Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

2023 SUMMARY OF BENEFITS
January 1, 2023 – December 31, 2023

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/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 BCBS 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.

SafeRide® is an independent company, offering transportation 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® Freedom (HMO-POS)	What You Should Know
Monthly Plan Premium	You pay $71 per month.	You pay $208 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 copayment for additional Medicare-covered days during your hospital admission.	**In-Network:** You pay $285 copayment per day, days 1 to 5. You pay $0 copayment for additional Medicare-covered days during your hospital admission.	**In-Network:** You pay $260 copayment per day, days 1 to 5. 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® Freedom (HMO-POS)	What You Should Know
Inpatient Hospital Coverage (continued)	**Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	**Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	
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.

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 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.	
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,

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
Preventive Care (continued)				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.
Emergency Care	You pay $95 copayment.	You pay $95 copayment.	You pay $95 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® Freedom (HMO-POS)	What You Should Know
Diagnostic Services/Labs/ Imaging (continued) 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.	
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.	

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) 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.	
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.

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 (continued) 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.
Dental Services Medicare covered limited dental services	**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: Cleaning, Dental x-ray(s), and Oral Exam(s) Up to 2 per year	You pay $0 copayment per service.	You pay $0 copayment per service.	You pay $0 copayment per service.	The Plan will pay up to the annual allowance for each service covered.
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).	

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) Restorative (e.g., restorations) Periodontics (e.g., scaling) Oral Surgery (e.g., extractions) Endodontics (e.g., root canal) Prosthodontics (e.g., select crowns, dentures, and bridges) Prosthetic Maintenance (e.g., denture or bridge repairs)	**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. 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.

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	**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 Eyewear Allowance	$225 Allowance every year towards purchase of contact lenses and eyeglasses (frames and lenses).	$275 Allowance every year towards purchase of contact lenses and eyeglasses (frames and lenses).	$250 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 1-5. 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% coinsurance. **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 20% coinsurance. **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 $0 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.	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 $196 copayment per day for days 21 through 100. **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 $0 copayment for days 1 to 20. You pay a $196 copayment per day for days 21 through 100. **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 $0 copayment for days 1 to 20. You pay a $196 copayment per day for days 21 through 100. **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. We cover up to 100 days in a Skilled Nursing Facility.
Physical Therapy	**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
Physical Therapy (continued)	**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.	
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.

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	**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	Not Covered	
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	**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	Not Covered	
Tier 5: Specialty	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-day supply: You pay 33%	**Preferred Pharmacy** 30-day supply: You pay 33% **Standard Pharmacy** 30-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® Freedom (HMO-POS)	What You Should Know
Tier 5: Specialty (continued)	**Preferred Pharmacy/Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33%	**Preferred Pharmacy/Mail Order** 90-day supply: You pay 33% **Standard Pharmacy** 90-day supply: You pay 33%		
Insulin	**30-day supply of select insulin:** $25 at a preferred pharmacy $30 at a standard pharmacy. **90-day supply of select insulin:** $50 at a preferred pharmacy $60 at a standard pharmacy.	**30-day supply of select insulin:** $25 at a preferred pharmacy $30 at a standard pharmacy. **90-day supply of select insulin:** $50 at a preferred pharmacy $60 at a standard pharmacy.	Not Covered	Costs will remain the same through the deductible, initial and coverage gap phases of the Part D benefit.
Phase 2: Coverage Gap Once you and your plan's total spending adds up to **$4,660**, 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 **$7,400** during the year, which includes your deductible, copayments, and coinsurances, you enter the catastrophic coverage stage. You pay whatever is greater: **5%** coinsurance or **$4.15** for generics **$10.35** for 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	

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
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. **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.	Prior Authorization may be required.
Speech and Language 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) Speech and Language 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.	
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.	
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.	

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) (continued) 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.
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® Freedom (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.
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:** 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.	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® Freedom (HMO-POS)	What You Should Know
Wellness Programs Fitness Silver&Fit participating fitness clubs/ exercise centers Silver&Fit Home Fitness Program Silver&Fit non-participating fitness clubs and exercise centers	 You pay a $0 annual fee. You pay a $0 annual fee. You will be reimbursed up to an annual allowance of $150.	 You pay a $0 annual fee. You pay a $0 annual fee. You will be reimbursed up to an annual allowance of $150.	 You pay a $0 annual fee. You pay a $0 annual fee. 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 fee for the home fitness program over-the-phone or online using a debit or credit card. These copayments are not included in the Out-of-Pocket Maximum.
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.
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	 You pay $0 copayment. You pay $30 copayment. You pay 20% coinsurance. You pay $0 copayment.	 You pay $0 copayment. You pay $30 copayment. You pay 20% coinsurance. You pay $0 copayment.	 You pay $5 copayment. You pay $35 copayment. You pay $0 copayment You pay $5 copayment.	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.

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
Telehealth (continued) MDLive Behavior Health visit Out-of-Network	You pay $30 copayment. Not covered	You pay $30 copayment. Not covered	You pay $35 copayment. Not covered	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).
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® Freedom (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)	**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.

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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).

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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, 2024.

- ☐ 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.

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