Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

2026 SUMMARY OF BENEFITS

January 1, 2026 – December 31, 2026

Medicare Blue Choice® Optimum (HMO-POS) (H3351-006)
Medicare Blue Choice® Freedom (HMO-POS) (H3351-007)

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. (EOC)" You can also see the Evidence of Coverage on our website **medicare.excellusbcbs.com.**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medicare Blue Choice Optimum (HMO-POS) and Medicare Blue Choice Freedom (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 or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Sections in this booklet

- Things to know about **Medicare Blue Choice Optimum (HMO-POS) and Medicare Blue Choice Freedom (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much you pay for covered services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Benefits

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

Things to know about Medicare Blue Choice Optimum (HMO-POS) and Medicare Blue Choice Freedom (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.**

Who can join?

To join **Medicare Blue Choice Optimum (HMO-POS) or 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.

Which doctors, hospitals, and pharmacies can I use?

Medicare Blue Choice Optimum (HMO-POS) and Medicare Blue Choice Freedom (HMO-POS) have a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can use providers that are not in our network.

Medicare Blue Choice Optimum (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.** Or call us and we will send you a copy of the directory.

Medicare Blue Choice Optimum (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.** Or call us and we will send you a copy of our formulary.

In addition, **Medicare Blue Choice Optimum (HMO-POS) and Medicare Blue Choice Freedom (HMO-POS)** cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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

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.

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

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

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

SafeRide® is an independent company, offering transportation services 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. 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.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Monthly Premium, Deductible, and Limits on How Much you pay for covered services			
Monthly Plan Premium	You pay $224.80 per month.	You pay $0 per month.	You must continue to pay your Medicare Part B premium.
Optional Supplemental Dental	Additional premium of $26 per month	Additional premium of $26 per month	
Part B Premium Reduction	Not applicable.	$35 reduction of monthly premium you pay to the Social Security Administration.	
Deductible	$100 per year for prescription drugs on Tiers 3, 4 and 5. There is no medical deductible.	Not applicable.	You must pay your Part D deductible before the plan will contribute to the costs of your prescriptions.
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs.)	$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.
Covered Medical and Hospital Benefits			
Inpatient Hospital Coverage	**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.
Outpatient Hospital Coverage	**In-Network:** You pay $250 copayment. **Out-of-Network:**	**In-Network:** You pay $250 copayment. **Out-of-Network:**	Prior Authorization is required.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Outpatient Hospital Coverage (continued)	You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	
Ambulatory Surgery Center	**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 Care	**In-Network:** You pay $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.	**In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $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 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.	
Preventive Care	**In-Network:** You pay $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.	**In-Network:** You pay $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.	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 Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Preventive Care (continued)			an office visit copayment will apply to the care received for the new or existing medical condition. Additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $115 copayment.	You pay $115 copayment.	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Covered worldwide.
Urgently Needed Services	You pay $40 copayment.	You pay $50 copayment.	Covered worldwide.
Diagnostic Services/Labs/ Imaging Diagnostic Radiology Service (e.g., MRI, CT scans) Lab Services - Diagnostics	**In-Network:** You pay $150 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 $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.	**In-Network:** You pay $150 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 $10 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 for some services. Contact us for more information.

Premiums and Benefits	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 $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.	**In-Network:** You pay $10 copayment. **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:** You pay $40 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 $40 copayment. **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:** You pay 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:** You pay 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.	
Hearing Services Diagnostic Hearing Exam	**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.	
Routine Hearing Exam (One routine hearing exam each year.)	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered.	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered.	You must see a TruHearing provider. One routine hearing exam each year.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Hearing Services (continued) Hearing Aids	**In-Network (per aid):** $499 copay for Advanced Aid. $799 copay for Premium Aid. $50 additional cost for optional hearing aid rechargeability. **Out-of-Network:** Not covered.	**In-Network (per aid):** $499 copay for Advanced Aid. $799 copay for Premium Aid. $50 additional cost for optional 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.	**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.	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.
Preventive dental services per year (Includes up to 2 cleaning(s), 2 oral exam(s), and 4 dental x-ray(s) films.)	**In-Network:** You pay $0 copayment per service.	**In-Network:** You pay $0 copayment per service.	For out-of-network services, 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.
Annual Allowance Restorative (e.g., restorations) Periodontics (e.g., scaling) Oral Surgery (e.g., extractions)	$500 per calendar year for in and out of network benefits (services above the limit are your responsibility). **In-Network:** You pay $0 copayment per service. **Out-of-Network:** You pay $0 copayment per service.	$500 per calendar year for in and out of network benefits (services above the limit are your responsibility). **In-Network:** You pay $0 copayment per service. **Out-of-Network:** You pay $0 copayment 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.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Dental Services (continued) Endodontics (e.g., root canal) Prosthodontics (e.g., select crowns, dentures, and bridges) Prosthetic Maintenance (e.g., denture or bridge repairs)			See the Evidence of Coverage for more information. Limited to specific dental codes Exclusions apply, for example tooth implants are not covered.
Optional Supplemental Dental Annual Allowance	Additional premium of $26 per month $500 per calendar year for in and out of network benefits (services above the limit are your responsibility). This is in addition to the $500 annual allowance included in your plan.	Additional premium of $26 per month $500 per calendar year for in and out of network benefits (services above the limit are your responsibility). This is in addition to the $500 annual allowance included in your plan.	Additional dental benefits available with a separate premium. You will be responsible for the additional cost if your provider does not participate in the network and charges more than the annual allowance.
Vision Services Diagnostic/ Treatment Eye Exam	**In-Network:** You pay $40 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 $40 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse maximum $3,000 for out-of-network (POS) services per calendar year.	
Routine Eye Exam	**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 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 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.	
Routine Eyewear Allowance	$200 annual allowance	$200 annual allowance	Allowance towards purchase of contact lenses and eyeglasses (frames and lenses).
Mental Health Services Inpatient Visit	**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 $3,000 maximum 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 $3,000 maximum 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.
Individual and Group Outpatient Therapy Visit	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Skilled Nursing Facility	**In-Network:** You pay $0 copayment for days 1 through 20. You pay a $218 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copayment for days 1 through 20. You pay a $218 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	Prior Authorization may be required.
Ambulance	You pay $150 copayment.	You pay $150 copayment.	Prior Authorization may be required.
Transportation (Various modes of transportation are available based on your needs.)	12 one-way trips to a health-related location through SafeRide.	12 one-way trips to a health-related location through SafeRide.	There will be a limit of 50 miles per one-way ride.
Medicare Part B Drugs **Part B Insulin used in a traditional insulin pump**	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. **In-Network:** You pay $35 copayment. **Out-of-Network:** You pay $35 copayment.	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. **In-Network:** You pay $35 copayment. **Out-of-Network:** You pay $35 copayment.	Prior Authorization may be required. Part B drugs may be subject to step therapy requirements. 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 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. Insulin costs will be either a copayment or coinsurance based on your plan benefit, the maximum fair price for a covered insulin or the negotiated price under your plan, whichever is less. The maximum insulin copayment is $35 for a one-month supply. Insulins are not subject to the deductible; costs will be the same through the deductible and initial coverage phases of your benefit.	Not Covered. Not Covered.	
Medicare Part D Deductible	$100 per year for prescription drugs on Tiers 3, 4 and 5.	Not Covered.	You must pay your Part D deductible before the plan will contribute to the costs of your prescriptions.
Tier 1 Preferred Generic		Not Covered.	
Preferred Pharmacy 30-day supply	Tier 1: You pay $0 Insulin: You pay $0	Not Covered.	
Standard Pharmacy 30-day supply	Tier 1: You pay $5 Insulin: You pay lesser of $5 or 25%	Not Covered.	

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Tier 1 Preferred Generic (continued) Preferred Pharmacy/Mail Order 90-day supply	Tier 1: You pay $0 Insulin: You pay $0	Not Covered.	
Standard Pharmacy 90-day supply	Tier 1: You pay $10 Insulin: You pay lesser of $10 or 25%	Not Covered.	
Tier 2 Generic		Not Covered.	
Preferred Pharmacy 30-day supply	Tier 2: You pay $5 Insulin: You pay lesser of $5 or 25%	Not Covered.	
Standard Pharmacy 30-day supply	Tier 2: You pay $10 Insulin: You pay lesser of $10 or 25%	Not Covered.	
Preferred Pharmacy/ Mail Order 90-day supply	Tier 2: You pay $10 Insulin: You pay lesser of $10 or 25%	Not Covered.	
Standard Pharmacy 90-day supply	Tier 2: You pay $20 Insulin: You pay lesser of $20 or 25%	Not Covered.	
Tier 3 Preferred Brand After you pay your deductible		Not Covered.	
Preferred Pharmacy 30-day supply	Tier 3: You pay 20% Insulin: You pay lesser of $25 or 20%	Not Covered.	
Standard Pharmacy 30-day supply	Tier 3: You pay 20% Insulin: You pay lesser of $30 or 20%	Not Covered.	

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Tier 3 Preferred Brand (continued) Preferred Pharmacy/ Mail Order 90-day supply	Tier 3: You pay 20% Insulin: You pay lesser of $50 or 20%	Not Covered.	
Standard Pharmacy 90-day supply	Tier 3: You pay 20% Insulin: You pay lesser of $60 or 20%	Not Covered.	
Tier 4 Non-Preferred Drug After you pay your deductible			
Preferred Pharmacy 30-day supply	Tier 4: You pay 37% Insulin: You pay lesser of $25 or 25%	Not Covered.	
Standard Pharmacy 30-day supply	Tier 4: You pay 50% Insulin: You pay lesser of $30 or 25%	Not Covered.	
Preferred Pharmacy/ Mail Order 90-day supply	Tier 4: You pay 37% Insulin: You pay lesser of $50 or 25%	Not Covered.	
Standard Pharmacy 90-day supply	Tier 4: You pay 50% Insulin: You pay lesser of $60 or 25%	Not Covered.	
Tier 5 Specialty After you pay your deductible		Not Covered.	
Preferred Pharmacy 30-day supply	Tier 5: You pay 31% Insulin: You pay lesser of $25 or 25%	Not Covered.	

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Tier 5 Specialty (continued) Standard Pharmacy 30-day supply	Tier 5: You pay 31% Insulin: You pay lesser of $30 or 25%	Not Covered.	
Preferred Pharmacy/ Mail Order 90-day supply	Tier 5: You pay 31% Insulin: You pay lesser of $50 or 25%	Not Covered.	
Standard Pharmacy 90-day supply	Tier 5: You pay 31% Insulin: You pay lesser of $60 or 25%	Not Covered.	
Phase 2: Catastrophic Coverage	In 2026, once you have paid **$2,100** (including your deductible, copayments, and coinsurances) you enter the catastrophic coverage stage. **You pay $0 for generics and brand drugs** and will remain in this stage for the rest of the calendar year. On January 1, 2027, you begin again in the deductible phase.	Not Covered.	
Additional Benefits			
Over the counter (OTC) Items	Not Covered.	You have $30 every quarter to spend on plan-approved OTC items.	Non-prescription OTC health related items are covered.
Acupuncture	**In-Network:** You pay 50% coinsurance. **Out-of-Network:** Not Covered	**In-Network:** You pay 50% coinsurance. **Out-of-Network:** Not Covered	For up to 10 visits per calendar year or up to 20 visits per calendar year for chronic lower back pain.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Meals	**In-Network:** Up to 2 home-delivered meals per day for 7-days. **Out-of-Network:** Not covered	**In-Network:** Up to 2 home-delivered meals per day for 7-days. **Out-of-Network:** Not covered	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 $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	
Speech and Language Therapy Visit	**In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	

Premiums and Benefits	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 $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	Routine foot exams and treatment are covered if you have Diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/ Supplies Durable Medical Equipment (e.g., Wheelchairs, Oxygen)	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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 $3,000 maximum 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.	**In-Network:** You pay a $0 copayment.	See the Evidence of Coverage for more information.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Medical Equipment/ Supplies (continued) Diabetes self-management training Therapeutic shoes or inserts	**Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year. **In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year.	**Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year. **In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year.	For people with Diabetes who have severe diabetic foot disease.
Wellness Programs Fitness Silver&Fit participating fitness centers Silver&Fit Home Fitness Kits	You pay a $0 annual fee. You pay a $0 annual fee.	You pay a $0 annual fee. You pay a $0 annual fee.	Non-participating fitness centers are not covered. Please see your Evidence of Coverage for more details.
Remote Access Technology	Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 711).	Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 711).	Intended to 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	One annual routine physical exam each calendar year.

Premiums and Benefits	Medicare Blue Choice Optimum (HMO-POS)	Medicare Blue Choice Freedom (HMO-POS)	What You Should Know
Immunizations	**In-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines. You pay 20% coinsurance for all other Medicare-Part B covered immunizations. **Out-of-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines. For all other Medicare-Part B covered immunizations, you pay 30% . The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year.	**In-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines. You pay 20% coinsurance for all other Medicare-Part B covered immunizations. **Out-of-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines. For all other Medicare-Part B covered immunizations, you pay 30% . The plan will reimburse $3,000 maximum for out-of-network (POS) services per calendar year.	Some vaccines are also covered under our Part D prescription drug benefit. Medicare- Part B covered immunizations are generally used for treatment of an injury or direct exposure to a disease or condition.
Telehealth Primary Specialists Behavioral Health visit Preferred partners visit Preferred partners Behavioral 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 $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 only. Contact a network doctor by phone or secure video. Telehealth doctors can diagnose symptoms and prescribe medication. Services available 24 hour a day, 7 days a week.
Chiropractic Care We cover manual manipulation of the spine to correct a subluxation	**In-Network:** You pay $15 copayment. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	A subluxation is when 1 or more of the bones in your spine move out of position.

Premiums and Benefits	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 $3,000 maximum 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 $3,000 maximum 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.	
Outpatient Substance Abuse Services Individual and Group therapy visit	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. The plan will reimburse $3,000 maximum 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 $3,000 maximum for out-of-network (POS) services per calendar year.	Prior Authorization may be required for some services.

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 inglés, 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: 如果您說英文，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-английски, 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 Anglè, gen sèvis asistans lengwistik ki disponib gratis pou ou. Gen aparèy ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma 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: 영어를 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 inglese, 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 ענגליש, זענען פרייַ שפּראַך הילף סערוויסעס פאראנען פאר אייך. פאסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמציע אין צוטריטלעכע פארמאַטן זענען אויך פאראנען פריי פון אפּצאל. איינרוף 1-877-883-9577 (TTY: 1-800-662-1220) אדער רעדט מיט אייער פראווייַדער.

Bengali: আপনি যদি ইংরেজি 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 angielsku, 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 الإنجليزية، 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 TTY: 1-800-662-1220) أو تحدث إلى مُقدم الرعاية الخاص بك.

French: Si vous parlez anglais, 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۔ 1-877-883-9577پر کال کریں (TTY: 1-800-662-1220) یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog: Kung nagsasalita ka ng English, 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 Αγγλικά, 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 anglisht, 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 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 medicare.excellusbcbs.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 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, 2027.

- ☐ 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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