Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

2018 SUMMARY OF BENEFITS
January 1, 2018 – December 31, 2018

Medicare Bassett (HMO-POS) (H3351-015)

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 Bassett (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: Delaware, Herkimer, and Otsego.

Medicare Bassett (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network. However, you will pay more when utilizing out-of-network services. 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 http://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.

For more information, please call us at the telephone numbers below or visit us at www.ExcellusMedicare.com.

If you are a member of one of these plans: Call toll-free at 1-877-883-9577;
(TTY users should call: 1-800-421-1220).

If you are not a member of one of these plans: Call toll-free at 1-800-659-1986;
(TTY users should call: 1-800-421-1220).

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

You can see our plan's provider/pharmacy directory at our website at www.ExcellusMedicare.com/Providers.

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 www.ExcellusMedicare.com. Or, call us and we will send you a copy of our formulary.

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

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Monthly Plan Premium	You pay $104 per month.	You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$6,700 for medical services you receive from In-Network providers.	The most you pay for copayments and coinsurance for medical services for the year.
Inpatient Hospital Coverage	**In-Network:** You pay $300 copayment per day for days 1 through 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance per stay.	Our plan covers an unlimited number of days for an inpatient hospital stay. Benefit is applied per admission. Prior Authorization is required. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Outpatient Hospital Coverage	**In-Network:** You pay $200 copayment. **Out-of-Network:** You pay 30% coinsurance.	Prior Authorization is required. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Doctor Visits ° Primary ° Specialist	**In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. **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.
Preventive Care	**In-Network:** You pay $0 copayment **Out-of-Network:** You pay $0 copayment or 30% coinsurance depending on the service.	See the Evidence of Coverage for a list of covered preventive services. If you are treated for a new or existing medical condition during a visit where a preventive screening is performed, an office visit copayment or coinsurance will apply to the care received for the new or existing medical condition. The plan will reimburse a maximum of $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.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Emergency Care	You pay $80 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.	
Diagnostic Services/Labs/ Imaging		
° Diagnostic Radiology Service *(e.g.,MRI, CT scans)*	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance.	Prior authorization is required for some services. Contact us for more information. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
° Lab Services	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance.	
° Diagnostic Tests and Procedures	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance.	

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Diagnostic Services/Labs/ Imaging *(Continued)*		
° X-Rays	**In-Network:** You pay $20 copayment. **Out-of-Network:** You pay 30% coinsurance.	
° Therapeutic Radiology (such as radiation treatment for cancer)	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 30% coinsurance.	
Hearing Services		
° Diagnostic/Treatment Exam	**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 Hearing Exam	**In-Network:** You pay $45 copayment. **Out-of-Network:** Not Covered.	One routine hearing exam each year. You must see a TruHearing provider to use this benefit. This copayment not included in the Out-of-Pocket Maximum.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Hearing Services *(Continued)*		
° Hearing Aid	$699 copayment Flyte Advanced Aid. $999 copayment Flyte Premium Aid.	From TruHearing Providers only. This copayment not included in the Out-of-Pocket Maximum.
Dental Services	Medicare covered limited dental services (This does not include routine services in connection with care, treatment, filling, removal or replacement of teeth): **In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance.	Medicare only covers certain limited dental procedures under specific conditions. Preventive dental services not covered.
Vision Services		
° Diagnostic/Treatment Exam	**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 Eye Exam	**In-Network:** You pay $35 copayment. **Out-of-Network:** Not Covered.	One routine Eye Exam each year.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Vision Services *(Continued)* ° Eyeglasses or Contacts after Cataract Surgery ° Routine Eyewear Allowance	 **In-Network:** You pay $35 copayment. **Out-of-Network:** You pay 30% coinsurance. Not Covered.	
Mental Health Inpatient Services ° Inpatient Visit ° Individual and Group Outpatient Therapy Visit	 **In-Network:** You pay $300 copayment per day for days 1 through 5. Thereafter, you pay $0 copayment for additional Medicare-covered days during your hospital admission. **Out-of-Network:** You pay 30% coinsurance. **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance.	 Our plan covers up to 190 days in a lifetime for inpatient mental health care in 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. Benefit is applied per admission. For Inpatient Mental Health Services, prior authorization is required. Prior Authorization may be required for some services. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Skilled Nursing Facility	**In-Network:** You pay $0 copayment per day for days 1 through 20. You pay a $167.50 copayment per day for days 21 through 100. **Out-of-Network:** You pay 30% coinsurance.	Our plan covers up to 100 days in a Skilled Nursing Facility. Prior authorization is required. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Physical Therapy	**In-Network:** You pay $35 copay. **Out-of-Network:** You pay 30% coinsurance.	Maximum combined coverage limit of $1,980 cap on Physical Therapy and Speech Therapy (2017 limit). These amounts may change for 2018. Once cap is met, covered services may be extended based on medical necessity. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year. See the Evidence of Coverage for more information.
Ambulance	You pay $200 copayment.	Prior Authorization may be required.
Transportation	Not Covered.	

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Medicare Part B Drugs	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance.	Prior Authorization is required. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Medicare Part D Prescription Drugs		
Phase 1: Initial Coverage	This plan does not have a deductible.	Cost-Sharing may change depending on the pharmacy you choose and what phase of the Part D benefit you are in. For more information, please call us or access our Evidence of Coverage online.
Tier 1: Preferred Generic	**Retail** 30-day supply: You pay $4 **Mail Order** 90-day supply: You pay $10	
Tier 2: Generic	**Retail** 30-day supply: You pay $8 **Mail Order** 90-day supply: You pay $20	

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Phase 1: Initial Coverage *(Continued)* **Tier 3: Preferred Brand**	**Retail** 30-day supply: You pay $45 **Mail Order** 90-day supply: You pay $112.50	
Tier 4: Non-Preferred Drug	**Retail** 30-day supply: You pay $95 **Mail Order** 90-day supply: You pay $237.50	
Tier 5: Specialty	**Retail** 30-day supply: You pay 33% coinsurance. **Mail Order** 90-day supply: You pay 33% coinsurance.	
Additional Benefits		
Rehabilitation Services ° Occupational Therapy Visit	**In-Network:** You pay $35 copay. **Out-of-Network:** You pay 30% coinsurance.	Maximum coverage limit of $1,980 cap on Occupational Therapy (2017 limit).

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Rehabilitation Services *(Continued)*		
° Speech and Language Therapy Visit	**In-Network:** You pay $35 copay. **Out-of-Network:** You pay 30% coinsurance.	Maximum combined coverage limit of $1,980 cap on Speech Therapy and Physical Therapy (2017 limit). These amounts may change for 2018. Once cap is met, covered services may be extended based on medical necessity.
° Cardiac Rehabilitation Services	**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. See the Evidence of Coverage for more information.
Foot Care (Podiatry Services)		
° Diagnostic Exams and Treatment	**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 Bassett (HMO-POS)	What You Should Know
Foot Care (Podiatry Services) *(Continued)* ° Routine Foot Care	**In-Network:** You pay $40 copayment. **Out-of-Network:** You pay 30% coinsurance.	Foot exams and treatment if you have Diabetes-related nerve damage and/or meet certain conditions.
Medical Equipment/Supplies ° Durable Medical Equipment (e.g., Wheelchairs, Oxygen) ° Prosthetics (e.g., Braces, Artificial Limbs – and related supplies)	**In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. **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 and Prosthetics.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Medical Equipment/Supplies *(Continued)*		
° Diabetes Supplies	**Diabetes Monitoring Supplies:** **In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. **Diabetes self-management training:** **In-Network:** You pay a $0 copayment. **Out-of-Network:** You pay 30% coinsurance.	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.
° Therapeutic shoes or inserts	**Therapeutic shoes or inserts:** **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance.	For people with Diabetes who have severe diabetic foot disease. See the Evidence of Coverage for more information.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Wellness Programs (e.g., Fitness)	Silver&Fit participating fitness clubs and exercise centers: You pay a $25 annual non-refundable fee. Silver&Fit Home Fitness Program: You pay a $10 annual non-refundable fee. Silver&Fit non-participating fitness clubs and exercise centers: You will be reimbursed up to an annual allowance of $150.	You are eligible for one of three Silver&Fit fitness program options each month. You cannot simultaneously enroll in multiple program options at the same time. These copayments not included in the Out-of-Pocket Maximum.
Routine Annual Physical Exam	**In-Network:** You pay $0 copayment. **Out-of-Network:** Not Covered.	One annual routine physical exam each calendar year.
Telemedicine *(Remote Access Technology)* ° Primary ° Specialists	**In-Network:** You pay $5 copayment. **Out-of-Network:** Not Covered. **In-Network:** You pay $40 copayment. **Out-of-Network:** Not covered.	A program that allows members to contact a network doctor either by phone, secure video on your personal computer or using a mobile device 24 hours a day, 7 days a week. Telemedicine doctors can diagnose symptoms, prescribe medication and send prescriptions to select pharmacies. This program is designed to handle non-emergency medical issues and should not be used when experiencing a medical emergency.

Premiums and Benefits	Medicare Bassett (HMO-POS)	What You Should Know
Chiropractic Care	**In-Network:** You pay $15 copayment. **Out-of-Network:** You pay 30% coinsurance.	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). The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Home Health Care	**In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance.	Prior Authorization is required. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.
Outpatient Dialysis Services	**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.	Prior Authorization may be required for some services. The plan will reimburse a maximum of $3,000 for out-of-network (POS) services per calendar year.

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-883-9577 (TTY: 1-800-421-1220).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-883-9577 (TTY: 1-800-421-1220).

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：1-800-421-1220）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-883-9577 (телетайп: 1-800-421-1220).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-883-9577 (TTY: 1-800-421-1220).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-883-9577 (TTY: 1-800-421-1220)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: 1-800-421-1220).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-883-9577 (TTY: 1-800-421-1220).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-659-1986 (TTY: ১-800-421-1220)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-883-9577 (TTY: 1-800-421-1220).

ملحوظة: إذا كنت تتحدث اذكر اللغة لديك، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-877-883-9577 (رقم هاتف الصم والبكم: 1-800-421-1220).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-883-9577 (ATS : 1-800-421-1220).

اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ 1-877-883-9577 (TTY: 1-800-421-1220).

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: 1-800-421-1220).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-883-9577 (TTY: 1-800-421-1220).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-883-9577 (TTY: 1-800-421-1220).

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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: 1-800-421-1220). Monday - Friday, 8 a.m. - 8 p.m.
From October 1 - February 14, 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: 1-800-421-1220)
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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B-5608 (Rev. 09/2016)