

Summary of Benefits for MediBlueSM HMO Essential and Select

Available in Dutchess, Orange, Putnam,
Rockland, Sullivan, Ulster and
Westchester Counties, NY

These plans are HMOs with a Medicare contract.

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Si usted necesita asistencia en español para poder entender este documento, podrá requerirla sin costo alguno llamándonos gratis al número telefónico que se muestra en este material.



Section 1

Introduction to the Summary of Benefits for MediBlue HMO Essential and Select January 1, 2008 - December 31, 2008

Thank you for your interest in MediBlue HMO Essential or Select. Our plan is offered by Empire Healthchoice HMO, Inc., a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call MediBlue HMO and ask for the "Evidence of Coverage."

You Have Choices in Your Health Care

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 MediBlue HMO Essential or Select. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call MediBlue HMO at the telephone number listed at the end of this introduction or 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 MediBlue HMO Essential, Select 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 plan covers 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 Essential and Select Available?

The service area for these plans include: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester counties, NY. You must live in one of these areas to join the plan.

Who Is Eligible to Join MediBlue HMO Essential or Select?

You can join MediBlue HMO Essential or Select 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 generally not eligible to enroll in

MediBlue HMO Essential or Select unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

MediBlue HMO Essential and Select have formed a network of doctors, specialists, and hospitals. You can only use doctors who are part 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's Not in Your Network?

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 these services.

Does My Plan Cover Medicare Part B or Part D Drugs?

MediBlue HMO Essential does cover Medicare Part B prescription drugs. **MediBlue HMO Essential** does NOT cover Medicare Part D prescription drugs. **MediBlue HMO Select** does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions if I Join This Plan?

MediBlue HMO Select 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 Select 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 www.mediblue.medicareplanrx.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**, 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 Select**, 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 HMO Select** for more details.

What Types of Drugs May Be Covered Under Medicare Part B?

Outpatient prescription drugs that may be covered under Medicare Part B include, but are not limited to,

the following types of drugs. Contact **MediBlue HMO Essential** 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

Please call Empire BlueCross BlueShield HMO for more information about this plan.

Visit us at www.empireblue.com, or call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. to 8 p.m.

For MediBlue HMO Essential and Select Plans:

Current members should call **1-800-499-9554** for questions related to the **Medicare Advantage** program (TTY/TDD: 1-800-241-6894).

Prospective members should call **1-800-809-7328** for questions related to the **Medicare Advantage** program (TTY/TDD: 1-800-241-6894).

For MediBlue HMO Select Plans:

Current members should call **1-800-499-9554** for questions related to the **Medicare Part D Prescription Drug** program (TTY/TDD: 1-800-241-6894).

Prospective members should call **1-800-809-7328** for questions related to the **Medicare Part D Prescription Drug** program (TTY/TDD: 1-800-241-6894).

For MediBlue HMO Essential and Select Plans:

For more information about Medicare, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

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

Section 2

Summary of Benefits for MediBlue HMO Essential and Select

If you have any questions about this plan's benefits or costs, please contact Empire BlueCross BlueShield HMO for details.

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<i>Important Information</i>			
1. Premium and Other Important Information	<p>You pay the Medicare Part B premium each month. (This amount is \$93.50 in 2007, and it may change in 2008.)</p> <p>Most people will pay the standard monthly Part B premium. However, some people will have to pay a higher premium because of their yearly income. For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium. (This amount is \$93.50 in 2007, and it may change in 2008.)</p> <p>Out-of-Network</p> <p>Unless otherwise noted, out-of-network services not covered.</p>	<p>General</p> <p>\$23 monthly plan premium in addition to your monthly Medicare Part B premium. (This amount is \$93.50 in 2007, and it may change in 2008.)</p> <p>Out-of-Network</p> <p>Unless otherwise noted, out-of-network services not covered.</p>
2. Doctor and Hospital Choice <i>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</i>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p> <p><i>See p. 23 for additional information about Doctor and Hospital Choice.</i></p>	<p>In-Network</p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p> <p><i>See p. 23 for additional information about Doctor and Hospital Choice.</i></p>

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<i>Inpatient Care</i>			
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period³:</p> <ul style="list-style-type: none"> ▪ Days 1 - 60: an initial deductible of \$992 in 2007 ▪ Days 61 - 90: \$248 per day in 2007 ▪ Days 91 - 150: \$496 per lifetime reserve day in 2007 <p>These amounts may change in 2008. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days⁴</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. 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.</p>	<p><i>In-Network</i></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 90: \$0 copay per day ▪ \$0 copay for additional hospital days <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><i>In-Network</i></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 90: \$0 copay per day ▪ \$0 copay for additional hospital days <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4. Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (See “Inpatient Hospital Care” above.)</p> <p>190-day limit in a Psychiatric Hospital</p>	<p><i>In-Network</i></p> <p>For hospital stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 90: \$0 copay per day <p>Plan covers 60 lifetime reserve days.</p>	<p><i>In-Network</i></p> <p>For hospital stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 90: \$0 copay per day <p>Plan covers 60 lifetime reserve days.</p>

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 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.

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<p>5. Skilled Nursing Facility <i>(in a Medicare-certified Skilled Nursing Facility)</i></p>	<p>For each benefit period³ after at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> ▪ Days 1 - 20: \$0 per day in 2007 ▪ Days 21 - 100: \$124 per day in 2007 <p>These amounts may change in 2008.</p> <p>100 days for each benefit period</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care.</p> <p>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.</p>	<p>Cost per lifetime reserve day:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 60: \$0 copay per day <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><i>See p. 23 for additional information about Inpatient Mental Health Care.</i></p> <p>General Prior authorization is required.</p> <p>In-Network For SNF stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 100: \$50 copay per day <p>100 days covered for each benefit period</p> <p>No prior hospital stay is required.</p>	<p>Cost per lifetime reserve day:</p> <ul style="list-style-type: none"> ▪ Days 1 - 10: \$125 copay per day ▪ Days 11 - 60: \$0 copay per day <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><i>See p. 23 for additional information about Inpatient Mental Health Care.</i></p> <p>General Prior authorization is required.</p> <p>In-Network For SNF stays:</p> <ul style="list-style-type: none"> ▪ Days 1 - 100: \$50 copay per day <p>100 days covered for each benefit period</p> <p>No prior hospital stay is required.</p>

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 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.

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<p>6. Home Health Care <i>(includes medically necessary, intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i></p>	<p>\$0 copay</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p>	<p>In-Network You must get care from a Medicare-certified hospice. <i>See p. 23 for additional information about Hospice.</i></p>	<p>In-Network You must get care from a Medicare-certified hospice. <i>See p. 23 for additional information about Hospice.</i></p>
Outpatient Care			
<p>8. Doctor Office Visits</p>	<p>20% coinsurance^{1, 2}</p>	<p>General See "Routine Physical Exams" for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$25 copay for each specialist visit for Medicare-covered benefits. <i>See p. 23 for additional information about Doctor Office Visits.</i></p>	<p>General See "Routine Physical Exams" for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$25 copay for each specialist visit for Medicare-covered benefits. <i>See p. 23 for additional information about Doctor Office Visits.</i></p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

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<p>9. Chiropractic Services</p>	<p>20% coinsurance Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>
<p>10. Podiatry Services</p>	<p>20% coinsurance^{1, 2} Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs</p>	<p>In-Network \$25 copay for each Medicare-covered visit. \$25 copay for up to 1 routine visit(s) every three months Medicare-covered podiatry benefits are for medically necessary foot care. See p. 24 for additional information about Podiatry Services.</p>	<p>In-Network \$25 copay for each Medicare-covered visit. \$25 copay for up to 1 routine visit(s) every three months Medicare-covered podiatry benefits are for medically necessary foot care. See p. 24 for additional information about Podiatry Services.</p>
<p>11. Outpatient Mental Health Care</p>	<p>50% coinsurance for most outpatient mental health services^{1, 2}</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual or group therapy visit. See p. 24 for additional information about Outpatient Mental Health Care.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual or group therapy visit. See p. 24 for additional information about Outpatient Mental Health Care.</p>

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12. Outpatient Substance Abuse Care	20% coinsurance ^{1, 2}	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual or group visits. <i>See p. 24 for additional information about Outpatient Substance Abuse Care.</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual or group visits. <i>See p. 24 for additional information about Outpatient Substance Abuse Care.</i></p>
13. Outpatient Services/Surgery	20% coinsurance for the doctor ^{1, 2} 20% of outpatient facility ^{1, 2}	<p>General Authorization rules may apply.</p> <p>In-Network \$300 copay for each Medicare-covered ambulatory surgical center visit. \$0 to \$300 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$300 copay for each Medicare-covered ambulatory surgical center visit. \$0 to \$300 copay for each Medicare-covered outpatient hospital facility visit.</p>
14. Ambulance Services <i>(medically necessary ambulance services)</i>	20% coinsurance ^{1, 2}	<p>In-Network \$100 copay for Medicare-covered ambulance benefits. <i>See p. 24 for additional information about Ambulance Services.</i></p>	<p>In-Network \$100 copay for Medicare-covered ambulance benefits. <i>See p. 24 for additional information about Ambulance Services.</i></p>
15. Emergency Care <i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i>	20% coinsurance for the doctor ^{1, 2} 20% of facility charge or a set copay per emergency room visit ^{1, 2} You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p>

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
	NOT covered outside the U.S. except under limited circumstances	<p><i>In- and Out-of-Network</i></p> <p>If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room visit.</p> <p><i>See p. 24 for additional information about Emergency Care.</i></p>	<p><i>In- and Out-of-Network</i></p> <p>If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room visit.</p> <p><i>See p. 24 for additional information about Emergency Care.</i></p>
<p>16. Urgently Needed Care <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i></p>	<p>20% coinsurance or a set copay^{1, 2}</p> <p>NOT covered outside the U.S. except under limited circumstances</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>	<p>General</p> <p>\$25 copay for Medicare-covered urgently needed care visits.</p>
<p>17. Outpatient Rehabilitation Services <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i></p>	<p>20% coinsurance^{1, 2}</p>	<p>General</p> <p>Authorization rules may apply.</p> <p><i>In-Network</i></p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p><i>In-Network</i></p> <p>\$25 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>

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Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<i>Outpatient Medical Services and Supplies</i>			
18. Durable Medical Equipment <i>(includes wheelchairs, oxygen, etc.)</i>	20% coinsurance ^{1, 2}	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
19. Prosthetic Devices <i>(includes braces, artificial limbs and eyes, etc.)</i>	20% coinsurance ^{1, 2}	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
20. Diabetes Self-Monitoring Training, and Nutrition Therapy, and Supplies <i>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</i>	20% coinsurance ^{1, 2}	<p>In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. <i>See p. 24 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies.</i></p>	<p>In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. <i>See p. 24 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies.</i></p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

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<p>21. Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and x-rays^{1,2}</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> \$0 copay for Medicare-covered: <ul style="list-style-type: none"> ▪ lab services ▪ diagnostic procedures and tests \$25 to \$50 copay for Medicare-covered X-rays. \$25 to \$50 copay for Medicare-covered diagnostic radiology services. \$50 to \$100 copay for Medicare-covered therapeutic radiology services. <p><i>See p. 24 for additional information about Diagnostic Tests, X-Rays and Lab Services.</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> \$0 copay for Medicare-covered: <ul style="list-style-type: none"> ▪ lab services ▪ diagnostic procedures and tests \$25 to \$50 copay for Medicare-covered X-rays. \$25 to \$50 copay for Medicare-covered diagnostic radiology services. \$50 to \$100 copay for Medicare-covered therapeutic radiology services. <p><i>See p. 24 for additional information about Diagnostic Tests, X-Rays and Lab Services.</i></p>
<p>Preventive Services</p>			
<p>22. Bone Mass Measurement <i>(for people with Medicare who are at risk)</i></p>	<p>20% coinsurance^{1,2}</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered bone mass measurement</p>
<p>23. Colorectal Screening Exams <i>(for people with Medicare age 50 and older)</i></p>	<p>20% coinsurance^{1,2}</p> <p>Covered when you are high risk or when you are age 50 and older</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered colorectal screenings</p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<p>24. Immunizations <i>(Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)</i></p>	<p>\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine^{1, 2} You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><i>In-Network</i> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines.</p>	<p><i>In-Network</i> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines.</p>
<p>25. Mammograms (Annual Screening) <i>(for women with Medicare age 40 and older)</i></p>	<p>20% coinsurance² No referral needed Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39</p>	<p><i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for Medicare-covered screening mammograms</p>	<p><i>General</i> Authorization rules may apply. <i>In-Network</i> \$0 copay for Medicare-covered screening mammograms</p>
<p>26. Pap Smears and Pelvic Exams <i>(for women with Medicare)</i></p>	<p>\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk 20% coinsurance for Pelvic Exams</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered pap smears and pelvic exams and ▪ up to 1 additional Pap smear and pelvic exam every year</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered pap smears and pelvic exams and ▪ up to 1 additional Pap smear and pelvic exam every year</p>
<p>27. Prostate Cancer Screening Exams <i>(for men with Medicare age 50 and older)</i></p>	<p>20% coinsurance for the digital rectal exam \$0 for the PSA test; 20% coinsurance for other related services Covered once a year for all men with Medicare over age 50</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered prostate cancer screening.</p>	<p><i>In-Network</i> \$0 copay for Medicare-covered prostate cancer screening.</p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
28. ESRD	20% coinsurance for dialysis ^{1, 2}	<p>General Authorization rules may apply. Out-of-area Renal Dialysis services do not require Authorization.</p> <p>In-Network \$0 copay for in and out-of-area dialysis \$0 copay for Nutrition Therapy for Renal Disease</p>	<p>General Authorization rules may apply. Out-of-area Renal Dialysis services do not require Authorization.</p> <p>In-Network \$0 copay for in and out-of-area dialysis \$0 copay for Nutrition Therapy for Renal Disease</p>
29. Prescription Drugs	Most drugs not covered (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)	<p>Drugs Covered Under Medicare Part B</p> <p>General Most drugs not covered. 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 10% of the cost for Part B-covered chemotherapy drugs.</p> <p>Drugs Covered Under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs Covered Under Medicare Part B</p> <p>General 10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 10% of the cost for Part B-covered chemotherapy drugs.</p> <p>Drugs Covered Under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://medibluemedicareplanrx.com on the web. Different out-of-pocket costs may apply for people who</p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
			<ul style="list-style-type: none"> ▪ have limited incomes, ▪ live in long-term care facilities, or ▪ have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from MediBlue HMO Select for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p> <p><i>In-Network</i></p> <p>\$0 deductible.</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p> <p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,510:</p> <p><i>Retail Pharmacy Formulary Generic</i></p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (30-day) supply of drugs ▪ \$15 copay for a three-month (90-day) supply of drugs

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
			<p>Formulary Preferred Brand</p> <ul style="list-style-type: none"> ▪ \$30 copay for a one-month (30-day) supply of drugs ▪ \$90 copay for a three-month (90-day) supply of drugs <p>Formulary Brand</p> <ul style="list-style-type: none"> ▪ \$65 copay for a one-month (30-day) supply of drugs ▪ \$195 copay for a three-month (90-day) supply of drugs <p>Specialty Formulary Brand</p> <ul style="list-style-type: none"> ▪ 30% coinsurance for a one-month (30-day) supply of drugs ▪ 30% coinsurance for a three-month (90-day) supply of drugs <p>Long-Term Care Pharmacy Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (31-day) supply of drugs <p>Formulary Preferred Brand</p> <ul style="list-style-type: none"> ▪ \$30 copay for a one-month (31-day) supply of drugs <p>Formulary Brand</p> <ul style="list-style-type: none"> ▪ \$65 copay for a one-month (31-day) supply of drugs <p>Specialty Formulary Brand</p> <ul style="list-style-type: none"> ▪ 30% coinsurance for a one-month (31-day) supply of drugs <p>Mail Order Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$10 copay for a three-month (90-day) supply of drugs <p>Formulary Preferred Brand</p> <ul style="list-style-type: none"> ▪ \$60 copay for a three-month (90-day) supply of drugs

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
			<p>Formulary Brand</p> <ul style="list-style-type: none"> ▪ \$130 copay for a three-month (90-day) supply of drugs <p>Specialty Formulary Brand</p> <ul style="list-style-type: none"> ▪ 30% coinsurance for a three-month (90-day) supply of drugs <p>Coverage Gap</p> <p>You pay the following:</p> <p>The plan covers All Generics through the gap.</p> <p>Retail Pharmacy Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (30-day) supply of drugs ▪ \$15 copay for a three-month (90-day) supply of drugs <p>Long-Term Care Pharmacy Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (31-day) supply of drugs <p>Mail Order Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$10 copay for a three-month (90-day) supply of drugs <p>For all other covered drugs, after your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> ▪ \$2.25 copay for generic (including brand drugs treated as generic) and

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
			<p>\$5.60 copay for all other drugs, or</p> <ul style="list-style-type: none"> ▪ 5% coinsurance. <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy.</p> <p>Out-of-Network Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,510:</p> <p>Out-of-Network Pharmacy Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (30-day) supply of drugs <p>Formulary Preferred Brand</p> <ul style="list-style-type: none"> ▪ \$30 copay for a one-month (30-day) supply of drugs <p>Formulary Brand</p> <ul style="list-style-type: none"> ▪ \$65 copay for a one-month (30-day) supply of drugs <p>Specialty Formulary Brand</p> <ul style="list-style-type: none"> ▪ 30% coinsurance for a one-month (30-day) supply of drugs <p>Out-of-Network Coverage Gap</p> <p>You pay the following:</p> <p>Formulary Generic</p> <ul style="list-style-type: none"> ▪ \$5 copay for a one-month (30-day) supply of drugs

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<p>30. Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered</p>	<p>In-Network \$0 copay for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered.</p> <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diagnostic hearing exams ■ Up to 1 routine hearing test every year ■ Up to 1 fitting evaluation(s) for a hearing aid every year \$0 copay for up to 2 hearing aids every three years.</p>	<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> ■ \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or ■ 5% coinsurance. <p>See p. 24 for additional information about Prescription Drugs.</p>
<p>31. Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered 20% coinsurance for diagnostic hearing exams^{1, 2}</p>	<p>In-Network \$0 copay for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered.</p> <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diagnostic hearing exams ■ Up to 1 routine hearing test every year ■ Up to 1 fitting evaluation(s) for a hearing aid every year \$0 copay for up to 2 hearing aids every three years.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diagnostic hearing exams ■ Up to 1 routine hearing test every year ■ Up to 1 fitting evaluation(s) for a hearing aid every year \$0 copay for up to 2 hearing aids every three years.</p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
<p>32. Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye^{1,2}</p> <p>Routine eye exams and glasses not covered</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery^{1, 2}</p> <p>Annual glaucoma screenings covered for people at risk^{1, 2}</p>	<p>\$1,000 limit for routine hearing aids every three years.</p> <p><i>See p. 24 for additional information about Hearing Services.</i></p> <p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. ▪ \$25 copay for exams to diagnose and treat diseases and conditions of the eye. ▪ \$10 copay for up to 1 routine eye exam every year ▪ \$0 copay for up to 1 pair of glasses every two years ▪ \$45 copay for up to 1 pair of contacts every two years <p>Plan offers additional vision benefits.</p> <p><i>See p. 24 for additional information about Vision Services.</i></p>	<p>\$1,000 limit for routine hearing aids every three years.</p> <p><i>See p. 24 for additional information about Hearing Services.</i></p> <p>General Authorization rules may apply.</p> <p>In-Network</p> <ul style="list-style-type: none"> ▪ \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. ▪ \$25 copay for exams to diagnose and treat diseases and conditions of the eye. ▪ \$10 copay for up to 1 routine eye exam every year ▪ \$0 copay for up to 1 pair of glasses every two years ▪ \$45 copay for up to 1 pair of contacts every two years <p>Plan offers additional vision benefits.</p> <p><i>See p. 24 for additional information about Vision Services.</i></p>
<p>33. Physical Exams</p>	<p>20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage^{1, 2}</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>\$10 copay for routine exams.</p> <p>No limit on the number of covered exams.</p> <p>\$10 copay for Medicare-covered benefits.</p> <p><i>See p. 25 for additional information about Physical Exams.</i></p>	<p>\$10 copay for routine exams.</p> <p>No limit on the number of covered exams.</p> <p>\$10 copay for Medicare-covered benefits.</p> <p><i>See p. 25 for additional information about Physical Exams.</i></p>

¹ Each year, you pay a total of one deductible. In 2007, this deductible is \$131, and it may change in 2008.

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

Benefit Category	Original Medicare	MediBlue HMO Essential	MediBlue HMO Select
Health/Wellness Education	Not covered	<p><i>In-Network</i> This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Smoking Cessation ▪ Health Club Membership/Fitness Classes ▪ Nursing Hotline <p><i>See p. 25 for additional information about Health/Wellness Education Benefits.</i></p>	<p><i>In-Network</i> This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Smoking Cessation ▪ Health Club Membership/Fitness Classes ▪ Nursing Hotline <p><i>See p. 25 for additional information about Health/Wellness Education Benefits.</i></p>

Section 3

2008 Summary of Benefits for MediBlue HMO Essential and Select

It's important that you understand your benefits so you can get the most out of your health care services, and we can serve you better. We want your benefit information to be easy to understand and simple for you to use.

Your plan was created to provide Medicare beneficiaries with coverage for medically-necessary hospital and doctor services with low or no monthly plan premiums. Your plan also may include Medicare Part D Prescription Drug Coverage. It also may include coverage for routine vision care, dental care, and hearing examinations.

This section provides important additional information about some of the benefits listed earlier in Section 2.

Doctor and Hospital Choice (see #2 in Section 2)

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 our large network of providers.

Your network specialist will also be able to arrange for hospitalization and other care that is medically necessary to diagnose or treat your condition, just like your PCP does.

Your network PCP or specialist must obtain prior authorization from us before you go to non-network doctors, specialists or hospitals.

You must receive all your medical care from network providers, except for emergency services, urgently needed services while you are out of the service area and renal dialysis (kidney) services that you get when you are temporarily outside of the plan's service area.

Inpatient Mental Health Care (see #4 in Section 2)

To obtain prior authorization for inpatient mental health care, contact the Behavioral Health Care program directly at 1-800-395-7792 (TDD 1-800-758-1769), Monday through Friday, 8:30 a.m. to 5 p.m. EST. In an emergency, if an advance call cannot be made, you should notify the Behavioral Health Care program within 24 hours (or as soon as reasonably possible) after treatment begins.

Hospice (see #7 in Section 2)

If you enroll in a Medicare-certified hospice, Original Medicare, not MediBlue, pays for your hospice services. Your hospice doctor can be a network provider or an out-of-network provider. If you choose to enroll in a Medicare-certified hospice, you remain a MediBlue member and MediBlue will continue to provide benefits for covered services that are unrelated to your terminal condition.

Respite care, another part of your hospice benefit, is temporary residential care for patients in order to provide relief for the permanent caregivers. You pay part of the cost for outpatient drugs and inpatient respite care.

Screening Services (see #8 in Section 2)

You do not pay a copayment for the following screening services, but you may pay an appropriate office visit copayment: *colorectal screenings, screening mammograms, bone mass measurement, Pap smears and pelvic exams, and prostate cancer screening exams.*

Podiatry Services (see #10 in Section 2)

Your plan covers one visit at network providers for routine foot care every three months. You pay your specialist copay. Coverage is limited to

medically necessary services for certain medical conditions affecting the legs and feet when self-treatment is not recommended.

Orthopedic shoes are not covered unless they are part of a leg brace and are included in the cost of the leg brace. Supportive devices for the feet also are not covered. However, orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

Outpatient Mental Health Care *(see #11 in Section 2)*

You must obtain authorization before you receive outpatient mental health care. Contact the Behavioral Health Care Program directly at 1-800-395-7792 (TDD 1-800-758-1769), Monday through Friday, 8:30 a.m. to 5 p.m. EST.

Outpatient Substance Abuse Care *(see #12 in Section 2)*

You must obtain authorization before you receive outpatient substance abuse care. Contact the Behavioral Health Care Program directly at 1-800-395-7792 (TDD 1-800-758-1769), Monday through Friday, 8:30 a.m. to 5 p.m. EST.

Ambulance Services *(see #14 in Section 2)*

You pay your ambulance copayment for each medically-necessary trip to the hospital or dialysis center, from the hospital or dialysis center, or between facilities.

Emergency Care *(see #15 in Section 2)*

You pay your emergency room (ER) copayment for each covered ER visit. If you are admitted to a hospital from an ER for the same or a related condition within the time frame described in Section 2, you will not pay your ER copayment, but you will pay your inpatient hospital copayment, if you have one.

Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies *(see #20 in Section 2)*

Doctor office visit copayments may apply if you receive other services during the office visit.

Diagnostic Tests, X-Rays and Lab Services *(see #21 in Section 2)*

Your share of the cost for network diagnostic tests and X-rays depends on where the service is performed.

You pay a lower copayment for diagnostic tests and X-rays performed in a network doctor's office.

You pay a higher copayment for diagnostic tests and X-rays performed in a network outpatient hospital or ambulatory facility.

The highest copayment applies to invasive procedures and tests such as cardiac catheterization and chemotherapy performed in a network outpatient hospital or ambulatory surgery facility.

Prescription Drugs *(see #29 in Section 2)*

If this plan includes Medicare Part D coverage, you will automatically be disenrolled from this plan if you apply for other Part D coverage. You cannot have two Part D plans at the same time.

Hearing Services *(see #31 in Section 2)*

To receive benefits, you must use network hearing providers for covered routine hearing services and to purchase a hearing aid. HEARx is the name of the network of hearing providers. To find a network provider, please call 1-800-323-3277, (TDD 1-800-688-4889), Monday through Friday, 8:30 a.m. to 3:30 p.m., Saturday 9 a.m. to 4 p.m. EST.

Vision Care *(see #32 in Section 2)*

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, please call 1-800-999-5431 (TDD 1-800-523-2847), Monday through Friday 8 a.m. to 8 p.m., Saturday 9 a.m. to 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 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.

The following routine vision services 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.
- Lost or broken lenses and frames that were purchased under your plan will not be replaced unless they are covered under a separate warranty.

In addition to routine vision services, your plan covers nonroutine diagnosis and treatment for diseases and conditions of the eye.

All services for non-routine vision care must be provided by network providers.

Physical Exams (see #33 in Section 2)

You pay a specialist copay for routine physical exams provided by a network specialist.

Health/Wellness Education (see p. 22 in Section 2)

You can enroll in the SilverSneakers® program — a fitness plan designed especially for Medicare-eligible individuals. The SilverSneakers® program includes:

- A complimentary basic membership in a participating fitness center in your area. You can use all the services available to fitness center members with a basic membership, such as steam and sauna rooms, exercise equipment, and SilverSneakers® classes custom-designed for all levels of fitness.
- Opportunities to join in fitness promotions and health education seminars.

There is not a separate charge for this program, as long as you only use services available with basic fitness center memberships.

After you enroll in this Medicare Advantage plan, you will receive a brochure that shows the participating fitness centers in your area and describes how to enroll in SilverSneakers.®

Contact Customer Service for more information on this program, or visit www.silversneakers.com

