



A nonprofit independent licensee of the Blue Cross Blue Shield Association

2027 SUMMARY OF BENEFITS

January 1, 2027 – December 31, 2027

Medicare Blue Choice® 030 (HMO-POS) (H3351-030)

Medicare Blue Choice® 031 (HMO-POS) (H3351-031)

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, call us and ask for the **"Evidence of Coverage."** You can also see the Evidence of Coverage on our website [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.com).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medicare Blue Choice 030 (HMO-POS) and Medicare Blue Choice 031 (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- 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).

Sections in this booklet

- Things to Know About **Medicare Blue Choice 030 (HMO-POS) and Medicare Blue Choice 031 (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits– **Medicare Blue Choice 031 (HMO-POS)** does not include Medicare Part D drug benefits

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

Things to Know About Medicare Blue Choice 030 (HMO-POS) and Medicare Blue Choice 031 (HMO-POS)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8:00 a.m. to 8:00 p.m., 7 days a week
- From April 1 to September 30, we're open 8:00 a.m. to 8:00 p.m., Monday through Friday
- If you are a member of one of these plans, call toll-free at 1-877-883-9577 (TTY 711).
- If you are not a member of one of these plans, call toll-free at 1-800-659-1986 (TTY 711).
- Our website: [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.com).

Who can join?

To join **Medicare Blue Choice 030 (HMO-POS)** and **Medicare Blue Choice 031 (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: Broome, Chemung, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Schuyler, St. Lawrence, Steuben, Tioga, Tompkins

Which doctors, hospitals, and pharmacies can I use?

Medicare Blue Choice 030 (HMO-POS) and **Medicare Blue Choice 031 (HMO-POS)** have a network of doctors, hospitals, and other providers.

Medicare Blue Choice 030 (HMO-POS) also has a network of pharmacies. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider/pharmacy directory at our website at [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.com). Or call us and we will send you a copy of the directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and more. Some of the extra benefits are outlined in this booklet.

Medicare Blue Choice 030 (HMO-POS) covers Part D drugs. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.com). Or call us and we will send you a copy of the formulary.

In addition, **Medicare Blue Choice 030 (HMO-POS)** and **Medicare Blue Choice 031 (HMO-POS)** cover Part B drugs including chemotherapy and some drugs administered by your provider.

How will I determine my drug costs with Medicare Blue Choice 030 (HMO-POS)?

Medicare Blue Choice 030 (HMO-POS) groups each medication into "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Excellus BlueCross BlueShield Medicare Advantage

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly Plan Premium	\$125.30 per month. You must continue to pay your Medicare Part B premium to the Social Security Administration.	You do not pay a separate monthly plan premium. You must continue to pay your Medicare Part B premium to the Social Security Administration.
Optional Supplemental Dental	Additional premium of \$35 per month.	Additional premium of \$35 per month.
Part B Premium Reduction	Not applicable.	Not applicable.
Deductible	Medicare Deductible: NA Prescription Drug Deductible: \$325 for Tiers 3, 4 and 5. You must pay your Part D deductible before the plan will contribute to the costs of your prescriptions.	Medicare Deductible: NA Prescription Drug Deductible: NA
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs.)	Your yearly limit(s) in this plan: \$7,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and copayments or coinsurance for your Part D prescription drugs.	Your yearly limit(s) in this plan: \$6,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital	In-Network: Days 1-5: \$350 copay per day for each admission. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.	In-Network: Days 1-5: \$325 copay per day for each admission Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Outpatient Hospital Coverage	In-Network: \$250 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.	In-Network: \$300 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.
Ambulatory Surgery Center	In-Network: \$250 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.	In-Network: \$300 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.
Doctor's Office Visits	In-Network: Primary care physician: \$0 copay. Specialist visit: \$30 copay. 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: Primary care physician: \$5 copay. Specialist visit: \$35 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Preventive Care	In-Network: \$0 copay for all preventive services covered under Original Medicare at zero cost. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. Any additional preventive services approved by Medicare during the contract year will be covered. 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 copay will apply to the care received for the new or existing medical condition.	In-Network: \$0 copay for all preventive services covered under Original Medicare at zero cost. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. Any additional preventive services approved by Medicare during the contract year will be covered. 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 copay will apply to the care received for the new or existing medical condition.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Emergency Care	In-Network: \$115 copay. Covered Worldwide: \$115 copay.	In-Network: \$115 copay. Covered Worldwide: \$115 copay.
Urgently Needed Services	In-Network: \$40 copay per visit. Covered Worldwide: \$40 copay per visit.	In-Network: \$40 copay per visit. Covered Worldwide: \$40 copay per visit.
Diagnostic Services		
Diagnostic Radiology Service (e.g., MRI, CT scan)	In-Network: \$250 copay. 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: \$150 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Lab Services - Diagnostics	In-Network: \$0 copay. 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: \$15 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Diagnostic Tests and Procedures	In-Network: \$0 copay. 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: \$15 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
X-Rays	In-Network: \$40 copay. 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: \$40 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Therapeutic Radiology (such as radiation treatment for cancer)	In-Network: 20% coinsurance. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization. Contact us for more information.	In-Network: 20% coinsurance. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization. Contact us for more information.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Hearing Services Diagnostic Hearing Exam Routine Hearing Exam Hearing Aids	In-Network: \$30 copay. 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: \$0 copay. Out-of-Network: Not covered. 1 visit covered every year by a TruHearing provider only. In-Network (per aid): \$299 copay for Standard Aid. \$499 copay for Advanced Aid. \$799 copay for Premium Aid. \$50 for hearing aid rechargeability. Out-of-Network: Not covered. You are eligible for hearing aids from TruHearing providers only. Copayments not included in the Out-of-Pocket Maximum.	In-Network: \$35 copay. 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: \$0 copay. Out-of-Network: Not covered. 1 visit covered every year by a TruHearing provider only. In-Network (per aid): \$299 copay for Standard Aid. \$499 copay for Advanced Aid. \$799 copay for Premium Aid. \$50 for hearing aid rechargeability. Out-of-Network: Not covered. You are eligible for hearing aids from TruHearing providers only. Copayments not included in the Out-of-Pocket Maximum.
Dental Services Medicare covered limited dental services. Preventive dental services per year Includes cleaning(s), oral exam(s), and x-ray(s). Limits apply. Annual Allowance	In-Network: \$30 copay. 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: \$0 copay per service. Does not include routine services in connection with care, replacement of teeth, treatment, filling, or removal. Medicare only covers limited dental procedures under specific conditions. For each service, we pay up to an annual allowance. Out-of-Network: Your plan will pay 100% of the allowance or dentist's charges, whichever is less. You are responsible for balances up to the dentist's charge. Not Covered	In-Network: \$35 copay. 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: \$0 copay per service. Does not include routine services in connection with care, replacement of teeth, treatment, filling, or removal. Medicare only covers limited dental procedures under specific conditions. For each service, we pay up to an annual allowance. Out-of-Network: Your plan will pay 100% of the allowance or dentist's charges, whichever is less. You are responsible for balances up to the dentist's charge. Not Covered

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Optional Supplemental Dental Annual Allowance 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)	Additional premium of \$35 per month \$1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility). In-Network: \$0 copay per service. Out-of-Network: \$0 copay per service. You will be responsible for the additional cost if your provider does not participate in the network and charges more than the annual allowance. Does not apply to preventive services. See the Evidence of Coverage for more information. Limited to specific dental codes. Exclusions apply, for example tooth implants are not covered.	Additional premium of \$35 per month \$1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility). In-Network: \$0 copay per service. Out-of-Network: \$0 copay per service. You will be responsible for the additional cost if your provider does not participate in the network and charges more than the annual allowance. Does not apply to preventive services. See the Evidence of Coverage for more information. Limited to specific dental codes. Exclusions apply, for example tooth implants are not covered.
Vision Services Diagnostic/ Treatment Eye Exam Routine Eye Exam One routine eye exam each year. Eyeglasses or Contacts after Cataract Surgery Routine Eyewear Allowance	In-Network: \$0 copay. 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: \$0 copay. Out-of-Network: Not covered. In-Network: \$30 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. \$200 annual allowance towards purchase of contact lenses and eyeglasses (frames and lenses).	In-Network: \$0 copay. 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: \$0 copay. Out-of-Network: Not covered. In-Network: \$35 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. \$200 annual allowance towards purchase of contact lenses and eyeglasses (frames and lenses) per calendar year.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Mental Health Care Inpatient Visit Individual and Group Outpatient Therapy Visit	In-Network: \$350 copay per day for 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. Benefit applied per admission. Prior authorization is required. Covers up to 190 days 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. In-Network: 20% coinsurance. 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: \$324 copay per day for 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. Benefit applied per admission. Prior authorization is required. Covers up to 190 days 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. In-Network: \$0 copayment. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Skilled Nursing Facility	In-Network: \$0 copay for days 1 to 20. \$221 copay per day for days 21 to 100. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.	In-Network: \$0 copay for days 1 to 20. \$221 copay per day for days 21 to 100. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. May require prior authorization.
Outpatient Rehabilitation Physical, occupational and speech and language therapy. Cardiac rehabilitation Services	In-Network: \$30 copay. 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: \$0 copay. 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: \$35 copay. 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: \$0 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Ambulance (Ground and Air)	In-Network & Out-of-Network: \$150 copay.	In-Network & Out-of-Network: \$200 copay.
Transportation	Not covered.	Not covered.
Medicare Part B Drugs Part B Insulin used in a traditional insulin pump	In-Network: 20% coinsurance. 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: \$35 copay. Out-of-Network: \$35 copay. Prior Authorization may be required. Part B drugs may be subject to step therapy requirements. For Part B chemotherapy drugs, the baseline cost is 20% with a 0-20% range for drugs impacted by the Inflation Rebate Program. Drugs and cost can change quarterly.	In-Network: 20% coinsurance. 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: \$35 copay. Out-of-Network: \$35 copay. Prior Authorization may be required. Part B drugs may be subject to step therapy requirements. For Part B chemotherapy drugs, the baseline cost is 20% with a 0-20% range for drugs impacted by the Inflation Rebate Program. Drugs and cost can change quarterly.
PRESCRIPTION DRUG BENEFITS		
Medicare Part D Deductible	\$325 per year prescription drugs on Tiers 3, 4 and 5. You must pay your Part D deductible before the plan contributes to your prescription drug costs.	Not Covered.
Initial Coverage	You pay the following until your total yearly drug costs reach \$2,400. Total yearly drug costs are the drug costs paid by both you and our Part D plan. Costs may vary depending on the pharmacy chosen. For more information, please call us or view the Evidence of Coverage. Insulin costs are based on plan benefits, the maximum fair price for covered insulin, or your plan's negotiated price, <u>whichever is less</u>. The <u>maximum</u> insulin cost for a 30-day supply is \$35. Insulin is not subject to the deductible.	Not Covered.

Benefits / Services		Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Tier 1 Preferred Generic			Not Covered.
30-day supply	Preferred Pharmacy: <u>Tier 1:</u> \$0 <u>Insulin:</u> \$0		Not Covered.
30-day supply	Standard Pharmacy: <u>Tier 1:</u> \$5 <u>Insulin:</u> The lesser of \$5 or 25%		Not Covered.
90-day supply	Preferred Pharmacy/Mail Order: <u>Tier 1:</u> \$0 <u>Insulin:</u> \$0		Not Covered.
90-day supply	Standard Pharmacy: <u>Tier 1:</u> \$10 <u>Insulin:</u> The lesser of \$10 or 25%		Not Covered.
Tier 2 Generic			Not Covered.
30-day supply	Preferred Pharmacy: <u>Tier 2:</u> \$5 <u>Insulin:</u> The lesser of \$5 or 25%		Not Covered.
30-day supply	Standard Pharmacy: <u>Tier 2:</u> \$10 <u>Insulin:</u> The lesser of \$10 or 25%		Not Covered.
90-day supply	Preferred Pharmacy/Mail Order: <u>Tier 2:</u> \$10 <u>Insulin:</u> The lesser of \$10 or 25%		Not Covered.
90-day supply	Standard Pharmacy: <u>Tier 2:</u> \$20 <u>Insulin:</u> The lesser of \$20 or 25%		Not Covered.
Tier 3 Preferred Brand After you pay the deductible			Not Covered.
30-day supply	Preferred Pharmacy: <u>Tier 3:</u> 20% <u>Insulin:</u> The lesser of \$25 or 20%		Not Covered.
30-day supply	Standard Pharmacy: <u>Tier 3:</u> 20% <u>Insulin:</u> The lesser of \$30 or 20%		Not Covered.
90-day supply	Preferred Pharmacy/Mail Order: <u>Tier 3:</u> 20% <u>Insulin:</u> The lesser of \$50 or 20%		Not Covered.
90-day supply	Standard Pharmacy: <u>Tier 3:</u> 20% <u>Insulin:</u> The lesser of \$60 or 20%		Not Covered.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Tier 4 Non-Preferred Drug After you pay the deductible		
30-day supply	Preferred Pharmacy: Tier 4: 30% <u>Insulin:</u> The lesser of \$25 or 25%	Not Covered.
30-day supply	Standard Pharmacy: Tier 4: 43% <u>Insulin:</u> The lesser of \$30 or 25%	Not Covered.
90-day supply	Preferred Pharmacy/Mail Order: Tier 4: 30% <u>Insulin:</u> The lesser of \$50 or 25%	Not Covered.
90-day supply	Standard Pharmacy: Tier 4: 43% <u>Insulin:</u> The lesser of \$60 or 25%	Not Covered.
Tier 5 Specialty After you pay the deductible		Not Covered.
30-day supply	Preferred Pharmacy: Tier 5: 29% <u>Insulin:</u> The lesser of \$25 or 25%	Not Covered.
30-day supply	Standard Pharmacy: Tier 5: 29% <u>Insulin:</u> The lesser of \$30 or 25%	Not Covered.
90-day supply	Preferred Pharmacy/Mail Order: Tier 5: 29% <u>Insulin:</u> The lesser of \$50 or 25%	Not Covered.
90-day supply	Standard Pharmacy: Tier 5: 29% <u>Insulin:</u> The lesser of \$60 or 25%	Not Covered.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach \$2,400 your Part D prescription drugs are covered in full.	Not Covered.
ADDITIONAL BENEFITS/SERVICES		
Medicare Covered Chiropractic Office Visits	In-Network: You pay \$15 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. We only cover manual manipulation of the spine to correct subluxation (when 1 or more of the bones in your spine move out of position).	In-Network: You pay \$5 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year. We only cover manual manipulation of the spine to correct subluxation (when 1 or more of the bones in your spine move out of position).
Fitness Program	Access to Silver&Fit participating fitness centers for no annual membership fee.	Access to Silver&Fit participating fitness centers for no annual membership fee.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Fitness Program (continued)	One Home Fitness kit per year for no annual fee. You can choose BOTH membership at a participating fitness center AND 1 Home Fitness Kit.	One Home Fitness kit per year for no annual fee. You can choose BOTH membership at a participating fitness center AND 1 Home Fitness Kit.
Medical Equipment/Supplies Durable Medical Equipment (e.g., Wheelchairs) Prosthetics (e.g., Braces) Diabetes monitoring supplies (blood glucose monitors, continuous glucose monitors, blood glucose test strips, and lancets) Diabetes self-management training Therapeutic shoes or inserts For people with Diabetes who have severe diabetic foot disease.	In-Network: 20% coinsurance. 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 may be required. In-Network: 20% coinsurance. 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 may be required. In-Network: \$5 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$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. See the Evidence of Coverage for more information. Prior authorization may be required. In-Network: \$0 copay. 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: 20% coinsurance. 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 may be required.	In-Network: 20% coinsurance. 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 may be required. In-Network: 20% coinsurance. 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 may be required. In-Network: \$5 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$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. See the Evidence of Coverage for more information. Prior authorization may be required. In-Network: \$0 copay. 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: 20% coinsurance. 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 may be required.

Benefits / Services	Medicare Blue Choice 030 (HMO-POS)	Medicare Blue Choice 031 (HMO-POS)
Virtual Doctor's Visits: Telehealth	In-Network: \$0 - \$30 copay per visit. 20% coinsurance for a behavioral health visit. * * \$0 copay per visit if using MD Live. \$30 copay per behavioral health visit if using MD Live. For non-emergency medical issues only. Contact a network doctor by phone or secure video. Telehealth doctors can diagnose symptoms and prescribe medication. Available 24 hours a day, 7 days a week. Out-of-Network: Not covered	In-Network: \$5 - \$35 copay per visit. \$0 copayment for a behavioral health visit. * * \$5 copay per visit if using MD Live. \$35 copay per behavioral health visit if using MD Live. For non-emergency medical issues only. Contact a network doctor by phone or secure video. Telehealth doctors can diagnose symptoms and prescribe medication. Available 24 hours a day, 7 days a week. Out-of-Network: Not covered
Home Health Care	In-Network: \$0 copay. 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: \$0 copay. Out-of-Network: You pay 30% coinsurance. The plan will reimburse maximum \$3,000 for out-of-network (POS) services per calendar year.
Post Discharge Meal Benefit	Not Covered.	Up to two home-delivered meals per day for 7-days. Available after an inpatient hospital, hospital observation, or Skilled Nursing Facility stay.

This document is available in other formats.

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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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.

Abbott Diabetes Care is the preferred supplier for Diabetic Monitoring supplies and is an independent company.

MD Live 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 BCBS members.

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. Silver&Fit is a trademark of ASH and used with permission herein.

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-883-9577 (TTY: 1-800-662-1220) or speak to your provider.

Spanish: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También se ofrecen de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-883-9577 (TTY: 1-800-662-1220) o hable con su proveedor.

Chinese-Traditional: 如果您說繁體中文，我們可免費提供語言援助服務。此外，我們亦可免費提供適當的輔助工具及服務，以協助您取得無障礙格式的資訊。請致電 1-877-883-9577 (TTY: 1-800-662-1220)，或洽詢您的醫療服務提供者。

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Кроме того, бесплатно предоставляются соответствующие вспомогательные услуги и сервисы для предоставления информации в доступных форматах. Позвоните по номеру 1-877-883-9577 (телетайп: 1-800-662-1220) или обратитесь к своему поставщику услуг.

Haitian Creole: Si w pale Kreyòl Ayisyen, gen sèvis asistans lengwistik ki disponib gratis pou ou. Gen aparèy ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòm ki aksesib ki disponib gratis tou. Rele nan 1-877-883-9577 (TTY: 1-800-662-1220) oswa pale ak pwofesyonèl swen sante w la.

Korean: 한국어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 이용 가능합니다. 1-877-883-9577(TTY: 1-800-662-1220)로 전화하거나 서비스 제공업체에 문의하십시오.

Italian: Se parla italiano, potrà usufruire di servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente adeguati servizi sussidiari e di assistenza per fornire informazioni in formati accessibili. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220) o consultare il proprio fornitore.

Yiddish: אויב איר רעדט יידיש, זענען פרייע שפראך הילף סערוויסעס פאראנען פאר אייך. פאסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמציע אין צוטריטלעכע פארמאטן זענען אויך פאראנען פריי פון אפצאל. איינרוף 1-877-883-9577 (TTY: 1-800-662-1220) אדער רעדט מיט אייער פראוויידער.

Bengali: আপনি যদি বাংলা বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য রয়েছে। তথ্য সহজলভ্য বিন্যাসে প্রদানের জন্য উপযুক্ত সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে পাওয়া যায়। 1-877-883-9577 (TTY: 1-800-662-1220) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

Polish: Jeśli mówi Pan/Pani po polsku, może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. W celu dostarczenia informacji w przystępnym formacie dostępne są również bezpłatne dodatkowe pomoce i usługi. Prosimy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220) lub porozmawiać ze swoim świadczeniodawcą.

Arabic: إن كنت تتحدث العربية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر المساعدات والخدمات الإضافية الملائمة لتقديم المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل بهذا الرقم 1-877-883-9577 (رقم الهاتف النصي لضعاف السمع-1-800-662-1220) أو تحدث إلى مُقدم الرعاية الخاص بك.

French: Si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Des aides et des services auxiliaires adaptés pour vous fournir des informations dans des formats accessibles vous sont également proposés gratuitement. Appelez le 1-877-883-9577 (TTY : 1-800-662-1220) ou parlez-en à votre prestataire.

Urdu: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں معاونت کی خدمات دستیاب ہیں۔ معلومات کو قابل رسائی انداز میں فراہم کرنے کے لیے مناسب معاون آلات اور خدمات بھی مفت فراہم کی جاتی ہیں۔ 1-877-883-9577 پر کال کریں (TTY: 1-800-662-1220) یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo ng tulong sa wika. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220) o makipag-usap sa iyong provider.

Greek: Εάν μιλάτε Ελληνικά, είναι διαθέσιμες για εσάς δωρεάν υπηρεσίες γλωσσικής βοήθειας. Επίσης, διατίθενται χωρίς χρέωση κατάλληλα βοηθητικά μέσα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε στο 1-877-883-9577 (TTY: 1-800-662-1220) ή μιλήστε με τον πάροχό σας.

Albanian: Nëse flisni shqip, ofrohen falas për ju shërbime të asistencës gjuhësore. Gjithashtu ofrohen falas mjete dhe shërbime ndihmëse të përshtatshme për të ofruar informacionin në formate të aksesueshme. Telefononi 1-877-883-9577 (TTY: 1-800-662-1220) ose flisni me ofruesin tuaj.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer care representative at 1-800-659-1986 (TTY 711).

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 [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.com) or call 1-800-659-1986 (TTY 711) 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 [medicare.excellusbcbs.com](https://www.medicare.excellusbcbs.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, 2028**.
- ☐ 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. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new 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.