.g., select crowns, dentures, and bridges) Prosthetic Maintenance (e.g., denture or bridge repairs)				The annual allowance does not apply to preventive services. See the Evidence of Coverage for more information. Limited to specific dental codes (exclusions apply).
Vision Services Diagnostic/ Treatment Exam	**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.	
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 $30 copayment.	**In-Network:** You pay $30 copayment.	**In-Network:** You pay $35 copayment.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Vision Services (continued) Eyeglasses or Contacts after Cataract Surgery Routine Eyewear Allowance	**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. $225 annual allowance	**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. $275 annual allowance	**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. $250 annual allowance	Allowance 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 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. **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 $285 copayment per day for days 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. **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 $260 copayment per day for days 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. **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 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® Freedom (HMO-POS)	What You Should Know
Mental Health Services (continued) Individual and Group Outpatient Therapy Visit	**In-Network:** You pay 20%. **Out-of-Network:** You pay 30% per visit. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay 20%. **Out-of-Network:** You pay 30% per visit. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0. **Out-of-Network:** You pay 30% per visit. The plan will reimburse maximum $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 $203 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30%. The plan will reimburse maximum $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 $203 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30%. The plan will reimburse maximum $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 $203 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30%. The plan will reimburse maximum $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.
Physical Therapy	**In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30%. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30%. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.	**In-Network:** You pay $35 copayment. **Out-of-Network:** You pay 30%. 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® Freedom (HMO-POS)	What You Should Know
Ambulance	You pay $200 copayment.	You pay $150 copayment.	You pay $150 copayment.	Prior Authorization may be required.
Transportation	12 one-way trips to a health-related location through SafeRide. Various modes of transportation are available based on your needs. There will be a limit of 50 miles per one-way ride.	12 one-way trips to a health-related location through SafeRide. Various modes of transportation are available based on your needs. There will be a limit of 50 miles per one-way ride.	12 one-way trips to a health-related location through SafeRide. Various modes of transportation are available based on your needs. There will be a limit of 50 miles per one-way ride.	
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.
Part B Insulin used in a traditional insulin pump	**In-Network:** You pay $35 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 $35 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 $35 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.	For Part B chemotherapy drugs, the baseline cost sharing is 20% with a 0-20% range for drugs impacted by the Inflation Rebate Program. Drugs and cost can change quarterly.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Medicare Part D Prescription Drugs				
Phase 1: Initial Coverage Cost-sharing may vary depending on the pharmacy you choose and what phase of the Part D benefit you are in. Please call us or see the Evidence of Coverage for more information.			Not Covered	
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	Not Covered	
Tier 1: Preferred Generic	**Preferred Pharmacy** 30-day supply: You pay $0 **Standard Pharmacy** 30-day supply: You pay $5 **Preferred Pharmacy/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/Mail Order** 90-day supply: You pay $0 **Standard Pharmacy** 90-day supply: You pay $10	Not Covered	After you pay your deductible (if applicable).
Tier 2: Generic	**Preferred Pharmacy** 30-day supply: You pay $15 **Standard Pharmacy** 30-day supply: You pay $20 **Preferred Pharmacy/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/Mail Order** 90-day supply: You pay $24 **Standard Pharmacy** 90-day supply: You pay $34	Not Covered	After you pay your deductible (if applicable).

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Tier 3: Preferred Brand	**Preferred Pharmacy** 30-day supply: You pay $42 **Standard Pharmacy** 30-day supply: You pay $47 **Preferred Pharmacy/Mail Order** 90-day supply: You pay $84 **Standard Pharmacy** 90-day supply: You pay $94 **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	**Preferred Pharmacy** 30-day supply: You pay $42 **Standard Pharmacy** 30-day supply: You pay $47 **Preferred Pharmacy/Mail Order** 90-day supply: You pay $84 **Standard Pharmacy** 90-day supply: You pay $94 **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	Not Covered	After you pay your deductible (if applicable). Insulin costs will remain the same through the deductible, initial and coverage gap phases of the Part D benefit.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Tier 4: Non-Preferred Drug	**Preferred Pharmacy** 30-day supply: You pay $95 **Standard Pharmacy** 30-day supply: You pay $100 **Preferred Pharmacy/Mail Order** 90-day supply: You pay $190 **Standard Pharmacy** 90-day supply: You pay $200 **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	**Preferred Pharmacy** 30-day supply: You pay $95 **Standard Pharmacy** 30-day supply: You pay $100 **Preferred Pharmacy/Mail Order** 90-day supply: You pay $190 **Standard Pharmacy** 90-day supply: You pay $200 **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	Not Covered	After you pay your deductible (if applicable). Insulin costs will remain the same through the deductible, initial and coverage gap phases of the Part D benefit.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Tier 5: Specialty	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-day supply: You pay 33% **Preferred Pharmacy/Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33% **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-day supply: You pay 33% **Preferred Pharmacy/Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33% **Insulin, Preferred Pharmacy** 30-day supply: You pay $25 **Insulin, Standard Pharmacy** 30-day supply: You pay $30 **Insulin, Preferred Pharmacy Or Mail Order** 90-day supply: You pay $50 **Insulin, Standard Pharmacy** 90-day supply: You pay $60	Not Covered	After you pay your deductible (if applicable). Insulin costs will remain the same through the deductible, initial and coverage gap phases of the Part D benefit.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Phase 2: Coverage Gap Once you and your plan's total spending adds up to **$5,030**, 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 **$8,000** during the year, which includes your deductible, copayments, and coinsurances, you enter the catastrophic coverage stage. **You pay $0 for generics and brand drugs.** 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.			Not Covered	
Additional Benefits				
Over the counter (OTC) Items	You have $50 every quarter to spend on plan-approved OTC items.	You have $50 every quarter to spend on plan-approved OTC items.	You have $50 every quarter to spend on plan-approved OTC items.	Non-prescription OTC health related items like vitamins are covered. Visit ExcellusMedicare.com for details.
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.
Meals	Up to two home-delivered meals per day for 7-days.	Up to two home-delivered meals per day for 7-days.	Up to two home-delivered meals per day for 7-days.	Available after an inpatient hospital, hospital observation, or Skilled Nursing Facility stay.
Rehabilitation Services Occupational Therapy Visit	**In-Network:** You pay $30 copayment.	**In-Network:** You pay $30 copayment.	**In-Network:** You pay $35 copayment.	Prior Authorization may be required.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Rehabilitation Services (continued) Occupational Therapy Visit	**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.	**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.	**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.
Speech and Language Therapy Visit	**In-Network:** You pay $30 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 $30 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 $35 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.	
Cardiac rehabilitation Services	**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.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Foot Care (Podiatry Services) Diagnostic Exams and Treatment	**In-Network:** You pay $30 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 $30 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 $35 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.	
Routine Foot Care	**In-Network:** You pay $30 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 $30 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 $35 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.	Foot exams and treatment are covered if you have Diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/ Supplies Durable Medical Equipment	**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.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Medical Equipment/ Supplies (continued) 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.
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 preferred 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.
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.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Medical Equipment/ Supplies (continued) Therapeutic shoes or inserts	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse a max $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 max $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 max $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.
Wellness Programs Fitness Silver&Fit participating fitness clubs	You pay a $0 annual fee.	You pay a $0 annual fee.	You pay a $0 annual fee.	You cannot enroll in a participating facility and a non-participating facility at the same time.
Silver&Fit Home Fitness Program	You pay a $0 annual fee.	You pay a $0 annual fee.	You pay a $0 annual fee.	These copayments are not included in the Out-of-Pocket Maximum.
Silver&Fit non-participating fitness clubs	You will be reimbursed up to a $150 annual allowance.	You will be reimbursed up to a $150 annual allowance.	You will be reimbursed up to a $150 annual allowance.	
Remote Access Technology	Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 1-800-662-1220).	Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 1-800-662-1220).	Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 1-800-662-1220).	Information is intended to help educate, not replace the advice of a medical professional.
Health Education: Chronic Kidney Disease	Members who have stage 4 or 5 chronic kidney disease will be offered a multi-disciplinary care team, to help navigate medical care services and follow their treatment plan.	Members who have stage 4 or 5 chronic kidney disease will be offered a multi-disciplinary care team, to help navigate medical care services and follow their treatment plan.	Members who have stage 4 or 5 chronic kidney disease will be offered a multi-disciplinary care team, to help navigate medical care services and follow their treatment plan.	The program is offered virtually and in-person.

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Health Education: Muscular Skeleton Disease	Members with a muscular skeletal condition which physical therapy might improve, may be eligible for physical therapy, health coaching, and dietary counselling.	Members with a muscular skeletal condition which physical therapy might improve, may be eligible for physical therapy, health coaching, and dietary counselling.	Members with a muscular skeletal condition which physical therapy might improve, may be eligible for physical therapy, health coaching, and dietary counselling.	The Plan will contact members who are eligible for the program. Services will be provided virtually or over-the-phone.
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.
Immunizations	**In-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines. You pay 20% coinsurance for all other Medicare-Part B covered immunizations. **Out-of-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines.	**In-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines. You pay 20% coinsurance for all other Medicare-Part B covered immunizations. **Out-of-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines.	**In-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines. You pay 20% coinsurance for all other Medicare-Part B covered immunizations. **Out-of-Network:** You pay $0 copayment for the flu, pneumonia, Hepatitis B, and COVID-19 vaccines.	

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
Immunizations (continued)	For all other Medicare-Part B covered immunizations, you pay 30% coinsurance. The plan will reimburse a max of $3,000 for out-of-network (POS) services per calendar year.	For all other Medicare-Part B covered immunizations, you pay 30% coinsurance. The plan will reimburse a max of $3,000 for out-of-network (POS) services per calendar year.	For all other Medicare-Part B covered immunizations, you pay 30% coinsurance. The plan will reimburse a max of $3,000 for out-of-network (POS) services per calendar year.	
Telehealth Primary Specialists Behavior Health visit MDLive visit MDLive Behavior Health visit Out-of-Network	 You pay $0 copayment. You pay $30 copayment. You pay 20% coinsurance. You pay $0 copayment. You pay $30 copayment. Not covered	 You pay $0 copayment. You pay $30 copayment. You pay 20% coinsurance. You pay $0 copayment. You pay $30 copayment. Not covered	 You pay $5 copayment. You pay $35 copayment. You pay $0 copayment You pay $5 copayment. You pay $35 copayment. Not covered	For non-emergency medical issues. Contact a network doctor by phone or secure video with a computer or mobile device. Telehealth doctors can diagnose and prescribe medication. MDLive available 24 hours a day, 7 days a week.
Chiropractic	**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 $15 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.	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).

Premiums and Benefits	Medicare Blue Choice® Value Plus (HMO-POS)	Medicare Blue Choice® Optimum (HMO-POS)	Medicare Blue Choice® Freedom (HMO-POS)	What You Should Know
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.	
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)	**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 $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).	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.

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 representative at 1-800-659-1986.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ExcellusMedicare.com or call 1-800-659-1986 to view a copy of the EOC.

- ☐ 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 request 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.

- ☐ Review the formulary to make sure your drugs are covered.

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, 2025.

- ☐ 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.

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-883-9577 (TTY: 1-800-662-1220). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-883-9577 (TTY: 1-800-662-1220). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如您需要此翻译服务，请致电 1-877-883-9577 (TTY: 1-800-662-1220)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-883-9577 (TTY: 1-800-662-1220)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-883-9577 (TTY: 1-800-662-1220). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-883-9577 (TTY: 1-800-662-1220). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-883-9577 (TTY: 1-800-662-1220) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-883-9577 (TTY: 1-800-662-1220). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-883-9577 (TTY: 1-800-662-1220)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-883-9577 (TTY: 1-800-662-1220). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-883-9577 (TTY: 1-800-662-1220). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-883-9577 (TTY: 1-800-662-1220)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-883-9577 (TTY: 1-800-662-1220). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-883-9577 (TTY: 1-800-662-1220). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-883-9577 (TTY: 1-800-662-1220). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220). Ta usługa jest bezpłatna.

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