Empire BlueCross BlueShield

An Anthem Company

Summary of Benefits

for **Empire MediBlue Access (PPO)**

Available in: Select Counties* in New York *See Page 2 for a list of counties.

Plan year: January 1, 2017 – December 31, 2017

In this section, you'll learn about some of the services we cover, what you'll pay for those services and other important details to help you choose the right Medicare Advantage plan for you. While the benefit information provided does not list every service that we cover or list every limitation or exclusion, you can get a complete list of those services. Just give us a call and ask for the *Evidence of Coverage.*

Have questions? Here's how to reach us and our hours of operation:

- If you **are not** a member of this plan, please call toll free **1-800-809-7328** (TTY: **711**), and follow the instructions to be connected to a representative.
- If you **are** a member of this plan, call our toll-free Customer Service number at **1-866-395-5175** (TTY: **711**).
- **8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.**
- You can learn more about us on our website at **www.empireblue.com/shop**.

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What you should know about our plan

Empire MediBlue Access (PPO) is a Medicare Advantage and prescription drug plan, which includes hospital, medical and prescription drug benefits in one plan. To join this plan, you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Our service area includes: NY: Bronx

With this plan, you have a choice to see any doctor or hospital, in-network or out-of-network. If you use a provider in our network, your out-of-pocket costs may be lower than using out-of-network providers. Ask your current doctor if he or she is in the plan's network.

You can find a doctor in the network online — visit **www.empireblue.com/shop** and choose Find a Doctor. *(Be sure to check that the doctor displays as "In-Network" for these plans.)* Or you can call Customer Service and request a copy of the provider directory.

What do we cover?

- Like all Medicare health plans, we cover everything that Original Medicare covers — Part A (hospital services) and Part B (medical services), plus more. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less (see benefits section for more details).
- Medicare Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider).
- To see if your drugs are covered, you can view the plan's *Formulary* (list of covered Part D prescription drugs) and any restrictions on our website at **www.empireblue.com/shop**. Or you can call us for a copy of the *Formulary*.

What are my drug costs?

Our plan groups each medication into one of six "tiers." The amount you pay depends on the drug's tier and what stage of the benefit you have reached (refer to **The four stages of coverage**).

How to find out what your covered drugs will cost:

Step 1: Find your drug on the *Formulary*.

Step 2: Next, identify the drug tier.

Step 3: Then, go to the Prescription Drug Benefits section further in this booklet to match the tier.

Can I use any pharmacy to fill my covered prescriptions?

To receive the lowest out-of-pocket costs on your covered Part D drugs, you must generally use a pharmacy in our network. If you use a pharmacy that is not in our network, you may pay more for your covered drugs.

You may be able to save even more money at pharmacies with preferred cost sharing

We've worked with certain network pharmacies to further reduce prices, so you can save more on your covered drugs. Having available preferred pharmacies does not mean you can't use other pharmacies in our network *(pharmacies with standard cost sharing)*, but you may pay more at a pharmacy with standard cost-sharing. Pharmacies with preferred cost-sharing have lower copays and coinsurance amounts for non-specialty drugs than pharmacies with standard cost-sharing.

For a complete listing of network pharmacies, refer to our plan's *Pharmacy Directory* on our website **www.empireblue.com/shop** (under *Useful Tools*, select **Find a Pharmacy**). Next to the pharmacy name, you will see a preferred cost-sharing indicator (a ♦ symbol). Or you can give us a call, and we will send you a copy.

How can I learn more about Medicare or compare my choices with other plans?

- Visit our online Medicare tutorial at **https://www.empireblue.com/medicarebasics/**.
- Refer to your current *Medicare & You* handbook. You can view it online at **www.medicare.gov** or call Medicare for a copy at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.
- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or you can go online to **www.medicare.gov** and use the Medicare Plan Finder.

Now that you are familiar with how Medicare works and some of the benefits included in our plans, it's time to consider the type of plan you may need. On the following pages, you can review our available plans with varying coverage levels to help you choose the right plan for you.

Be in the know

Before you continue, here are a few important things to know as you review our available plan options:

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Empire MediBlue Access (PPO)

How much is my premium?

$70.00 per month

You must continue to pay your Medicare Part B premium.

How much is my deductible?

This plan does not have a medical deductible.

$260.00 per year for Part D prescription drugs

Drugs listed on **Tier 1: Preferred Generic and Tier 6: Select Care Drugs** are excluded from the Part D deductible

Is there a limit on how much I will pay for my covered medical services? *(does not include Part D drugs)*

$6,200 per year from in-network providers

$9,000 per year from any provider

Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your limit for services received from in- and out-of-network providers will count toward the yearly limit. If you reach the limit on out-of-pocket costs, you will not have to pay any out-of-pocket costs for the rest of the year for covered in-network and out-of-network Part A and Part B services.

You will still need to pay your monthly premiums (if you have one) and cost sharing for your Part D prescription drugs.

Empire MediBlue Access (PPO)

Inpatient Hospital[1]

In-network:

- **Days 1 - 5: $315 per day, per admission / Days 6 - 90: $0 per day, per admission**

Out-of-network:

- **40% coinsurance per stay**

This plan covers unlimited inpatient days.

In-network and out-of-network per day cost-sharing applies to each inpatient admission. (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).

Doctor's Office Visits[1,2]

Primary care physician visit:

In-network: $20.00 copay
Out-of-network: $50.00 copay

Specialist visit:

In-network: $45.00 copay
Out-of-network: $75.00 copay

Preventive Care Screenings and Annual Physical Exams

Preventive care screenings:

In-network: $0.00 copay
Out-of-network: 40% coinsurance

Preventive Care Screenings and Annual Physical Exams - continued

Annual physical exam:

In-network: $0.00 copay
Out-of-network: 40% coinsurance

Covered Preventive care screenings:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual "Wellness" visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- HIV screening
- Lung cancer screenings
- Medical nutrition therapy services
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)

Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.

Emergency Care

$75.00 copay
This plan offers limited coverage for urgent and emergency care outside of the United States. This plan may provide coverage up to a $25,000 limit. If the cost of the service exceeds $25,000, you are responsible for the difference.

Empire MediBlue Access (PPO)

Urgently Needed Services

$55.00 copay

Diagnostic Radiology Services (such as MRIs, CT scans)[1,2]

In-Network: $50.00 - $150.00 copay
Out-of-network: 40% coinsurance

Costs for these services may vary based on place of service.

Diagnostic Tests and Procedures[1,2]

In-Network: $0.00 - $30.00 copay
Out-of-network: 40% coinsurance

Costs for these services may vary based on place of service.

Lab Services[1,2]

In-Network: $0.00 - $20.00 copay
Out-of-network: 40% coinsurance

Outpatient X-rays[1,2]

In-Network: $50.00 - $150.00 copay
Out-of-network: 40% coinsurance

Costs for these services may vary based on place of service.

Therapeutic Radiology Services (such as radiation treatment for cancer)[1,2]

In-Network: 20% coinsurance
Out-of-network: 40% coinsurance

Empire MediBlue Access (PPO)

Hearing Services[1,2]

Medicare covered hearing services
(Exam to diagnose and treat hearing and balance issues):

In-network: $45.00 copay
Out-of-network: 40% coinsurance

Routine hearing services:

Not Covered

Dental Services

Medicare covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth):

In-network: $0.00 copay
Out-of-network: 20% coinsurance

Preventive dental services:

This plan covers: 1 oral exam(s) every year, 1 cleaning(s) every year.

In-network: $0.00 copay
Out-of-network: 20% coinsurance

Comprehensive dental services:

Not Covered

Empire MediBlue Access (PPO)
Vision Services
Medicare covered vision services:
Exam to diagnose and treat diseases and conditions of the eye
In-network: $0.00 - $45.00 copay **Out-of-network: 40% coinsurance**
Eyeglasses or contact lenses after cataract surgery
In-network: $0.00 copay **Out-of-network: $0.00 copay**
Routine vision services:
Routine eye exam
This plan covers 1 routine eye exam(s) every year. $69.00 maximum eye exam coverage amount. **In-network: $0.00 copay** **Out-of-network: $0.00 copay**
Routine eye wear
Not Covered
Mental Health Care
Inpatient visit:[1]
In-network: Days 1-4: $275 per day, per admission / Days 5-90: $0 per day, per admission **Out-of-network: 40% per stay**

Mental Health Care - continued

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 services provided in a general hospital.

This plan covers unlimited inpatient days.

In-network and out-of-network per day cost-sharing applies to each inpatient admission. (note: transfers to an inpatient rehabilitation hospital is considered a new admission and cost-sharing per day applies).

Outpatient individual and group therapy visit:[1,2]

In-network: $40.00 copay
Out-of-network: $75.00 copay

Skilled Nursing Facility (SNF)[1]

In-network: Days 1 - 20: $0 per day / Days 21 - 100: $156 per day
Out-of-network: Days 1 - 20: $125 per day / Days 21 - 100: $170 per day

This plan covers up to 100 days in a Skilled Nursing Facility (SNF).

The copays for SNF benefits are based on benefit periods. A benefit period begins the day you're admitted to the hospital or skilled nursing facility and ends when you haven't received any inpatient hospital care or skilled nursing care for 60 days in a row. If you are admitted to an SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Empire MediBlue Access (PPO)

Outpatient Rehabilitation[1,2]

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

In-network: $0.00 copay
Out-of-network: 40% coinsurance

Pulmonary (lung) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions):

In-network: $0.00 copay
Out-of-network: 40% coinsurance

Occupational therapy visit:

In-network: $40.00 copay
Out-of-network: $75.00 copay

Physical therapy and speech/language therapy visit:

In-network: $40.00 copay
Out-of-network: $75.00 copay

Ambulance[1]

Ground/Water Ambulance:
In-network: $295.00 copay per trip
Out-of-network: $295.00 copay per trip

Air Ambulance:
In-network: 20% coinsurance per trip
Out-of-network: 20% coinsurance per trip

Transportation[1]

Not Covered

Foot Care *(podiatry services)*[1,2]

Medicare covered podiatry:

In-network: $45.00 copay
Out-of-network: $75.00 copay

Foot exams and treatment are covered if you have diabetes-related nerve damage and/or meet certain conditions.

Routine foot care:

Not Covered

Medical Equipment/Supplies[1]

Durable Medical Equipment (wheelchairs, oxygen, etc.)

In-network: 20% coinsurance
Out-of-network: 40% coinsurance

Medical supplies and prosthetic devices (braces, artificial limbs, etc.)

In-network: 20% coinsurance
Out-of-network: 40% coinsurance

Diabetic supplies and services

In-network: $0.00 copay
Out-of-network: 40% coinsurance

Empire MediBlue Access (PPO)

Wellness Programs

Healthways SilverSneakers®* Fitness program: You pay nothing

When you become our member, you can sign up for SilverSneakers. Additional details can be found at **www.silversneakers.com**. Or you can call SilverSneakers Customer Service at **1-855-741- 4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

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Medicare Part B Drugs[1]

In-network: 20% coinsurance
Out-of-network: 40% coinsurance

The four stages of drug coverage

What you pay for your covered drugs depends, in part, on which coverage stage you are in.




Stage 1	Stage 2	Stage 3	Stage 4
Deductible	**Initial Coverage**	**Coverage Gap**	**Catastrophic Coverage**
If you have a deductible, you will pay **100%** of your drug cost until your deductible is met. (If you have no deductible, or if a specific drug tier does not apply to the deductible, you will skip to Stage 2.)	You will pay a copay or coinsurance, and your plan pays the rest for your covered drugs	In this stage, you pay a greater share of the costs. It begins after you and your plan have paid a certain amount, which can vary by plan, on covered drugs during Stages 1 and 2. See Stage 2: Initial Coverage below for the exact amount. After you enter the coverage gap, you pay **40%** of the plan's cost for covered brand-name drugs and **51%** of the plan's cost for covered generic drugs until your costs total **$4,950**. Some plans have additional coverage. See the Coverage Gap section on later pages for details.	In this stage, after your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of: • **5%** of the cost, or • **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs.

Which coverage stage am I in?

You will get an *Explanation of Benefits* (EOB) each month you fill a prescription. It will show which coverage stage you're in and how close you are to entering the next one.

Outpatient Prescription Drug Benefits

How much do I pay for Part D drugs?

Empire MediBlue Access (PPO)

Stage 1: Deductible

$260.00 deductible per year for Part D prescription drugs

Drugs listed on **Tier 1: Preferred Generic and Tier 6: Select Care Drugs** are excluded from the Part D deductible

Stage 2: Initial Coverage

After you pay your yearly deductible (if your plan has one), you pay the following until your total yearly drug costs reach **$3,700**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail-order pharmacies.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Stage 2: Initial Coverage - Preferred Retail Cost Sharing

Tier 1: Preferred Generic

One-month supply:
$3.00 copay
Three-month supply:
$9.00 copay

These drugs are excluded from the deductible.

Stage 2: Initial Coverage - Preferred Retail Cost Sharing - continued

Tier 2: Generic

One-month supply:
$10.00 copay
Three-month supply:
$30.00 copay

Tier 3: Preferred Brand

One-month supply:
$38.00 copay
Three-month supply:
$114.00 copay

Tier 4: Nonpreferred Drugs

One-month supply:
$88.00 copay
Three-month supply:
$264.00 copay

Tier 5: Specialty Tier

One-month supply:
27% of the cost
Three-month supply:
N/A

Tier 6: Select Care Drugs

One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

These drugs are excluded from the deductible.

Empire MediBlue Access (PPO)

Stage 2: Initial Coverage - Standard Retail Cost Sharing

Tier 1: Preferred Generic

One-month supply:
$8.00 copay
Three-month supply:
$24.00 copay

These drugs are excluded from the deductible.

Tier 2: Generic

One-month supply:
$15.00 copay
Three-month supply:
$45.00 copay

Tier 3: Preferred Brand

One-month supply:
$43.00 copay
Three-month supply:
$129.00 copay

Tier 4: Nonpreferred Drugs

One-month supply:
$93.00 copay
Three-month supply:
$279.00 copay

Tier 5: Specialty Tier

One-month supply:
27% of the cost
Three-month supply:
N/A

Stage 2: Initial Coverage - Standard Retail Cost Sharing - continued

Tier 6: Select Care Drugs

One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

These drugs are excluded from the deductible.

Stage 2: Initial Coverage - Standard Mail Order Cost Sharing

Tier 1: Preferred Generic

One-month supply:
$3.00 copay
Three-month supply:
$9.00

These drugs are excluded from the deductible.

Tier 2: Generic

One-month supply:
$10.00 copay
Three-month supply:
$30.00 copay

Tier 3: Preferred Brand

One-month supply:
$38.00 copay
Three-month supply:
$114.00 copay

Stage 2: Initial Coverage - Standard Mail Order Cost Sharing - continued

Tier 4: Nonpreferred Drugs

One-month supply:
$88.00 copay
Three-month supply:
$264.00 copay

Tier 5: Specialty Tier

One-month supply:
27% of the cost
Three-month supply:
N/A

Tier 6: Select Care Drugs

One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

These drugs are excluded from the deductible.

Stage 3: Coverage Gap

After you enter the coverage gap, you pay **40%** of the plan's cost for covered brand name drugs and **51%** of the plan's cost for covered generic drugs until your costs total **$4,950**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

You may pay even less for the generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. For additional gap coverage, see the chart that follows to find out how much your drugs will cost you.

Stage 3: Coverage Gap - Preferred Retail Cost Sharing

Tier 6: Select Care Drugs

Drugs Covered:
All
One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

Stage 3: Coverage Gap - Standard Retail Cost Sharing

Tier 6: Select Care Drugs

Drugs Covered:
All
One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

Stage 3: Coverage Gap - Standard Mail Order Cost-Sharing

Tier 6: Select Care Drugs

Drugs Covered:
All
One-month supply:
$0.00 copay
Three-month supply:
$0.00 copay

Stage 4: Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of:

- **5%** of the cost, or
- **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs.

Additional Benefits

Empire MediBlue Access (PPO)
Chiropractic Care[1,2]
In-Network: $20.00 copay **Out-of-network: $75.00 copay**

Medicare coverage includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).

Home Health Care[1,2]
In-Network: $0.00 copay **Out-of-network: 40% coinsurance**

Outpatient Substance Abuse[1,2]
Individual & Group therapy visit:
In-Network: $40.00 copay **Out-of-network: 40% coinsurance**

Outpatient Surgery[1,2]
Ambulatory surgical center:
In-Network: 15% coinsurance **Out-of-network: 40% coinsurance**
Outpatient hospital:
In-Network: 20% coinsurance **Out-of-network: 40% coinsurance**

Empire MediBlue Access (PPO)
Renal Dialysis
In-Network: 20% coinsurance **Out-of-network: 20% coinsurance**

More ways we support your health

Empire BlueCross BlueShield: We're here to help.

Empire BlueCross BlueShield is more than a company that provides medical coverage. We're a group of people committed to your health. Now, when times are tougher for many of us, Empire BlueCross BlueShield is committed to helping everyone get the tools and solutions they need to lead healthier lives.

Looking for Medicare coverage that goes beyond original Medicare?

Empire BlueCross BlueShield works with the federal government to bring you even more benefits than you get with Original Medicare. Lower copays, extra benefits, pharmacy and medical coverage, advice from nurses and many other important health benefits are yours from one company.

Our plan gives you extra benefits not included in Original Medicare, such as:

Empire MediBlue Access (PPO)
LiveHealth Online: LiveHealth Online provides members with access to a doctor via live, two-way video on a computer, smartphone or tablet.
24/7 Nurse HelpLine: 24-hour access to a nurse helpline, 7 days a week, 365 days a year.
Healthways SilverSneakers®* Fitness program: You pay nothing

When you become our member, you can sign up for SilverSneakers. Additional details can be found at **www.silversneakers.com**. Or you can call SilverSneakers Customer Service at **1-855-741-4985** (TTY: **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

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Optional Supplemental Benefits – Package 1
Preventive Dental Package

Empire MediBlue Access (PPO)

How much is the monthly premium?

Additional **$18.00** per month. You must keep paying your Medicare Part B premium and your **$70.00** monthly plan premium.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

In-network and Out-of-network:
The plan will pay up to **$500** for the following preventive dental benefits each year (benefit maximum).

Talk to your provider and confirm all coverage, costs and codes prior to services being rendered.

Empire MediBlue Access (PPO)

Benefits included:

In-network:

You pay no copay for:

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year
- Two fluoride treatments

Out-of-network:

You pay 20% of the providers charges for:

- Two exams
- Two cleanings
- Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year
- Two fluoride treatments

As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 1 – Preventive Dental Package. Please reference the Evidence of Coverage for additional details about this package.

Optional Supplemental Benefits – Package 2
Dental and Vision Package

Empire MediBlue Access (PPO)

How much is the monthly premium?

Additional **$28.00** per month. You must keep paying your Medicare Part B premium and your **$70.00** monthly plan premium.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

In-network and Out-of-network:
DENTAL:
The plan will pay up to **$1,000** for dental benefits each year (benefit maximum).

Talk to your provider and confirm all coverage, costs and codes prior to services being rendered.

Empire MediBlue Access (PPO)

Benefits included:

DENTAL:
In-network:

You pay no copay for:

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year
- Two fluoride treatments.

You pay 20% as your portion of the covered charges for certain restorative dental services (fillings).

You pay 50% as your portion of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions

Out-of-network:

You pay 30% of the providers charges for:

- Two exams
- Two cleanings
- Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year.
- Two fluoride treatments.

You pay 60% of the provider's charges for certain restorative dental services (fillings).

Empire MediBlue Access (PPO)

Benefits included: - continued

You pay 75% as your portion of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions

Exclusions & Limitations for this benefit package:

Dentures and crowns are excluded.

VISION:
You can select the option of:

- Paying **$10 copay** for 1 pair of standard plastic (single, bifocal or trifocal) lenses and receiving a retail allowance of **$100** for 1 eyeglass frame every calendar year.

OR

- Alternatively, if you want contact lenses instead of eyeglass lenses and frames, the plan will cover up to **$150** for contact lenses every calendar year.

Exclusions & Limitations for this benefit package:

Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.

As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 2 – Dental and Vision Package. Please reference the Evidence of Coverage for additional details about this package.

Optional Supplemental Benefits – Package 3
Enhanced Dental and Vision Package

Empire MediBlue Access (PPO)

How much is the monthly premium?

Additional **$38.00** per month. You must keep paying your Medicare Part B premium and your **$70.00** monthly plan premium.

How much is the deductible?

This package does not have a deductible.

Is there a limit on how much the plan will pay?

In-network and Out-of-network:
DENTAL:
The plan will pay up to **$1,500** for dental benefits each year (benefit maximum).

Talk to your provider and confirm all coverage, costs and codes prior to services being rendered.

Empire MediBlue Access (PPO)

Benefits included:

DENTAL:
In-network:

You pay no copay for:

- Two exams
- Two cleanings
- Dental X-rays: include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year
- Two fluoride treatments.

You pay 20% as your portion of the covered charges for certain restorative dental services (fillings).

You pay 50% as your portion of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions
- Crowns (once per tooth every five years)
- Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- Denture adjustment, repair, replacement, rebasing and relining
- Local anesthesia (a drug to numb a part of the body) or regional block anesthesia

Out-of-network:

You pay 30% of the providers charges for:

Benefits included: - continued

- Two exams
- Two cleanings
- Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/ series of bitewing X-rays each year **and** up to seven Periapical images per calendar year.
- Two fluoride treatments.

You pay 60% of the provider's charges for certain restorative dental services (fillings).

You pay 75% as your portion of the covered charges for certain endodontic, periodontic, and oral surgery dental services which include, but are not limited to, the following:

- Root canal treatment
- Periodontal scaling and root planing
- Simple and surgical extractions
- Crowns (once per tooth every five years)
- Complete denture, immediate denture, or partial denture (one set of dentures every five years)
- Denture adjustment, repair, replacement, rebasing and relining
- Local anesthesia (a drug to numb a part of the body) or regional block anesthesia

VISION:
You can select the option of:

- Paying **$10 copay** for 1 pair of standard plastic (single, bifocal or trifocal) lenses and receiving a retail allowance of **$150** for 1 eyeglass frame every calendar year.

OR

- Alternatively, if you want contact lenses instead of eyeglass lenses and frames, the plan will cover up to **$200** for contact lenses every calendar year.

Benefits included: - continued

Exclusions & Limitations for this benefit package:
Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.

As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 3 – Enhanced Dental and Vision Package. Please reference the Evidence of Coverage for additional details about this package.

This document is available in other formats such as Braille. This information is available for free in other languages. Please call our Customer Service number at **1-866-395-5175** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week, October 1 to February 14 (except holidays); 8 a.m. to 8 p.m., Monday – Friday, February 15 to September 30 (except holidays).

Este documento está disponible en otros formatos, como braille. Esta información está disponible en otros idiomas de manera gratuita. LLame al servicio de atención al cliente al **1-866-395-5175**(TTY: **711**), de 8 a. m. a 8 p. m., los 7 dias de la semana (excepto los dias feriados) desde el 1° de octubre hasta el 14 de febrero, y de 8 a. m. a 8 p. m., de lunes a viernes (except los dias feriados) del 15 de febrero hasta el 30 de septiembre.

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 co-payments/co-insurance 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.

Out-of-network/non-contracted providers are under no obligation to treat Empire BlueCross BlueShield members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Empire BlueCross BlueShield is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross BlueShield depends on contract renewal.

Services provided by Empire HealthChoice Assurance, Inc. licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-395-5175 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-395-5175 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-395-5175 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-395-5175 (رقم هاتف الصم والبكم: 711).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-866-395-5175 (TTY: 711)।

Chinese: 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 1-866-395-5175（TTY：711）。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-395-5175 (ATS : 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-395-5175 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-395-5175 (TTY: 711).

Haitian: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-395-5175 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-395-5175 (TTY: 711) पर कॉल करें।

Indonesian: PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-866-395-5175 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-395-5175 (TTY: 711).

Kirundi: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-395-5175 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-395-5175 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-866-395-5175 (टिटिवाइ: 711) ।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-395-5175 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-395-5175 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-395-5175 (телетайп: 711).

Serbian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-395-5175 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-395-5175 (TTY: 711).

Urdu:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .1-866-395-5175 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-395-5175 (TTY: 711).

Yiddish:

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 711) 1-866-395-5175 .

Empire BlueCross BlueShield - H3342

2016 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.

2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2016, Empire BlueCross BlueShield received the following Overall Star Rating from Medicare.

3 Stars

We received the following Summary Star Rating for Empire BlueCross BlueShield's health/drug plan services:

Health Plan Services:	★★★ 3 Stars
Drug Plan Services:	★★★★ 4 Stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

This information is available for free in other languages. Please call our Customer Service number at 800-797-6308 (TTY: 711), 8 a.m. to 8 p.m., seven days a week, October 1 to February 14 (except holidays); 8 a.m. to 8 p.m., Monday – Friday, February 15 to September 30 (except holidays).

Esta información está disponible sin cargo en otros idiomas. Por favor llame a nuestro número de Servicio al Cliente al 800-797-6308 (TTY: 711), de 8 a. m. a 8 p. m., los 7 días de la semana (excepto los días feriados) desde el 1° de octubre hasta el 14 de febrero, y de 8 a. m. a 8 p. m., de lunes a viernes (excepto los días feriados) del 15 de febrero hasta el 30 de septiembre.

本資訊另免費提供其他語言版本。請致電 800-797-6308 聯絡我們的客戶服務部（聽語障用戶請致電：711），服務時間為 10 月 1 日至 2 月 14 日，週一至週日（節假日除外），上午 8 點到晚 8 點；2 月 15 日至 9 月 30 日，週一至週五（節假日除外），上午 8 點到晚 8 點 。

Current members please call 866-395-5175 (toll-free) or 711 (TTY).

Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

Empire BlueCross is an LPPO plan with a Medicare contract. Enrollment in Empire BlueCross depends on contract renewal.

It’s important we treat you fairly
That’s why we follow Federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.