



Summary of Benefits

MediBlueSM

Rockland and Westchester



www.empireblue.com

H3370 H3342

Introduction to the Summary of Benefits for:

MediBlue

MediBlue HMO Essential
MediBlue HMO Plus
MediBlue HMO Select
MediBlue PPO Essential
MediBlue PPO Plus
MediBlue Total Solutions

January 1, 2007 – December 31, 2007
Rockland and Westchester Counties



Thank you for your interest in MediBlue.

- **MediBlue HMO Essential, MediBlue HMO Plus and MediBlue HMO Select** are HMO plans offered by Empire HealthChoice HMO, Inc., a Medicare Advantage Health Maintenance Organization (HMO).
- **MediBlue Total Solutions** is offered by Empire HealthChoice HMO, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. Please call MediBlue Total Solutions to find out if you are eligible to join. Our number is listed at the end of this introduction.
- **MediBlue PPO Essential and MediBlue PPO Plus** are PPO plans offered by Empire HealthChoice Assurance, Inc., a Medicare Advantage Preferred Provider Organization (PPO).

This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover, every limitation or every exclusion. To get a complete list of our benefits, please contact us and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTHCARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan like our plans. You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may be able to join or leave a plan only at certain times. Please call us at the telephone number listed at the end of this introduction or call **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare our health plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plans cover and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE ARE MEDIBLUE HMO SELECT, MEDIBLUE HMO PLUS, MEDIBLUE HMO ESSENTIAL, MEDIBLUE PPO PLUS AND MEDIBLUE PPO ESSENTIAL AVAILABLE?

The service area for these plans includes Rockland and Westchester Counties, NY. You must live in one of these counties to join these plans. There is more than one plan listed in the Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call customer service for more information.

WHO IS ELIGIBLE TO JOIN MEDIBLUE?

You can join MediBlue if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are not eligible to enroll in MediBlue.

WHERE IS MEDIBLUE TOTAL SOLUTIONS AVAILABLE?

The service area for this plan includes: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester Counties, NY. You must live in one of these places to join this plan.

WHO IS ELIGIBLE TO JOIN MEDIBLUE TOTAL SOLUTIONS?

You can join this plan if you are entitled to Medicare Part A and enrolled in Medicare Part B, live in the service area, and meet specific enrollment criteria.

CAN I CHOOSE MY DOCTORS?

MediBlue has formed a network of doctors, specialists and hospitals.

- With **MediBlue HMO Essential, MediBlue HMO Plus, MediBlue HMO Select and MediBlue Total Solutions**, you can only use doctors who are part of our network.
- With **MediBlue PPO Essential and MediBlue PPO Plus**, you can use any doctor who is part of our network. You may also go to doctors outside of our network.

The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at **www.empireblue.com**. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO IS NOT IN YOUR NETWORK?

With **MediBlue HMO Essential, MediBlue HMO Plus, MediBlue HMO Select** and **MediBlue Total Solutions**: If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Empire BlueCross BlueShield HMO nor the Original Medicare Plan will pay for those services.

With **MediBlue PPO Essential** and **MediBlue PPO Plus**: You can go to doctors, specialists or hospitals in- or out-of-network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in- and/or out-of-network. For more information, call the telephone number at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

MediBlue HMO Essential and **MediBlue PPO Essential** cover Medicare Part B prescription drugs. They do NOT cover Medicare Part D prescription drugs.

MediBlue HMO Plus, MediBlue HMO Select, MediBlue PPO Plus, and **MediBlue Total Solutions** cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN MEDIBLUE HMO PLUS, MEDIBLUE HMO SELECT, MEDIBLUE PPO PLUS, OR MEDIBLUE TOTAL SOLUTIONS?

MediBlue has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.empireblue.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

MediBlue HMO Plus, MediBlue HMO Select, MediBlue PPO Plus and **MediBlue Total Solutions** use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to the coverage limitations on certain drugs or change how much you pay for a drug. If we make a formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you, and you can see our complete formulary on our Web site at www.empireblue.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join **MediBlue HMO Select, MediBlue HMO Plus, MediBlue PPO Plus** or **MediBlue Total Solutions**, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling **1-800-Medicare (1-800-633-4227)**, TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of **MediBlue HMO Plus, MediBlue PPO Plus** or **MediBlue Total Solutions** you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact MediBlue for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact us for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

For more information about our plans, or for questions related to the Medicare Advantage and Medicare Part D Prescription Drug programs, visit us at www.empireblue.com or call Member Services at the phone numbers listed below, seven days a week, 8:00 a.m. – 8:00 p.m. EST.

Current **MediBlue HMO Essential, MediBlue HMO Plus, MediBlue HMO Select** and **MediBlue Total Solutions** members should call **1-800-499-9554. (TTY/TDD 1-800-241-6894).**

Current **MediBlue PPO Essential**, and **MediBlue PPO Plus** members should call **1-866-395-5175. (TTY/TDD 1-800-241-6894).**

Prospective members should call **1-800-809-7328. (TTY/TDD 1-800-241-6894).**

For more information about Medicare call **1-800-MEDICARE (1-800-633-4227).**

TTY users should call **1-800-486-2048**. You can call 24 hours a day, 7 days a week. Or visit medicare.gov on the web.

If you have special needs, this document may be available in other formats.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
Important Information			
<p>1 - Premium and Other Important Information</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2007, some people will have to pay a higher premium because of their yearly income (over \$80,000 for singles, \$160,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0078.</p>	<p>You pay the Medicare Part B premium of \$93.50 each month. (This is the 2007 amount and may change January 1, 2008.)</p>	<p>You pay \$7 each month for your plan benefits and an additional \$19 premium for your Medicare Part D prescription benefits.</p> <p>You also continue to pay the Medicare Part B premium of \$93.50 each month for your plan benefits and your Medicare Part D prescription drug benefits. (This is the 2007 amount and may change January 1, 2008.)</p>	<p>There is no additional premium beyond the Medicare Part B premium of \$93.50 each month for your plan benefits and your Medicare Part D prescription drug benefits. (This is the 2007 amount and may change January 1, 2008.)</p>

Important Information

There is no additional premium beyond the Medicare Part B premium of \$93.50 each month for your plan benefits. (This is the 2007 amount and may change January 1, 2008.)

You pay \$54.10 each month for your plan benefits and an additional \$21.90 premium for your Medicare Part D prescription benefits.

You also continue to pay the Medicare Part B premium of \$93.50 each month. (This is the 2007 amount and may change January 1, 2008.)

You pay a \$150 yearly deductible for the following plan services when received out-of-network only:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor Office Visits
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Ambulance Services
- Urgently Needed Care
- Outpatient Rehabilitation Services
- Durable Medical Equipment
- Prosthetic Devices
- Diabetes Self-Monitoring Training and Supplies
- Diagnostic Tests, X-Rays, and Lab Services
- Bone Mass Measurement
- Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Dental Services
- Physical Exams
- Transportation
- Health/Wellness Education

You pay \$50 each month for your plan benefits.

You also continue to pay the Medicare Part B premium of \$93.50 each month. (This is the 2007 amount and may change January 1, 2008.)

You pay a \$150 yearly deductible for the following plan services when received out-of-network only:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor Office Visits
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Ambulance Services
- Urgently Needed Care
- Outpatient Rehabilitation Services
- Durable Medical Equipment
- Prosthetic Devices
- Diabetes Self-Monitoring Training and Supplies
- Diagnostic Tests, X-Rays, and Lab Services
- Bone Mass Measurement
- Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Dental Services
- Physical Exams
- Transportation
- Health/Wellness Education
- Comprehensive Outpatient Rehabilitation Facility (CORF)

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
1 - Premium and Other Important Information (cont.)			
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16)	You may go to any doctor, specialist or hospital that accepts Medicare.	You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals. A separate doctor office visit co-payment may apply for certain services.	You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals. A separate doctor office visit co-payment may apply for certain services.
Inpatient Care			
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period (3): Days 1 – 60: an initial deductible of \$992 Days 61 – 90: \$248 each day Days 91 – 150: \$496 each lifetime reserve day (4) (These are 2007 amounts and may change January 1, 2008.)	You pay: – \$125 each day for day(s) 1 – 10 – \$0 each day for day(s) 11 – 90 for a Medicare-covered stay at a network hospital You are covered for 60 lifetime reserve days. You pay: – \$125 each day for lifetime reserve day(s) 1 – 10 – \$0 each day for lifetime reserve day(s) 11 – 60 There is no co-payment for additional days received at a network hospital.	You pay: – \$400 each day for day(s) 1 – \$125 each day for day(s) 2 – 10 – \$0 each day for day(s) 11 – 90 for a Medicare-covered stay at a network hospital. You are covered for 60 lifetime reserve days. You pay: – \$400 each day for lifetime reserve day(s) 1 – \$125 each day for lifetime reserve day(s) 2 – 10 – \$0 each day for lifetime reserve day(s) 11 – 60 There is no co-payment for additional days received at a network hospital.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
	<p>continued from pg. 7</p> <ul style="list-style-type: none"> - Comprehensive Outpatient Rehabilitation Facility (CORF) - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood <p>If there is no note on an out-of-network service, then the note describes the in-network service. Contact plan for details.</p>	<p>continued from pg. 7</p> <ul style="list-style-type: none"> - Partial Hospitalization - Other Health Care Professional - Cardiac Rehabilitation Services - Renal Dialysis - Blood <p>If there is no note on an out-of-network service, then the note describes the in-network service. Contact plan for details.</p>
<p>You must go to network doctors, specialists, and hospitals.</p> <p>You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit co-payment may apply for certain services.</p>	<p>You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out-of-network services.</p> <p>You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit co-payment may apply for certain services.</p>	<p>You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out-of-network services.</p> <p>You do NOT need a referral to go to network doctors, specialists, and hospitals.</p> <p>A separate doctor office visit co-payment may apply for certain services.</p>
<p>Inpatient Care</p>		
<p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for day(s) 1 - 10 - \$0 each day for day(s) 11 - 90 For a Medicare-covered stay at a network hospital. <p>You are covered for 60 lifetime reserve days.</p> <p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for lifetime reserve day(s) 1 - 10 - \$0 each day for lifetime reserve day(s) 11 - 60 <p>There is no co-payment for additional days received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for day(s) 1 - 10 - \$0 each day for day(s) 11 - 90 for a Medicare-covered stay at a network hospital <p>You are covered for 60 lifetime reserve days.</p> <p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for day(s) 1 - 10 - \$0 each day for day(s) 11 - 60 <p>You pay 20% of the cost for each stay at an out-of-network hospital.</p> <p>There is no co-payment for additional days received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for day(s) 1 - 10 - \$0 each day for day(s) 11 - 90 for a Medicare-covered stay at a network hospital <p>You are covered for 60 lifetime reserve days.</p> <p>You pay:</p> <ul style="list-style-type: none"> - \$125 each day for day(s) 1 - 10 - \$0 each day for day(s) 11 - 60 <p>You pay 20% of the cost for each stay at an out-of-network hospital.</p> <p>There is no co-payment for additional days received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services) (cont.)	continued from page 8 Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	continued from page 8 You are covered for unlimited days each benefit period. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.	continued from page 8 You are covered for unlimited days each benefit period. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.
4 - Inpatient Mental Health Care	You pay the same deductible and co-payments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	There is no co-payment for services received at a network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.	There is no co-payment for services received at a network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.
5 - Skilled Nursing Facility (In a Medicare-certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 – 20: \$0 for each day Days 21 – 100: \$124 for each day (These are 2007 amounts and may change January 1, 2008.) There is a limit of 100 days for each benefit period. (3)	You pay: – \$50 each day for day(s) 1 – 100 for a stay at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.	You pay: – \$55 each day for day(s) 1 – 100 for a stay at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
(4) Lifetime reserve days can only be used once.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>continued from page 9 Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>	<p>continued from page 9 Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>	<p>continued from page 9 Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>
<p>There is no co-payment for services received at a network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>	<p>There is no co-payment for services received at a network hospital. You pay 50% of the cost for each stay at an out-of-network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>	<p>There is no co-payment for services received at a network hospital. You pay 50% of the cost for each stay at an out-of-network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>
<p>You pay: – \$50 each day for day(s) 1 – 100 for a stay at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay: – \$50 each day for day(s) 1 – 100 for a stay at a Skilled Nursing Facility. You pay 50% of the cost for services at an out-of-network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay: – \$50 each day for day(s) 1 – 100 for a stay at a Skilled Nursing Facility. You pay 50% of the cost for services at an out-of-network Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
6 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no co-payment for all covered home health visits.	There is no co-payment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.	There is no co-payment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
Outpatient Care			
8 - Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$25 for each specialist visit for Medicare-covered services. See #32 – Physical – Exams for more information.	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$30 for each specialist visit for Medicare-covered services. See #32 – Physical Exams – for more information.
9 - Chiropractic Services	You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care. You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). Authorization rules may apply for services. Contact plan for details.	You pay \$30 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). Authorization rules may apply for services. Contact plan for details.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>There is no co-payment for Medicare-covered home health visits.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>There is no co-payment for Medicare-covered home health visits.</p> <p>You pay 20% for out-of-network home health visits.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>There is no co-payment for Medicare-covered home health visits.</p> <p>You pay 20% for out-of-network home health visits.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>	<p>You must receive care from a Medicare-certified hospice.</p>
<p>Outpatient Care</p>		
<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p> <p>See #32 – Physical Exams – for more information</p>	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay 20% for each out-of-network primary care doctor office visit.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p> <p>You pay 20% for each out-of-network specialist visit.</p> <p>See #32 – Physical – Exams for more information.</p>	<p>You pay \$15 for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay 20% for each out-of-network primary care doctor office visit.</p> <p>You pay \$25 for each specialist visit for Medicare-covered services.</p> <p>You pay 20% for each out-of-network specialist visit.</p> <p>See #32 – Physical Exams – for more information.</p>
<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p> <p>You pay 50% of the cost for out-of-network chiropractic services.</p>	<p>You pay \$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services. Contact plan for details.</p> <p>You pay 50% of the cost for out-of-network chiropractic services.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
10 - Podiatry Services	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$25 for each Medicare-covered visit (medically necessary foot care) - \$25 for each routine visit up to 1 visit(s) every three months 	<p>You pay:</p> <ul style="list-style-type: none"> - \$30 for each Medicare-covered visit (medically necessary foot care) - \$30 for each routine visit up to 1 visit(s) every three months
11 - Outpatient Mental Health Care	<p>You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
12 - Outpatient Substance Abuse Care	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit.</p> <p>Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit.</p> <p>Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>
13 - Outpatient Services/Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>You pay \$300 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$0 to \$300 for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$300 for each Medicare-covered visit to an ambulatory surgical center.</p> <p>You pay \$0 to \$300 for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>You pay:</p> <ul style="list-style-type: none"> – \$25 for each Medicare-Covered visit (medically necessary foot care). – \$25 for each routine visit up to 1 visit(s) every three months. 	<p>You pay:</p> <ul style="list-style-type: none"> – \$25 for each Medicare-covered visit (medically necessary foot care). – \$25 for each routine visit up to 1 visit(s) every three months You pay 20% of the cost for out-of-network podiatry services. 	<p>You pay:</p> <ul style="list-style-type: none"> – \$25 for each Medicare-covered visit (medically necessary foot care). – \$25 for each routine visit up to 1 visit(s) every three months You pay 20% of the cost for out-of-network podiatry services.
<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit. Authorization rules may apply for services. Contact plan for details.</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit. You pay 50% of the cost for out-of-network Mental Health services. You pay 50% of the cost for out-of-network Mental Health services with a psychiatrist. Authorization rules may apply for services. Contact plan for details.</p>	<p>For Medicare-covered Mental Health services, you pay \$25 for each individual/group therapy visit. You pay 50% of the cost for out-of-network Mental Health services. You pay 50% of the cost for out-of-network Mental Health services with a psychiatrist. Authorization rules may apply for services. Contact plan for details.</p>
<p>For Medicare-covered services, you pay \$25 for each individual/group visit. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit. You pay 50% of the cost for out-of-network outpatient substance abuse services. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>	<p>For Medicare-covered services, you pay \$25 for each individual/group visit. You pay 50% of the cost for out-of-network outpatient substance abuse services. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield.</p>
<p>You pay \$300 for each Medicare-covered visit to an ambulatory surgical center. You pay \$0 to \$300 for each Medicare-covered visit to an outpatient hospital facility. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$300 for each Medicare-covered visit to an ambulatory surgical center. You pay \$0 to \$300 for each Medicare-covered visit to an outpatient hospital facility. You pay 20% of the cost for services at an out-of-network ambulatory surgical center. You pay 20% of the cost for services at an out-of-network outpatient hospital facility. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$300 for each Medicare-covered visit to an ambulatory surgical center. You pay \$0 to \$300 for each Medicare-covered visit to an outpatient hospital facility. You pay 20% of the cost for services at an out-of-network ambulatory surgical center. You pay 20% of the cost for services at an out-of-network outpatient hospital facility. Authorization rules may apply for services. Contact plan for details.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
14 - Ambulance Services (Medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	You pay \$50 for Medicare-covered ambulance services. Authorization rules may apply for services. Contact plan for details.	You pay \$50 for Medicare-covered ambulance services. Authorization rules may apply for services. Contact plan for details.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care)	You pay 20% of the facility charge or applicable co-payment for each emergency room visit; you DO NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition. Worldwide coverage.	You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition. Worldwide coverage.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area)	You pay 20% of Medicare-approved amounts or applicable co-payment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay \$25 for each Medicare-covered urgently needed care visit. Worldwide coverage.	You pay \$30 for each Medicare-covered urgently needed care visit. Worldwide coverage.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay \$25 for each Medicare-covered Occupational Therapy visit. You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.	You pay \$30 for each Medicare-covered Occupational Therapy visit. You pay \$30 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>You pay \$50 for Medicare-covered ambulance services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$50 for Medicare-covered ambulance services.</p> <p>You pay 20% of the cost for out-of-network ambulance services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$50 for Medicare-covered ambulance services.</p> <p>You pay 20% of the cost for out-of-network ambulance services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p> <p>Worldwide coverage.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p> <p>Worldwide coverage.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.</p> <p>Worldwide coverage.</p>
<p>You pay \$25 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>	<p>You pay \$25 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>	<p>You pay \$25 for each Medicare-covered urgently needed care visit.</p> <p>Worldwide coverage.</p>
<p>You pay \$25 for each Medicare-covered Occupational Therapy visit.</p> <p>You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay \$25 for each Medicare-covered Occupational Therapy visit.</p> <p>You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</p> <p>You pay 50% of the cost for out-of-network Occupational Therapy services.</p>	<p>You pay \$25 for each Medicare-covered Occupational Therapy visit.</p> <p>You pay \$25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</p> <p>You pay 50% of the cost for out-of-network Occupational Therapy services.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
17 - Outpatient Rehabilitation Services (cont.) (Occupational Therapy, Physical Therapy, Speech and Language Therapy)		continued from page 16 Authorization rules may apply for services. Contact plan for details.	continued from page 16 Authorization rules may apply for services. Contact plan for details.
Outpatient Medical Services and Supplies			
18 - Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.
19 - Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.
20 - Diabetes Self-Monitoring Training and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Diabetes self-monitoring training. There is no co-payment for Diabetes supplies.	There is no co-payment for Diabetes self-monitoring training. There is no co-payment for Diabetes supplies.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
	<p>continued from page 17</p> <p>You pay 50% of the cost for out-of-network Physical Therapy and/or Speech/Language Therapy services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>continued from page 17</p> <p>You pay 50% of the cost for out-of-network Physical Therapy and/or Speech Language Therapy services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>Outpatient Medical Services and Supplies</p>		
<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>You pay 50% of the cost for durable medical equipment purchased out-of-network.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>You pay 50% of the cost for durable medical equipment purchased out-of-network.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>You pay 50% of the cost for prosthetic devices purchased out-of-network.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay 20% of the cost for each Medicare-covered item.</p> <p>You pay 50% of the cost for prosthetic devices purchased out-of-network.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>There is no co-payment for Diabetes self-monitoring training.</p> <p>There is no co-payment for Diabetes supplies.</p>	<p>There is no co-payment for Diabetes self-monitoring training.</p> <p>You pay 20% of the cost for out-of-network Diabetes self-monitoring training.</p> <p>There is no co-payment for Diabetes supplies.</p> <p>You pay 50% of the cost for each Diabetes supply item purchased out-of-network.</p>	<p>There is no co-payment for Diabetes self-monitoring training.</p> <p>You pay 20% of the cost for out-of-network Diabetes self-monitoring training.</p> <p>There is no co-payment for Diabetes supplies.</p> <p>You pay 50% of the cost for each Diabetes supply item purchased out-of-network.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
21 - Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no co-payment for Medicare-approved lab services.	You pay: – \$0 to \$300 for each Medicare-covered clinical/diagnostic lab service – \$0 to \$300 for each Medicare-covered radiation therapy service – \$0 to \$35 for each Medicare-covered X-ray visit Authorization rules may apply for services. Contact plan for details.	You pay: – \$0 to \$300 [or 0% to 20% of the cost] for each Medicare-covered clinical/diagnostic lab service – \$0 to \$300 [or 0% to 20% of the cost] for each Medicare-covered radiation therapy service – 0% to 20% of the cost for each Medicare-covered X-ray visit Authorization rules may apply for services. Contact plan for details.
Preventive Services			
22 - Bone Mass Measurement (For people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for each Medicare-covered Bone Mass Measurement.	There is no co-payment for each Medicare-covered Bone Mass Measurement.
23 - Colorectal Screening Exams (For people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Medicare-covered Colorectal Screening Exams.	There is no co-payment for Medicare-covered Colorectal Screening Exams.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)	There is no co-payment for the Pneumonia and Flu vaccines. No referral is necessary for Medicare-covered influenza and pneumonia vaccines. There is no co-payment for the Hepatitis B vaccine.	There is no co-payment for the Pneumonia and Flu vaccines. No referral is necessary for Medicare-covered influenza and pneumonia vaccines. There is no co-payment for the Hepatitis B vaccine.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>You pay:</p> <ul style="list-style-type: none"> – \$0 to \$300 for each Medicare-covered clinical/diagnostic lab service – \$0 to \$300 for each Medicare-covered radiation therapy service – \$0 to \$35 for each Medicare-covered X-ray visit <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> – \$0 to \$300 for each Medicare-covered clinical/diagnostic lab service – \$0 to \$300 for each Medicare-covered radiation therapy service – \$0 to \$35 for each Medicare-covered X-ray visit <p>Authorization rules may apply for services. Contact plan for details.</p> <ul style="list-style-type: none"> – 20% of the cost for each out-of-network clinical/diagnostic lab service – 20% of the cost for each out-of-network radiation therapy service – 20% of the cost for out-of-network X-ray services <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> – \$0 to \$300 for each Medicare-covered clinical/diagnostic lab service – \$0 to \$300 for each Medicare-covered radiation therapy service – \$0 to \$35 for each Medicare-covered X-ray visit <p>Authorization rules may apply for services. Contact plan for details.</p> <ul style="list-style-type: none"> – 20% of the cost for each out-of-network clinical/diagnostic lab service – 20% of the cost for each out-of-network radiation therapy service – 20% of the cost for out-of-network X-ray services <p>Authorization rules may apply for services. Contact plan for details.</p>
Preventive Services		
<p>There is no co-payment for each Medicare-covered Bone Mass Measurement.</p>	<p>There is no co-payment for each Medicare-covered Bone Mass Measurement.</p> <p>You pay 20% of the cost for each out-of-network Bone Mass Measurement.</p>	<p>There is no co-payment for each Medicare-covered Bone Mass Measurement.</p> <p>You pay 20% of the cost for each out-of-network Bone Mass Measurement.</p>
<p>There is no co-payment for Medicare-covered Colorectal Screening Exams.</p>	<p>There is no co-payment for Medicare-covered Colorectal Screening Exams.</p> <p>You pay 20% of the cost for each out-of-network Colorectal Screening exam.</p>	<p>There is no co-payment for Medicare-covered Colorectal Screening Exams.</p> <p>You pay 20% of the cost for each out-of-network Colorectal Screening exam.</p>
<p>There is no co-payment for the Pneumonia and Flu vaccines.</p> <p>No referral is necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no co-payment for the Hepatitis B vaccine.</p>	<p>There is no co-payment for the Pneumonia and Flu vaccines.</p> <p>No referral is necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no co-payment for the Hepatitis B vaccine.</p> <p>You pay 20% of the cost for each out-of-network Immunization.</p>	<p>There is no co-payment for the Pneumonia and Flu vaccines.</p> <p>No referral is necessary for Medicare-covered influenza and pneumonia vaccines.</p> <p>There is no co-payment for the Hepatitis B vaccine.</p> <p>You pay 20% of the cost for each out-of-network immunization.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
24 - Immunizations (cont.) (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.		
25 - Mammograms (Annual Screening) (For women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2) No referral is necessary for Medicare-covered screenings.	There is no co-payment for Medicare-covered Screening Mammograms. No referral is necessary for Medicare-covered screenings.	There is no co-payment for Medicare-covered Screening Mammograms. No referral is necessary for Medicare-covered screenings.
26 - Pap Smears and Pelvic Exams (For women with Medicare)	There is no co-payment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	There is no co-payment for: – Medicare-covered Pap Smears and Pelvic Exams – Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year	There is no co-payment for: – Medicare-covered Pap Smear and Pelvic Exams. – Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year
27 - Prostate Cancer Screening Exams (For men with Medicare age 50 and older)	There is no co-payment for approved lab services and a co-payment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no co-payment for Medicare-covered Prostate Cancer Screening Exams.	There is no co-payment for Medicare-covered Prostate Cancer Screening Exams.
28 - Prescription Drugs Drugs covered under Medicare Part B (Original Medicare)		You pay \$0 for Part B-covered drugs.	You pay \$0 for Part B-covered drugs.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>There is no co-payment for Medicare-covered Screening Mammograms.</p> <p>No referral is necessary for Medicare-covered screenings.</p>	<p>There is no co-payment for Medicare-covered Screening Mammograms.</p> <p>You pay 20% of the cost for each out-of-network Screening Mammogram.</p> <p>No referral is necessary for Medicare-covered screenings.</p>	<p>There is no co-payment for Medicare-covered Screening Mammograms.</p> <p>You pay 20% of the cost for each out-of-network Screening Mammogram.</p> <p>No referral is necessary for Medicare-covered screenings.</p>
<p>There is no co-payment for:</p> <ul style="list-style-type: none"> - Medicare-covered Pap Smear and Pelvic Exams. - Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year 	<p>There is no co-payment for:</p> <ul style="list-style-type: none"> - Medicare-covered Pap Smears and Pelvic Exams - Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year <p>You pay 20% of the cost for each out-of-network Pap Smear and Pelvic Exam.</p>	<p>There is no co-payment for:</p> <ul style="list-style-type: none"> - Medicare-covered Pap Smears and Pelvic Exams - Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year <p>You pay 20% of the cost for each out-of-network Pap Smear and Pelvic Exam.</p>
<p>There is no co-payment for Medicare-covered Prostate Cancer Screening Exams.</p>	<p>There is no co-payment for Medicare-covered Prostate Cancer Screening Exams.</p> <p>You pay 20% of the cost for each out-of-network Prostate Screening Exam.</p>	<p>There is no co-payment for Medicare-covered Prostate Cancer Screening Exams.</p> <p>You pay 20% of the cost for each out-of-network Prostate Screening Exam.</p>
<p>You pay 100% for most prescription drugs.</p> <p>You pay \$0 for Part B-covered drugs.</p>	<p>You pay \$0 for Part B-covered drugs.</p>	<p>You pay 100% for most prescription drugs.</p> <p>You pay \$0 for Part B-covered drugs.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
<p data-bbox="65 118 436 186">Drugs covered under Medicare Part D (Prescription Drug Benefit)</p> <p data-bbox="65 732 436 760">Deductible</p> <p data-bbox="65 781 436 808">Initial Coverage</p> <p data-bbox="65 889 436 917">In-Network Retail Pharmacy</p>	<p data-bbox="447 118 816 146">continued from page 22</p> <p data-bbox="447 164 816 293">You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p data-bbox="837 118 1417 146">continued from page 22</p> <p data-bbox="837 164 1417 537">This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at empireblue.com.</p> <p data-bbox="837 553 1417 716">People who have limited incomes, who live in long-term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.</p> <p data-bbox="837 732 1417 760">There is no deductible.</p> <p data-bbox="837 781 1417 878">Before the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay the following for prescription drugs:</p> <ul data-bbox="837 894 1417 1268" style="list-style-type: none"> - \$10 for a one-month (30 day) supply of Formulary Generic drugs. - \$30 for a one-month (30 day) supply of Formulary Preferred Brand drugs. - \$75 for a one-month (30 day) supply of Formulary Brand drugs. - 25% coinsurance for a one-month (30 day) supply of Specialty Formulary Brand drugs. - \$30 for a three-month (90 day) supply of Formulary Generic drugs. 	<p data-bbox="1440 118 2020 146">continued from page 22</p> <p data-bbox="1440 164 2020 537">This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at empireblue.com.</p> <p data-bbox="1440 553 2020 716">People who have limited incomes, who live in long-term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.</p> <p data-bbox="1440 732 2020 760">There is no deductible.</p> <p data-bbox="1440 781 2020 878">Before the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay the following for prescription drugs:</p> <ul data-bbox="1440 894 2020 1268" style="list-style-type: none"> - \$10 for a one-month (30 day) supply of Formulary Generic drugs - \$37 for a one-month (30 day) supply of Formulary Preferred Brand drugs - \$80 for a one-month (30 day) supply of Formulary Brand drugs - 25% coinsurance for a one-month (30 day) supply of Specialty Formulary Brand drugs - \$30 for a three-month (90 day) supply of Formulary Generic drugs

MEDIBLUE HMO ESSENTIAL**continued from page 23**

This plan does not cover Medicare Part D prescription drugs.

Please contact the plan for details.

MEDIBLUE PPO PLUS**continued from page 23**

This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at empireblue.com.

People who have limited incomes, who live in long-term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.

There is no deductible.

Before the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay the following for prescription drugs:

- \$10 for a one-month (30 day) supply of Formulary Generic drugs.
- \$30 for a one-month (30 day) supply of Formulary Preferred Brand drugs.
- \$75 for a one-month (30 day) supply of Formulary Brand drugs.
- 25% coinsurance for a one-month (30 day) supply of Specialty Formulary Brand drugs.
- \$30 for a three-month (90 day) supply of Formulary Generic drugs.
- \$90 for a three-month (90 day) supply of Formulary Preferred Brand drugs.

MEDIBLUE PPO ESSENTIAL**continued from page 23**

This plan does not cover Medicare Part D prescription drugs.

Please contact the plan for details.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
In-Network Retail Pharmacy (cont.)		<p>continued from page 24</p> <ul style="list-style-type: none"> - \$90 for a three-month (90 day) supply of Formulary Preferred Brand drugs. - \$225 for a three-month (90 day) supply of Formulary Brand drugs. - 25% coinsurance for a three-month (90 day) supply of Specialty Formulary Brand drugs. 	<p>continued from page 24</p> <ul style="list-style-type: none"> - \$111 for a three-month (90 day) supply of Formulary Preferred Brand drugs - \$240 for a three-month (90 day) supply of Formulary Brand drugs - 25% coinsurance for a three-month (90 day) supply of Specialty Formulary Brand drugs
Mail Order		<ul style="list-style-type: none"> - \$20 for a three-month (90 day) supply of mail-order Formulary Generic drugs. - \$60 for a three-month (90 day) supply of mail-order Formulary Preferred Brand drugs. - \$150 for a three-month (90 day) supply of mail-order Formulary Brand drugs. - 25% coinsurance for a three-month (90 day) supply of mail-order Specialty Formulary Brand drugs. 	<ul style="list-style-type: none"> - \$20 for a three-month (90 day) supply of Formulary Generic drugs - \$74 for a three-month (90 day) supply of Formulary Preferred Brand drugs - \$160 for a three-month (90 day) supply of Formulary Brand drugs - 25% coinsurance for a three-month (90 day) supply of mail-order Specialty Formulary Brand drugs.
Coverage After You Reach Your Initial Coverage Limit		<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach \$3,850.</p>	<p>After the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach \$3,850.</p>
Catastrophic Coverage		<p>After your yearly out-of-pocket drug costs reach \$3,850, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.15 for generic (including brand drugs treated as generic) and \$5.35 for all other drugs, or - 5% coinsurance. 	<p>After your yearly out-of-pocket drug costs reach \$3,850 you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.15 for generic (including brand drugs treated as generic) and \$5.35 for all other drugs, or - 5% coinsurance.

continued from page 25

- \$225 for a three-month (90 day) supply of Formulary Brand drugs.
- 25% coinsurance for a three-month (90 day) supply of Specialty Formulary Brand drugs.

- \$20 for a three-month (90 day) supply of mail-order Formulary Generic drugs.
- \$60 for a three-month (90 day) supply of mail-order Formulary Preferred Brand drugs.
- \$150 for a three-month (90 day) supply of mail-order Formulary Brand drugs.
- 25% coinsurance for a three-month (90 day) supply of mail-order Specialty Formulary Brand drugs.

After the total yearly drug costs (paid by both you and your plan) reach \$2,400, you pay 100% of your prescription drug costs until your yearly out-of-pocket drug costs reach \$3,850.

After your yearly out-of-pocket drug costs reach \$3,850, you pay the greater of:

- \$2.15 for generic (including brand drugs treated as generic) and \$5.35 for all other drugs, or
- 5% coinsurance.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
General Information		<p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from MediBlue HMO Select for certain prescription drugs.</p> <p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.</p> <p>Please contact the plan for details.</p>	<p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from MediBlue HMO Plus for certain prescription drugs.</p> <p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.</p> <p>Please contact the plan for details.</p>
Additional Benefits (what Original Medicare does not cover)			
29 - Dental Services	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive dental services.	In general, you pay 100% for preventive dental services.
30 - Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - Routine hearing tests up to 1 visit(s) every year - Fittings evaluations for a hearing aid up to 1 visit(s) every year <p>There is no co-payment for hearing aids up to 2 aid(s) every three years.</p> <p>You are covered up to \$1,000 for hearing aids every three years.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - Routine hearing tests up to 1 visit(s) every year - Fittings evaluations for a hearing aid up to 1 visit(s) every year <p>There is no co-payment for hearing aids up to 2 aid(s) every three years.</p> <p>You are covered up to \$1,000 for hearing aids every three years.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
	<p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from MediBlue PPO Plus for certain prescription drugs.</p> <p>Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.</p> <p>Please contact the plan for details.</p>	
<p>Additional Benefits (what Original Medicare does not cover)</p>		
<p>In general, you pay 100% for preventive dental services.</p>	<p>In general, you pay 100% for preventive dental services.</p>	<p>In general, you pay 100% for preventive dental services.</p>
<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - Routine hearing tests up to 1 visit(s) every year - Fittings evaluations for a hearing aid up to 1 visit(s) every year <p>There is no co-payment for hearing aids up to 2 aid(s) every three years.</p> <p>You are covered up to \$1,000 for hearing aids every three years.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - Routine hearing tests up to 1 visit(s) every year - Fittings evaluations for a hearing aid up to 1 visit(s) every year <p>There is no co-payment for hearing aids up to 2 aid(s) every three years.</p> <p>You are covered up to \$1,000 for hearing aids every three years.</p> <p>You pay 50% of the cost for out-of-network hearing exams.</p> <p>You pay 50% of the cost for out-of-network hearing aids.</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - Routine hearing tests up to 1 visit(s) every year - Fittings evaluations for a hearing aid up to 1 visit(s) every year <p>There is no co-payment for hearing aids up to 2 aid(s) every three years.</p> <p>You are covered up to \$1,000 for hearing aids every three years.</p> <p>You pay 50% of the cost for out-of-network hearing exams.</p> <p>You pay 50% of the cost for out-of-network hearing aids.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
31 - Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$0 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) - \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$10 for each Routine eye exam, limited to 1 exam(s) every year - \$0 for glasses, limited to 1 pair(s) of glasses every two years - \$45 for contacts, limited to 1 pair(s) of contacts every two years <p>Additional vision benefits are available. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> - \$0 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - \$30 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) - \$10 for each Routine eye exam, limited to 1 exam(s) every year - \$0 for glasses, limited to 1 pair(s) of glasses, every two years - \$45 for contacts, limited to 1 pair(s) of contacts every two years <p>Additional vision benefits are available. Authorization rules may apply for services. Contact plan for details.</p>
32 - Physical Exams	<p>If your coverage through Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage.</p>	<p>You pay \$15 for Medicare-covered services. You pay \$15 for each exam. You are covered for an unlimited number of exams.</p>	<p>You pay \$15 for Medicare-covered services. You pay \$15 for each exam. You are covered for an unlimited number of exams.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>You pay:</p> <ul style="list-style-type: none"> – \$0 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) – \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) – \$10 for each Routine eye exam, limited to 1 exam(s) every year – \$0 for glasses, limited to 1 pair(s) of glasses, every two years – \$45 for contacts, limited to 1 pair(s) of contacts every two years <p>Additional vision benefits are available. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> – \$0 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) – \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) – \$10 for each Routine eye exam, limited to 1 exam(s) every year <p>You pay 50% of the cost for out-of-network eye exams.</p> <ul style="list-style-type: none"> – \$0 for glasses, limited to 1 pair(s) of glasses every two years – \$45 for contacts, limited to 1 pair(s) of contacts every two years <p>You pay 50% of the cost of out of network eyewear.</p> <p>You are covered up to \$45 for eye exams every year.</p> <p>Additional vision benefits are available. Authorization rules may apply for services. Contact plan for details.</p>	<p>You pay:</p> <ul style="list-style-type: none"> – \$0 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) – \$25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) – \$10 for each Routine eye exam, limited to 1 exam(s) every year <p>You pay 50% of the cost for out-of-network eye exams.</p> <ul style="list-style-type: none"> – \$0 for glasses, limited to 1 pair(s) of glasses every two years – \$45 for contacts, limited to 1 pair(s) of contacts every two years <p>You pay 50% of the cost of out of network eyewear.</p> <p>You are covered up to \$45 for eye exams every year.</p> <p>Additional vision benefits are available. Authorization rules may apply for services. Contact plan for details.</p>
<p>You pay \$15 for Medicare-covered services. You pay \$15 for each exam. You are covered for an unlimited number of exams.</p>	<p>You pay \$15 for Medicare-covered services. You pay 20% of the cost for each out-of-network routine physical exam. You pay \$15 for each exam. You are covered for an unlimited number of exams.</p>	<p>You pay \$15 for Medicare-covered services. You pay 20% of the cost for each out-of-network routine physical exam. You pay \$15 for each exam. You are covered for an unlimited number of exams.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE HMO SELECT	MEDIBLUE HMO PLUS
32 - Physical Exams (cont.)	<p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount. (1)(2)</p>		
Health/Wellness Education	<p>You pay 100%.</p>	<p>You are covered for the following:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline 	<p>You are covered for the following:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

MEDIBLUE HMO ESSENTIAL	MEDIBLUE PPO PLUS	MEDIBLUE PPO ESSENTIAL
<p>You are covered for the following:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline 	<p>You are covered for the following:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline 	<p>You are covered for the following:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
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Important Information

Because you are eligible for benefits from Medicaid, the State is required to cover Medicare cost-sharing amounts that you would otherwise be required to pay. These amounts may differ based on what kind of Medicaid benefits you have. The cost-sharing amounts you will pay are listed below. In addition, you will have to pay the co-payment amounts listed below for Part D drug coverage. Contact your plan for additional information.

1 - Premium and Other Important Information	You pay the Medicare Part B premium of \$93.50 each month. (This is the 2007 amount and may change January 1, 2008.)	There is no additional premium beyond the Medicare Part B premium of \$93.50 each month for your plan benefits and your Medicare Part D prescription drug benefits. (This is the 2007 amount and may change January 1, 2008.)
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16)	You may go to any doctor, specialist or hospital that accepts Medicare.	You must go to network doctors, specialists, and hospitals. You do NOT need a referral to go to network doctors, specialists, and hospitals.

Summary of Benefits Inpatient Care

3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>You pay for each benefit period (3):</p> <p>Days 1 – 60: an initial deductible of \$992</p> <p>Days 61 – 90: \$248 each day</p> <p>Days 91 – 150: \$496 each lifetime reserve day (4)</p> <p>(These are 2007 amounts and may change January 1, 2008.)</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>	<p>There is no co-payment for Inpatient Hospital services received at a network hospital.</p> <p>You are covered for unlimited days each benefit period.</p> <p>Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>
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(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
4 - Inpatient Mental Health Care	You pay the same deductible and co-payments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	There is no co-payment for services received at a network hospital. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 - 20: \$0 for each day Days 21 - 100: \$124 for each day (These are 2007 amounts and may change January 1, 2008.) There is a limit of 100 days for each benefit period. (3)	There is no co-payment for services received at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply for services. Contact plan for details.
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no co-payment for all covered home health visits.	There is no co-payment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
Outpatient Care		
8 - Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for each primary care doctor office visit for Medicare-covered services. There is no co-payment for each specialist visit for Medicare-covered services. See #32 - Physical Exams - for more information.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
9 - Chiropractic Services	<p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>There is no co-payment for Medicare-covered chiropractic services (manual manipulation of the spine to correct subluxation).</p> <p>Authorization rules may apply for services.</p> <p>Contact plan for details.</p>
10 - Podiatry Services	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>There is no co-payment for:</p> <ul style="list-style-type: none"> - Medicare-covered podiatry services (medically necessary foot care) - Routine visits up to 1 visit(s) every three months
11 - Outpatient Mental Health Care	<p>You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)</p>	<p>There is no co-payment for each Medicare-covered visit for Mental Health services.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
12 - Outpatient Substance Abuse Care	<p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>There is no co-payment for each Medicare-covered visit.</p> <p>Except in an emergency, your provider must obtain authorization from Empire BlueCross BlueShield HMO.</p>
13 - Outpatient Services/Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor. (1)(2)</p> <p>You pay 20% of outpatient facility charges. (1)(2)</p>	<p>There is no co-payment for each Medicare-covered visit to an ambulatory surgical center.</p> <p>There is no co-payment for each Medicare-covered visit to an outpatient hospital facility.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
14 - Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	There is no co-payment for Medicare-covered ambulance services. Authorization rules may apply for services. Contact plan for details.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable co-payment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	There is no co-payment for each Medicare-covered emergency room visit. Worldwide coverage.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable co-payment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	There is no co-payment for each Medicare-covered urgently needed care visit. Worldwide coverage.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for each Medicare-covered Occupational Therapy visit. There is no co-payment for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. Authorization rules may apply for services. Contact plan for details.

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
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Outpatient Medical Services and Supplies

18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Medicare-covered items. Authorization rules may apply for services. Contact plan for details.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Medicare-covered items. Authorization rules may apply for services. Contact plan for details.
20 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Diabetes self-monitoring training. There is no co-payment for Diabetes supplies.
21 - Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no co-payment for Medicare-approved lab services.	There is no co-payment for the following Medicare-covered service(s): - clinical/diagnostic lab services - radiation therapy - X-ray visits Authorization rules may apply for services. Contact plan for details.

Preventive Services

22 - Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for each Medicare-covered Bone Mass Measurement.
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(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There is no co-payment for Medicare-covered Colorectal Screening Exams.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no co-payment for the Pneumonia and Flu vaccines. No referral is necessary for Medicare-covered influenza and pneumonia vaccines There is no co-payment for the Hepatitis B vaccine.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings.	There is no co-payment for Medicare-covered Screening Mammograms. No referral necessary for Medicare-covered screenings.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	There is no co-payment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	There is no co-payment for: – Medicare-covered Pap Smears and Pelvic Exams – Additional Pap Smears and Pelvic Exams up to 1 Pap Smear(s) and Pelvic Exam(s) every year

(1) Each year, you pay a total of one \$131 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no co-payment for approved lab services and a co-payment of 20% of Medicare-approved amounts for other related services. (1)(2)	There is no co-payment for Medicare-covered Prostate Screening Exams.
28 - Prescription Drugs Drugs covered under Medicare Part B (Original Medicare) Drugs covered under Medicare Part D Deductible Initial Coverage In-Network Retail Pharmacy Mail Order	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program	You pay \$0 for Part B-covered drugs. This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.empireblue.com Depending upon your income level, you pay a \$0 to \$53 yearly deductible. Depending upon your income level, you pay the lesser of \$0 to \$2.15 or 15% coinsurance for generic drugs (including brand drugs treated as generic) and the lesser of \$0 to \$5.35 or 15% coinsurance for all other drugs. You may receive drugs for the following: - one-month (30 day) supply - three-month (90 day) supply You may receive drugs for the following: - three-month (90 day) supply

(1) Each year, you pay a total of one \$131 deductible.
 (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
<p>31 - Vision Services</p>	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no co-payment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye) - Routine eye exams up to 1 visit(s) every year <p>There is no co-payment for the following items:</p> <ul style="list-style-type: none"> - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - Glasses, limited to 1 pair(s) of glasses every two years - Contacts, limited to 1 pair(s) of contacts every two years <p>Additional vision benefits are available.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
<p>32 - Physical Exams</p>	<p>If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.(1)(2)</p>	<p>There is no co-payment for routine physical exams.</p> <p>You are covered for an unlimited number of exams.</p>

(1) Each year, you pay a total of one \$131 deductible.
(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

BENEFIT CATEGORY	ORIGINAL MEDICARE	MEDIBLUE TOTAL SOLUTIONS
Health/Wellness Education	You pay 100%.	You are covered for the following: <ul style="list-style-type: none"> - Written health education materials, including Newsletter - Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline
Transportation (Routine)	You pay 100%	There is no co-payment for each round trip up to 12 trip(s) to Plan-approved location every year. Authorization rules may apply for services. Contact plan for details.

Important Information About MediBlue Benefits

PREMIUM AND OTHER IMPORTANT INFORMATION

MediBlue PPO Essential and MediBlue PPO Plus

- The \$150 annual out-of-network deductible is a combined total of both Medicare-Covered and Non-Medicare Covered services and applies only to out-of-network benefits; there is no deductible for in-network benefits.
- For members receiving in-network services, their providers are responsible for obtaining authorization. However, members are requested to obtain authorization for services received from out-of-network providers. Please call Medical Management for authorization at **1-800-441-2411**, 24 hours a day, 7 days a week.

MediBlue Total Solutions is available to anyone who is eligible for both Medicare and Medicaid. To learn more about this plan or to find out if you are eligible, please call **1-800-809-7328**. (TTY/TDD 1-800-241-6894).

DOCTOR AND HOSPITAL CHOICE

MediBlue PPO Essential and MediBlue PPO Plus

- As a PPO member, you will be able to receive covered services from any licensed physician. We encourage you to select an in-network physician to coordinate your care with other in-network providers when needed. This will allow you to keep your out-of-pocket costs low and your medical expenses predictable.
- “Primary Care” is subject to a lower co-payment than specialty care and includes services rendered from the following specialties: Obstetrics/Gynecology, Internal Medicine, Preventive Medicine, Pediatrics, Adolescent Medicine, Family Practice, General Practice, Geriatrics, Nurse Practitioner, and Certified Nurse Midwife.
- There is a 20% coinsurance per visit for both out-of-network primary care doctors, as well as out-of-network specialists. If you choose to see an out-of-network physician, please be sure the provider you have selected accepts Medicare. If the physician does not accept Medicare, you may be responsible for paying any additional balances, over the amount reimbursed by Medicare so your out-of-pocket costs may be higher.

MediBlue HMO Essential, MediBlue HMO Plus and MediBlue Total Solutions

- As an HMO member, you can see any network specialist you choose without getting a referral from your PCP. This means you can select and contact any physician or specialist directly from MediBlue’s large network of providers.
- Although you will need to select a PCP for all your primary care services, your network specialist will also be able to arrange for hospitalization and other care which is medically necessary to diagnose or treat your condition, just as your PCP does.
- Your network PCP or network specialist must obtain prior authorization from Empire for you to go to non-network doctors, specialists or hospitals.

INPATIENT HOSPITAL CARE

- The in-network inpatient co-payment applies per admission/stay, not per benefit period.
- PPO members pay 20% of the cost for each stay at an out-of-network hospital up to a \$5,000 out-of-pocket maximum per admission for acute care only. This out-of-pocket maximum does not apply to inpatient admissions/stays for mental health care, alcohol and/or substance abuse. See Inpatient Mental Healthcare for information about mental health care, alcohol and/or substance abuse.

INPATIENT MENTAL HEALTHCARE

- To obtain prior authorization for inpatient mental health care, contact Empire-Magellan Behavioral Health Care Program directly at **1-800-395-7792** (TDD 973-515-2847), Monday through Friday, 9:00 a.m. to 5:00 p.m. In an emergency, if an advance call cannot be made, you should notify Empire-Magellan Behavioral Health Care Program within 24 hours (or as soon as reasonably possible) after treatment begins.
- PPO members pay 50% of the cost for out-of-network inpatient psychiatric hospital care, including substance abuse and inpatient rehabilitation, with no out-of-pocket maximum.

HOSPICE

- If you enroll in a Medicare-certified hospice, Original Medicare not MediBlue pays for the hospice services you receive. Your hospice doctor can be an in-network provider or an out-of-network provider. If you choose to enroll in a Medicare-certified hospice, you remain a MediBlue member and continue to get the rest of your care that is unrelated to your terminal condition through MediBlue.
- Respite care, another facet of your hospice benefit, is temporary residential care for patients that provides relief for the permanent caregivers. You pay part of the cost for outpatient drugs and inpatient respite care.

PODIATRY SERVICES

- MediBlue offers coverage routine foot care, which is limited to one visit every three months. Orthopedic shoes are excluded unless they are part of a leg brace and are included in the cost of the leg brace. Supportive devices for the feet are also excluded. However, orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

OUTPATIENT MENTAL HEALTHCARE

- To obtain prior authorization for outpatient mental healthcare, contact Empire-Magellan Behavioral Health Care Program directly at **1-800-395-7792** (TDD 973-515-2847), Monday through Friday, 9:00 a.m. to 5:00 p.m.

OUTPATIENT SUBSTANCE ABUSE CARE

- To obtain prior authorization for outpatient substance abuse care, contact Empire-Magellan Behavioral Health Care Program directly at **1-800-395-7792** (TDD 973-515-2847), Monday through Friday, 9:00 a.m. to 5:00 p.m.

OUTPATIENT SERVICES/SURGERY

- The highest co-payment applies to invasive procedures and tests such as cardiac catheterization and chemotherapy when they are performed in an in-network outpatient hospital or ambulatory surgery facility.
- The \$0 co-payment applies to surgery performed in an in-network doctor's office.
- PPO members pay 20% of the cost for services performed in an out-of-network doctor's office, outpatient hospital or ambulatory surgery facility. If the physician does not accept Medicare, you may be responsible for paying any additional balances over the amount reimbursed by Medicare.

TRANSPORTATION

For **MediBlue Total Solutions** members, you are covered for transportation services when you use our contracted network transportation provider. You are covered for up to \$40.00 for each one-way trip.

OUTPATIENT REHABILITATION SERVICES

- No authorization is required for the initial evaluation. Authorization only required after the initial evaluation for continued services.

DURABLE MEDICAL EQUIPMENT

- Authorization is required for certain items.

PROSTHETIC DEVICES

- Authorization is required for certain items.

DIABETES SELF-MONITORING TRAINING AND SUPPLIES

- To receive in-network benefits, you must have services rendered by your network provider, or he/she must authorize and arrange services through a network specialist.

- Doctor office co-payment may apply if other services are rendered during the office visit.
- To receive in-network benefits, diabetic supplies, including but not limited to blood glucose monitors, lancets, syringes and other diabetic supplies, must be purchased through network Durable Medical Equipment suppliers, not through network pharmacies.

DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES

- Authorization is required for certain radiological services.
- The highest co-payment applies to invasive procedures and tests such as cardiac catheterization and chemotherapy when they are performed in an in-network outpatient hospital or ambulatory surgery facility.
- The \$0 co-payment applies to services performed in an in-network doctor's office.
- PPO members pay 20% of the cost for services performed in an out-of-network doctor's office, outpatient hospital or ambulatory surgery facility. If the physician does not accept Medicare, you may be responsible for paying any additional balances over the amount reimbursed by Medicare.

OUTPATIENT PRESCRIPTION DRUGS

MediBlue HMO Plus, MediBlue PPO Plus and MediBlue Total Solutions

- Drugs on our formulary are organized into four different tiers: Formulary Generic, Formulary Preferred Brand, Formulary Brand, and Specialty Formulary Brand. The co-payments you pay vary depending on the tier of the drug, with Formulary Generics in tier one costing the least and Specialty Formulary Brands in tier four costing the most. Please refer to our formulary for more detailed information.

DENTAL SERVICES

MediBlue Total Solutions

- You must use our network of dental providers for all routine exams, cleanings and X-rays. "Doral Services of NY, LLC." is the name of MediBlue's network of dental providers. To find a network provider to access your routine benefits, please call **1-800-896-2377**. For the hearing impaired, please call TDD/TTY 1-800-466-7566. Coverage is for routine diagnostic and preventive dental care every six months.

- The following dental X-rays are limited to one per 36 months: Intraoral complete series, Intraoral occlusal film, and Panoramic film.
- The following dental X-rays are limited to one per 6 months: Single film bitewings, Two film bitewings, and Four film bitewings.
- No limits on Intraoral periapical 1st film, Intraoral periapical each additional and posterior-anterior lateral skull film.
- No coverage for fluoride treatments, Restorative services, Endodontics services, Oral Surgery, Anesthesia, Major Restorations, Periodontics, and Prosthetics (such as dentures and partials).

HEARING SERVICES

- To receive in-network benefits, you must use our network of hearing providers for all routine hearing services and purchase of a hearing aid. "HEARx" is the name of the network of hearing providers. To find a network provider to access your routine hearing services, please call **1-800-878-0759** (TDD 1-800-688-4889), Monday through Friday, 8:30 a.m. – 3:30 p.m., Saturday 9 a.m. – 4:00 p.m. EST.

MediBlue PPO

- The in-network maximum benefits and the out-of-network maximum benefits cannot be combined.
- As a PPO member, if you choose to go to a provider that is not part of the HEARx network, you will need to submit a claim to HEARx for reimbursement. Claims for out-of-network benefits must be submitted to: HearUSA, 1250 Northpoint Parkway, West Palm Beach, FL 33407, Attention: Network Claims.

VISION SERVICES

- To receive in-network benefits for routine vision services, you must use our network of vision providers. "Davis Vision Network" is the name of the network of routine vision service providers. To find a network provider to access your routine vision services, please call **1-800-999-5431** (TDD 1-800-523-2847), Monday through Friday, 8 a.m. – 8 p.m., Saturday 9 a.m. – 4 p.m. EST.
- You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.

- You are limited to one routine eye exam every 12 months.
- You are limited to one pair of plan eyeglasses or contact lenses every 24 months.
- In addition to plan eyeglasses, there are other options available to members, including special lenses and coatings, frames and contact lenses, etc. Ask Davis Vision for details.
- Under routine vision services, the following are excluded:
 - Orthoptic care (a technique of eye exercise designed to correct the visual axes of eyes not properly coordinated for binocular vision), vision training or any associated supplemental testing
 - Special procedures such as radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services
 - Two pairs of glasses in lieu of bifocals
 - Lenses and frames furnished under your plan, which are lost or broken, will not be replaced unless they are covered under a separate warranty
- In addition to routine vision services, members are also covered for non-routine diagnosis and treatment for diseases and conditions of the eye. All in-network services for non-routine vision care must be provided by network providers and specialists.

MediBlue PPO

- The in-network maximum benefits and the out-of-network maximum benefits cannot be combined.
- As a PPO member, if you choose to go to a provider that is not part of the Davis Vision network, you will need to submit a claim to Davis Vision for reimbursement. Claims for out-of-network benefits must be submitted to: Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.
- PPO members pay 20% for diagnosis and treatment for diseases and conditions of the eye when services are performed by out-of-network providers. If the physician does not accept Medicare, you may be responsible for paying any additional balances over the amount reimbursed by Medicare.

ROUTINE PHYSICAL EXAMS

- For HMO members, routine physical exams rendered by a network specialist are subject to the specialist co-payment.
- For PPO members, “Primary Care” is subject to a lower co-payment than specialty care and includes services rendered from the following network provider specialties: Obstetrics/Gynecology, Internal Medicine, Preventive Medicine, Pediatrics, Adolescent Medicine, Family Practice, General Practice, Geriatrics, Nurse Practitioner, and Certified Nurse Midwife.
- PPO members pay 20% for physical exams rendered by out-of-network doctors. If the physician does not accept Medicare, you may be responsible for paying any additional balances over the amount reimbursed by Medicare.

HEALTH/ WELLNESS EDUCATION

- You pay \$0 for 24-hour access to health information and registered nurse counseling, as well as workshops on illness prevention and health promotion services received in-network.
- PPO members pay 50% of the cost for the following Health and Wellness Education services received out-of-network: Health Education Classes, Newsletters, Smoking Cessation, Health Club Membership/Fitness Class and Nursing Hotline.
- The SilverSneakers® Fitness Program is a total health and fitness program that is beneficial for persons of all fitness levels. You receive a free membership that allows you access to contracted full-service fitness centers throughout your area. SilverSneakers is not a gym membership, but a specialized program designed specifically for seniors. Gym memberships or other fitness programs that do not offer the SilverSneakers Fitness Program and do not meet the criteria of the SilverSneakers Fitness Program are excluded.



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H3370 H3342 2007 MN SB/CMS Approved 08/06