# 2024 Summary of Benefits Blue Medicare HMO℠

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare HMO plans for **January 1, 2024 – December 31, 2024.**

**Plans:**
**Medical Only (HMO-POS):** H3449-012
**Essential (HMO):** H3449-027-001, H3449-027-002
**Essential Plus (HMO-POS):** H3449-023-001, H3449-023-002, H3449-023-004, H3449-023-005
**Choice (HMO):** H3449-026
**Enhanced (HMO-POS):** H3449-024-001, H3449-024-002, H3449-024-003

- The benefits information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. Visit **Medicare.BlueCrossNC.com/forms-library** and click on the Evidence of Coverage tab.
- Blue Medicare HMO has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for their services.
- Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of North Carolina (Blue Cross NC) members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.
- With a HMO-POS (Point of Service) plan, you can go outside the network for your dental benefits. For dental services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.
- Cost sharing may vary depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
- Plans may offer supplemental benefits in addition to Part C and Part D benefits.
- Blue Cross and Blue Shield of North Carolina is an HMO and HMO-POS plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
- For more information about Original Medicare or to request the *Medicare & You* handbook from Medicare, call 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, 7 days a week, 24 hours a day. Or visit **Medicare.gov**.
- For more details, call **1-800-665-8037** (TTY: 711), current members call **1-888-310-4110** (TTY: 711), 7 days a week, 8 a.m. – 8 p.m., visit **Medicare.BlueCrossNC.com** or contact your Blue Cross NC Authorized Independent Agent.



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MedicareRx Prescription Drug Coverage

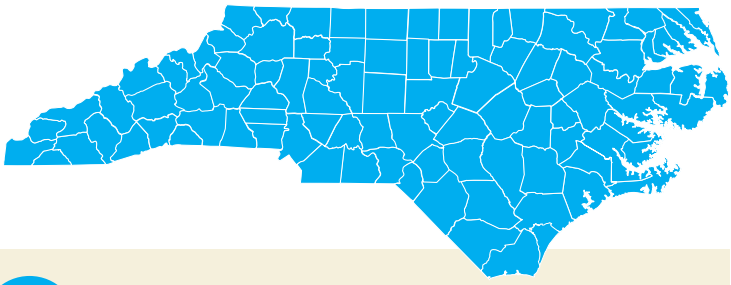
# Summary of Benefits

## Plan Offering and Premium by County

Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.

**Blue Medicare Medical Only℠ (HMO-POS)** H3449-012 **Monthly Premium: $0**

| | | | | | |
|---|---|---|---|---|---|
| Alamance | Catawba | Franklin | Jones | Pamlico | Surry |
| Alexander | Chatham | Gaston | Lee | Pasquotank | Swain |
| Alleghany | Cherokee | Gates | Lenoir | Pender | Transylvania |
| Anson | Chowan | Graham | Lincoln | Perquimans | Tyrrell |
| Ashe | Clay | Granville | Macon | Person | Union |
| Avery | Cleveland | Greene | Madison | Pitt | Vance |
| Beaufort | Columbus | Guilford | Martin | Polk | Wake |
| Bertie | Craven | Halifax | McDowell | Randolph | Warren |
| Bladen | Cumberland | Harnett | Mecklenburg | Richmond | Washington |
| Brunswick | Currituck | Haywood | Mitchell | Robeson | Watauga |
| Buncombe | Dare | Henderson | Montgomery | Rockingham | Wayne |
| Burke | Davidson | Hertford | Moore | Rowan | Wilkes |
| Cabarrus | Davie | Hoke | Nash | Rutherford | Wilson |
| Caldwell | Duplin | Hyde | New Hanover | Sampson | Yadkin |
| Camden | Durham | Iredell | Northampton | Scotland | Yancey |
| Carteret | Edgecombe | Jackson | Onslow | Stanly | |
| Caswell | Forsyth | Johnston | Orange | Stokes | |



**Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.**

**Please note:** To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

# Summary of Benefits

## BlueMedicare Medical Only℠ (HMO-POS) H3449-012

| | | |
|---|---|---|
| **Monthly Premium:** | You must also continue to pay your Medicare Part B premium. | $0 |
| **Part B Premium Reduction:** | Monthly reduction. | $50 monthly |
| **Deductible:** | This plan has no medical deductible. | $0 |
| **Annual Maximum Out-of-Pocket Amount:** | Does not include prescription drugs. | $3,900 |

| Benefits | What You Should Know | |
|---|---|---|
| **Inpatient Hospital Care:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $295 copay |
| | **Days 6–90:** | $0 copay |
| | **Days 91 and beyond:** | $0 copay |
| **Outpatient Services:*** | **Outpatient Hospital:** Per stay. | $275 copay |
| | **Ambulatory Surgical Center:** | $225 copay |
| **Doctor Visit:** | **Primary:** | $0 copay |
| | **Specialist:** | $25 copay |
| **Preventive Care:** | Any additional preventive services approved by Medicare during the contract year will be covered. | $0 copay |
| **Emergency Care:** | If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. | $120 copay |
| **Urgently Needed Services:** | | $60 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Medical Only℠ (HMO-POS) H3449-012

| Benefits | What You Should Know | | PCP Office | Any Other Setting |
|---|---|---|---|---|
| **Diagnostic Services/ Labs/ Imaging:*** | **Diagnostic Tests and Procedures:** | | $0 copay | $25 copay |
| | **Lab Services:** | | $0 copay | $5 copay |
| | **Diagnostic Radiological Services:** | **MRI, CT and Other Nuclear Medicine:** | $0 copay | Lesser of 20% of cost or $150 copay |
| | | **PET:** | $0 copay | $300 copay |
| | | **All Other Services:** | $0 copay | $75 copay |
| | **Therapeutic Radiological Services:** | | $0 copay | Lesser of 20% of cost or $60 copay |
| | **X-rays:** | | $0 copay | $15 copay |
| **Hearing Services:** | **Medicare-Covered Hearing Exam:** | Exams to diagnose and treat hearing and balance issues. | $25 copay | |
| | **Routine Hearing Exam:** | One per year. Must use designated providers. | $0 copay | |
| | **Hearing Aids:** | One per ear, per year. Must use designated providers. | $699–$999 copay | |
| **Dental Services:** | **Medicare-Covered Dental Services:*** | Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures. | $25 copay | |
| | **Comprehensive and Preventive Dental:**** | $2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures. | $0 copay*** | |

*May require prior authorization.
**Certain limits apply. Combined yearly allowance. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.
***Must use designated providers.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Medical Only℠ (HMO-POS) H3449-012

| Benefits | | What You Should Know | |
|---|---|---|---|
| **Vision Services:** | **Routine Eye and Contact Lens Exams:** | One of each per calendar year. | $25 copay |
| | **Prescription Eyewear Allowance:** | $300 yearly allowance. | $0 copay |
| | **Medicare-Covered Eye Exam:** | For the diagnosis and treatment of illnesses and injuries of the eye. | $25 copay |
| | **Glaucoma Screening and Diabetic Eye Exam:** | For people who are at high risk of glaucoma or have diabetes. | $0 copay |
| | **Eyewear After Cataract Surgery:** | One pair of eyeglasses or one pair of contact lenses. | 20% of cost |
| **Mental Health Services:** | **Inpatient:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $295 copay |
| | | **Days 6–90:** | $0 copay |
| | **Outpatient:** (Mental health* and substance use.) | Individual and group sessions. | $25 copay |
| **Skilled Nursing Facility:*** | (Cost share applies per day. Benefit period applied per admission.) | **Days 1–20:** | $0 copay |
| | | **Days 21–60:** | $203 copay |
| | | **Days 61–100:** | $0 copay |
| **Outpatient Rehabilitation Services:** | **Physical and Speech Language Therapy:** | | $25 copay |
| | **Occupational Therapy:** | | $25 copay |
| | **Cardiac Rehab Services:** | | $0 copay |
| | **Pulmonary Rehab Services:** | | $15 copay |
| **Ambulance Services:*** | Covers medically necessary ground and air ambulance services. | | $250 copay |
| **Transportation:** | 24 one-way rides to health-related locations. | | $0 copay |
| **Medicare Part B Drugs:**** | **Part B Insulins:** 30-day supply. | | $35 copay |
| | **Chemotherapy and Other Part B Drugs:** | | 0–20% of cost |

*May require prior authorization.
**May require prior authorization. Based on Inflation Reduction Act mandates.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Medical Only℠ (HMO-POS) H3449-012

### Other Covered Benefits

| Benefit | What You Should Know | | |
|---|---|---|---|
| **Podiatry Services:** | Foot care. | | $25 copay |
| **Medical Equipment and Supplies:** | **Durable Medical Equipment and Supplies:*** | | 20% of cost |
| | **Diabetic Shoes or Inserts:** | | 20% of cost |
| | **Diabetes Supplies:*** | Preferred Brands | $0 copay |
| | | Non-Preferred Brands** | 20% of cost |
| **Healthy Aging and Exercise Program:** | Must use participating facilities. | | $0 copay*** |
| **Over-the-Counter Products Allowance:** | Must use participating retail locations. Funds do not roll over quarter-to-quarter. | | $100 quarterly |
| **Meals Benefit:** | Two meals per day for 14 days post-discharge. | | $0 copay |
| **Support for Caregivers:** | Support and resources for non-professional caregivers. | | $0 copay |
| **In-Home Assistance:** | 60 hours per year. | | $0 copay |
| **Personal Emergency Response System:** | Wearable device with fast access to emergency services. | | $0 copay |
| **Home Safety Devices:†** | Two devices per year. | | $0 copay |

*May require prior authorization.
**With a medical exception.
***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
† Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## Plan Offering and Premium by County

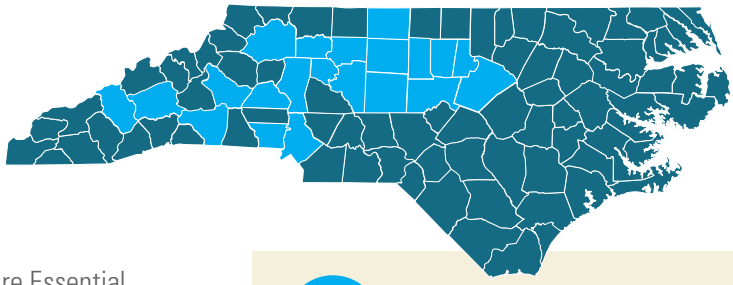
Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.

### Blue Medicare Essential℠ (HMO) H3449-027-001 — Monthly Premium: $0

| | | | | | |
|---|---|---|---|---|---|
| Alamance | Chatham | Forsyth | Iredell | Rockingham | Wilkes |
| Buncombe | Davidson | Gaston | Mecklenburg | Rutherford | Yadkin |
| Burke | Davie | Guilford | Orange | Wake | |
| Catawba | Durham | Haywood | Randolph | | |

### Blue Medicare Essential℠ (HMO) H3449-027-002 — Monthly Premium: $0

| | | | | | |
|---|---|---|---|---|---|
| Alexander | Cherokee | Granville | Macon | Perquimans | Tyrrell |
| Alleghany | Chowan | Greene | Madison | Person | Union |
| Anson | Clay | Halifax | Martin | Pitt | Vance |
| Ashe | Cleveland | Harnett | McDowell | Polk | Warren |
| Avery | Columbus | Henderson | Mitchell | Richmond | Washington |
| Beaufort | Craven | Hertford | Montgomery | Robeson | Watauga |
| Bertie | Cumberland | Hoke | Moore | Rowan | Wayne |
| Bladen | Currituck | Hyde | Nash | Sampson | Wilson |
| Brunswick | Dare | Jackson | New Hanover | Scotland | Yancey |
| Cabarrus | Duplin | Johnston | Northampton | Stanly | |
| Caldwell | Edgecombe | Jones | Onslow | Stokes | |
| Camden | Franklin | Lee | Pamlico | Surry | |
| Carteret | Gates | Lenoir | Pasquotank | Swain | |
| Caswell | Graham | Lincoln | Pender | Transylvania | |



Counties where Blue Medicare Essential (HMO) is available:

001 002

**Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.**

**Please note:** To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

# Summary of Benefits

## BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

| | | |
|---|---|---|
| **Monthly Premium:** | You must also continue to pay your Medicare Part B premium. | $0 |
| **Part B Premium Reduction:** | Monthly reduction. | $60 monthly |
| **Annual Deductible:** | This plan has no medical deductible. | $0 |
| **Annual Maximum Out-of-Pocket Amount:** | Does not include prescription drugs. | $8,300 |

| Benefits | What You Should Know | | |
|---|---|---|---|
| **Inpatient Hospital Care:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | | $335 copay |
| | **Days 6–90:** | | $0 copay |
| | **Days 91 and beyond:** | | $0 copay |
| **Outpatient Services:*** | **Outpatient Hospital:** Per stay. | 001: | $295 copay |
| | | 002: | $345 copay |
| | **Ambulatory Surgical Center:** | | $275 copay |
| **Doctor Visit:** | **Primary:** | 001: | $5 copay |
| | | 002: | $10 copay |
| | **Specialist:** | | $45 copay |
| **Preventive Care:** | Any additional preventive services approved by Medicare during the contract year will be covered. | | $0 copay |
| **Emergency Care:** | If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. | | $100 copay |
| **Urgently Needed Services:** | | | $55 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## Blue Medicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

| Benefits | | What You Should Know | PCP Office | Any Other Setting |
|---|---|---|---|---|
| Diagnostic Services/ Labs/ Imaging:* | Diagnostic Tests and Procedures: | | $0 copay | $25 copay |
| | Lab Services: | | $0 copay | $5 copay |
| | Diagnostic Radiological Services: | MRI, CT and Other Nuclear Medicine: | $0 copay | Lesser of 20% of cost or $150 copay |
| | | PET: | $0 copay | $300 copay |
| | | All Other Services: | $0 copay | $75 copay |
| | Therapeutic Radiological Services: | | $0 copay | Lesser of 20% of cost or $60 copay |
| | X-rays: | | $0 copay | $15 copay |
| Hearing Services: | Medicare-Covered Hearing Exam: | Exams to diagnose and treat hearing and balance issues. | $45 copay | |
| | Routine Hearing Exam: | One per year. Must use designated providers. | $0 copay | |
| | Hearing Aids: | One per ear, per year. Must use designated providers. | $699–$999 copay | |
| Dental Services: | Medicare-Covered Dental Services:* | Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures. | $45 copay | |
| | Preventive Dental: | Oral exams, cleanings, X-rays and screenings.** | $0 copay | |

*May require prior authorization.
**Certain limits apply. Must use designated providers.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

| Benefits | | What You Should Know | |
|---|---|---|---|
| **Vision Services:** | **Routine Eye and Contact Lens Exams:** | One of each per calendar year. | $25 copay |
| | **Prescription Eyewear Allowance:** | $100 yearly allowance. | $0 copay |
| | **Medicare-Covered Eye Exam:** | For the diagnosis and treatment of illnesses and injuries of the eye. | $25 copay |
| | **Glaucoma Screening and Diabetic Eye Exam:** | For people who are at high risk of glaucoma or have diabetes. | $0 copay |
| | **Eyewear After Cataract Surgery:** | One pair of eyeglasses or one pair of contact lenses. | 20% of cost |
| **Mental Health Services:** | **Inpatient:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $300 copay |
| | | **Days 6–90:** | $0 copay |
| | **Outpatient:** (Mental health* and substance use.) | Individual and group sessions. | $40 copay |
| **Skilled Nursing Facility:*** | (Cost share applies per day. Benefit period applied per admission.) | **Days 1–20:** | $0 copay |
| | | **Days 21–60:** | $203 copay |
| | | **Days 61–100:** | $0 copay |
| **Outpatient Rehabilitation Services:** | **Physical and Speech Language Therapy:** | | $25 copay |
| | **Occupational Therapy:** | | $25 copay |
| | **Cardiac Rehab Services:** | | $0 copay |
| | **Pulmonary Rehab Services:** | | $15 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

| Benefits | What You Should Know | |
|---|---|---|
| **Ambulance Services:*** | Covers medically necessary ground and air ambulance services. | $275 copay |
| **Transportation:** | | Not covered |
| **Medicare Part B Drugs:**** | **Part B Insulins:** 30-day supply. | $35 copay |
| | **Chemotherapy and Other Part B Drugs:** | 0–20% of cost |

## Part D, Prescription Drug Benefit Stages

H3449-027-001
H3449-027-002

| | | |
|---|---|---|
| **Annual Deductible:** | **Tiers 1, 2, 3 and 6:** $0 **Tiers 4 and 5:** $375<br>This is the set amount that you pay before your plan begins to pay its share of the cost. Your deductible does not apply to covered insulin products and most adult Part D vaccines. | |
| **Initial Coverage Limit (ICL):** | **Begins after you pay your yearly deductible.** You remain in this stage until your costs on covered drugs reach **$5,030**.[1] The amount you pay in this stage is shown in the chart on the next page. | |
| **Coverage Gap:** | **Begins when your total year-to-date costs on covered drugs exceed $5,030.** In this stage, you'll pay **25%** of the cost for your drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$8,000**.[2] Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at Preferred pharmacies or a **$3** copayment at Standard (non-preferred) pharmacies. | |
| **Catastrophic Coverage:** | **Begins when your total year-to-date costs on covered drugs exceed $8,000.** During this stage, your plan will pay the full cost for your covered Part D drugs. | |

*May require prior authorization.
**May require prior authorization. Based on Inflation Reduction Act mandates.
1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
2 Total year-to-date includes drug costs that only you have paid.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

| Prescription Drug Initial Coverage Limit (ICL) | | Preferred Retail Pharmacies | | Preferred Mail Order | Standard (Non-Preferred) Pharmacies | |
|---|---|---|---|---|---|---|
| | | 1-month 30-day supply | 3-months 90-day supply | 3-months 90-day supply | 1-month 30-day supply* | 3-months 90-day supply |
| **Preferred Generic Drugs:** (Tier 1) | | $0 copay | $0 copay | $0 copay | $15 copay | $45 copay |
| **Generic Drugs:** (Tier 2) | | $6 copay | $18 copay | $0 copay | $20 copay | $60 copay |
| **Preferred Brand Drugs:** (Tier 3) | | $45 copay | $135 copay | $90 copay | $47 copay | $141 copay |
| **Non-Preferred Drugs:** (Tier 4) | | $99 copay | $297 copay | $198 copay | $100 copay | $300 copay |
| **Specialty Tier Drugs:** (Tier 5) | | 27% of cost | N/A | N/A | 27% of cost | N/A |
| **Select Care Drugs:** (Tier 6) | | $0 copay | $0 copay | $0 copay | $3 copay | $3 copay |
| **Insulins:** | Tier 3: | $35 copay | $105 copay | $90 copay | $35 copay | $105 copay |
| | Tier 4: | $35 copay | $105 copay | $105 copay | $35 copay | $105 copay |

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.
Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## Blue Medicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

### Other Covered Benefits

| Benefit | What You Should Know | | |
|---|---|---|---|
| **Podiatry Services:** | Foot care. | | $45 copay |
| **Medical Equipment and Supplies:** | **Durable Medical Equipment and Supplies:*** | | 20% of cost |
| | **Diabetic Shoes or Inserts:** | | 20% of cost |
| | **Diabetes Supplies:*** | Preferred Brands | $0 copay |
| | | Non-Preferred Brands** | 20% of cost |
| **Healthy Aging and Exercise Program:** | Must use participating facilities. | | $0 copay*** |
| **Meals Benefit:** | Two meals per day for 14 days post-discharge. | | $0 copay |
| **Support for Caregivers:** | Support and resources for non-professional caregivers. | | $0 copay |
| **Personal Emergency Response System:** | Wearable device with fast access to emergency services. | | $0 copay |
| **Home Safety Devices:†** | Two devices per year. | | $0 copay |

*May require prior authorization.
**With a medical exception.
***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
† Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## Plan Offerings and Premiums by County

Blue Medicare Essential Plus (HMO-POS) is available in all 100 North Carolina counties.

### Blue Medicare Essential Plus℠ (HMO-POS) H3449-023-001 — Monthly Premium: $0

| | | | | | |
|---|---|---|---|---|---|
| Alamance | Chatham | Forsyth | Iredell | Rockingham | Wilkes |
| Buncombe | Davidson | Gaston | Mecklenburg | Rutherford | Yadkin |
| Burke | Davie | Guilford | Orange | Wake | |
| Catawba | Durham | Haywood | Randolph | | |

### Blue Medicare Essential Plus℠ (HMO-POS) H3449-023-002 — Monthly Premium: $0

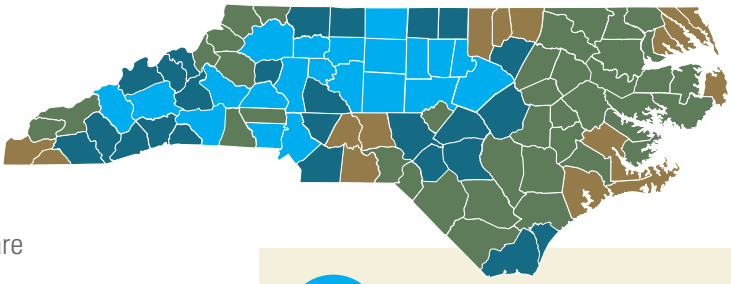
| | | | | | |
|---|---|---|---|---|---|
| Alexander | Franklin | Johnston | Mitchell | Polk | Transylvania |
| Brunswick | Harnett | Macon | Moore | Rowan | Union |
| Cabarrus | Henderson | Madison | New Hanover | Stokes | Yancey |
| Caswell | Hoke | McDowell | Person | Surry | |
| Cumberland | Jackson | | | | |

### Blue Medicare Essential Plus℠ (HMO-POS) H3449-023-004 — Monthly Premium: $0

| | | | | | |
|---|---|---|---|---|---|
| Anson | Cherokee | Currituck | Montgomery | Perquimans | Vance |
| Camden | Clay | Dare | Onslow | Stanly | Warren |
| Carteret | Craven | Granville | Pasquotank | | |

### Blue Medicare Essential Plus℠ (HMO-POS) H3449-023-005 — Monthly Premium: $0

| | | | | | |
|---|---|---|---|---|---|
| Alleghany | Chowan | Greene | Lincoln | Richmond | Washington |
| Ashe | Cleveland | Halifax | Martin | Robeson | Watauga |
| Avery | Columbus | Hertford | Nash | Sampson | Wayne |
| Beaufort | Duplin | Hyde | Northampton | Scotland | Wilson |
| Bertie | Edgecombe | Jones | Pamlico | Swain | |
| Bladen | Gates | Lee | Pender | Tyrrell | |
| Caldwell | Graham | Lenoir | Pitt | | |



Counties where Blue Medicare Essential Plus (HMO-POS) is available:

001 002 004 005

**Blue Medicare Essential Plus (HMO-POS) is available in all 100 North Carolina counties.**

**Please note:** To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| | | | |
|---|---|---|---|
| **Monthly Premium:** | You must also continue to pay your Medicare Part B premium. | | $0 |
| **Deductible:** | These plans have no medical deductible. | | $0 |
| **Annual Maximum Out-of-Pocket:** | Does not include prescription drugs. | 001: 002: | $3,500 |
| | | 004: 005: | $4,900 |

| Benefits | What You Should Know | | |
|---|---|---|---|
| **Inpatient Hospital Care:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | | $335 copay |
| | **Days 6–90:** | | $0 copay |
| | **Days 91 and beyond:** | | $0 copay |
| **Outpatient Services:*** | **Outpatient Hospital:** Per stay. | | $295 copay |
| | **Ambulatory Surgical Center:** | | $275 copay |
| **Doctor Visit:** | **Primary:** | | $0 copay |
| | **Specialist:** | 001: 002: | $15 copay |
| | | 004: 005: | $25 copay |
| **Preventive Care:** | Any additional preventive services approved by Medicare during the contract year will be covered. | | $0 copay |
| **Emergency Care:** | If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. | | $120 copay |
| **Urgently Needed Services:** | | | $60 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| Benefits | | What You Should Know | PCP Office | Any Other Setting |
|---|---|---|---|---|
| **Diagnostic Services/ Labs/ Imaging:*** | **Diagnostic Tests and Procedures:** | | $0 copay | $25 copay |
| | **Lab Services:** | | $0 copay | $5 copay |
| | **Diagnostic Radiological Services:** | **MRI, CT and Other Nuclear Medicine:** | $0 copay | Lesser of 20% of cost or $150 copay |
| | | **PET:** | $0 copay | $300 copay |
| | | **All Other Services:** | $0 copay | $75 copay |
| | **Therapeutic Radiological Services:** | | $0 copay | Lesser of 20% of cost or $60 copay |
| | **X-rays:** | | $0 copay | $15 copay |
| **Hearing Services:** | **Medicare-Covered Hearing Exam:** | Exams to diagnose and treat hearing and balance issues. | 001: 002: | $15 copay |
| | | | 004: 005: | $25 copay |
| | **Routine Hearing Exam:** | One per year. Must use designated providers. | | $0 copay |
| | **Hearing Aids:** | One per ear, per year. Must use designated providers. | | $699–$999 copay |
| **Dental Services:** | **Medicare-Covered Dental Services:*** | Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures. | 001: 002: | $15 copay |
| | | | 004: 005: | $25 copay |
| | **Comprehensive and Preventive Dental:** | $2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.** | | $0 copay*** |

*May require prior authorization.
**Certain limits apply. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please see the Evidence of Coverage for more information.
***Must use designated providers.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| Benefits | What You Should Know | | | |
|---|---|---|---|---|
| **Vision Services:** | **Routine Eye and Contact Lens Exams:** | One of each per calendar year. | 001: 002: | $15 copay |
| | | | 004: 005: | $25 copay |
| | **Prescription Eyewear Allowance** | $300 yearly allowance. | | $0 copay |
| | **Medicare-Covered Eye Exam:** | For the diagnosis and treatment of illnesses and injuries of the eye. | 001: 002: | $15 copay |
| | | | 004: 005: | $25 copay |
| | **Glaucoma Screening and Diabetic Eye Exam:** | For people who are at high risk of glaucoma or have diabetes. | | $0 copay |
| | **Eyewear After Cataract Surgery:** | One pair of eyeglasses or one pair of contact lenses. | | 20% of cost |
| **Mental Health Services:** | **Inpatient:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | | $300 copay |
| | | **Days 6–90:** | | $0 copay |
| | **Outpatient:** (Mental health* and substance use.) | Individual and group sessions. | 001: 002: | $15 copay |
| | | | 004: 005: | $25 copay |
| **Skilled Nursing Facility:*** | (Cost share applies per day. Benefit period applied per admission.) | **Days 1–20:** | | $0 copay |
| | | **Days 21–60:** | | $203 copay |
| | | **Days 61–100:** | | $0 copay |
| **Outpatient Rehabilitation Services:** | **Physical and Speech Language Therapy:** | | | $10 copay |
| | **Occupational Therapy:** | | | $10 copay |
| | **Cardiac Rehab Services:** | | | $0 copay |
| | **Pulmonary Rehab Services:** | | | $15 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| Benefits | What You Should Know | |
|---|---|---|
| **Ambulance Services:*** | Covers medically necessary ground and air ambulance services. | $275 copay |
| **Transportation:** | 24 one-way rides to health-related locations. | $0 copay |
| **Medicare Part B Drugs:**** | **Part B Insulins:** 30-day supply. | $35 copay |
| | **Chemotherapy and Other Part B Drugs:** | 0–20% of cost |

## Part D, Prescription Drug Benefit Stages

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| | | |
|---|---|---|
| **Annual Deductible:** | **Tiers 1, 2, 3 and 6:** $0 | **Tiers 4 and 5:** $150 |
| | This is the set amount that you pay before your plan begins to pay its share of the cost. Your deductible does not apply to covered insulin products and most adult Part D vaccines. | |
| **Initial Coverage Limit (ICL):** | **Begins after you pay your yearly deductible.** You remain in this stage until your costs on covered drugs reach **$5,030**.[1] The amount you pay in this stage is shown in the chart on the next page. | |
| **Coverage Gap:** | **Begins when your total year-to-date costs on covered drugs exceed $5,030.** In this stage, you'll pay **25%** of the cost of your drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$8,000**.[2] Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at Preferred pharmacies or a **$3** copayment at Standard (non-preferred) pharmacies. | |
| **Catastrophic Coverage:** | **Begins when your total year-to-date costs on covered drugs exceed $8,000.** During this stage, your plan will pay the full cost for your covered Part D drugs. | |

*May require prior authorization.
**May require prior authorization. Based on Inflation Reduction Act mandates.
1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
2 Total year-to-date includes drug costs that only you have paid.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

| Prescription Drug Initial Coverage Limit (ICL) | Preferred Retail Pharmacies | | Preferred Mail Order | Standard (Non-Preferred) Pharmacies | |
|---|---|---|---|---|---|
| | 1-month 30-day supply | 3-months 90-day supply | 3-months 90-day supply | 1-month 30-day supply* | 3-months 90-day supply |
| **Preferred Generic Drugs:** (Tier 1) | $0 copay | $0 copay | $0 copay | $15 copay | $45 copay |
| **Generic Drugs:** (Tier 2) | $6 copay | $18 copay | $0 copay | $20 copay | $60 copay |
| **Preferred Brand Drugs:** (Tier 3) | $45 copay | $135 copay | $90 copay | $47 copay | $141 copay |
| **Non-Preferred Drugs:** (Tier 4) | $99 copay | $297 copay | $198 copay | $100 copay | $300 copay |
| **Specialty Tier Drugs:** (Tier 5) | 30% of cost | N/A | N/A | 30% of cost | N/A |
| **Select Care Drugs:** (Tier 6) | $0 copay | $0 copay | $0 copay | $3 copay | $3 copay |
| **Insulins:** Tier 3: | $35 copay | $105 copay | $90 copay | $35 copay | $105 copay |
| **Insulins:** Tier 4: | $35 copay | $105 copay | $105 copay | $35 copay | $105 copay |

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.
Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Essential Plus℠ (HMO-POS)

H3449-023-001
H3449-023-002
H3449-023-004
H3449-023-005

### Other Covered Benefits

| Benefit | What You Should Know | | |
|---|---|---|---|
| **Podiatry Services:** | Foot care. | 001: 002: | $15 copay |
| | | 004: 005: | $25 copay |
| **Medical Equipment and Supplies:** | **Durable Medical Equipment and Supplies:*** | | 20% of cost |
| | **Diabetic Shoes or Inserts:** | | 20% of cost |
| | **Diabetes Supplies:*** | Preferred Brands | $0 copay |
| | | Non-Preferred Brands** | 20% of cost |
| **Healthy Aging and Exercise Program:** | Must use participating facilities. | | $0 copay*** |
| **Over-the-Counter Products Allowance:** | Must use participating retail locations. Funds do not roll over quarter-to-quarter. | 001: | $120 quarterly |
| | | 002: | $95 quarterly |
| | | 004: | $90 quarterly |
| | | 005: | $95 quarterly |
| **Meals Benefit:** | Two meals per day for 14 days post-discharge. | | $0 copay |
| **Support for Caregivers:** | Support and resources for non-professional caregivers. | | $0 copay |
| **In-Home Assistance:** | 60 hours per year. | | $0 copay |
| **Personal Emergency Response System:** | Wearable device with fast access to emergency services. | | $0 copay |
| **Home Safety Devices:†** | Two devices per year. | | $0 copay |

*May require prior authorization.
**With a medical exception.
***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
† Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.

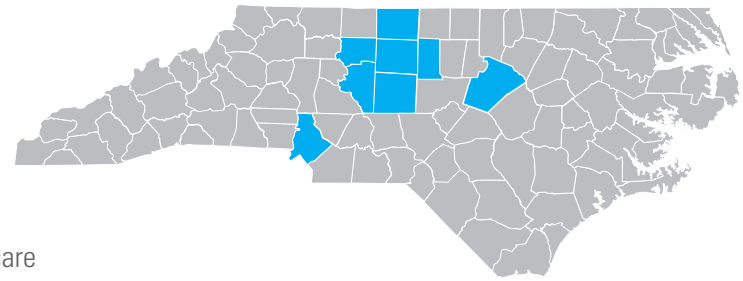
# Summary of Benefits

## Plan Offering and Premium by County

### Blue Medicare Choice℠ (HMO)

H3449-026 **Monthly Premium: $0**

| | | | |
|---|---|---|---|
| Alamance | Forsyth | Mecklenburg | Rockingham |
| Davidson | Guilford | Randolph | Wake |



Counties where Blue Medicare Choice (HMO) is available:

026

**Please note:** To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO) H3449-026

| | | |
|---|---|---|
| **Monthly Premium:** | You must also continue to pay your Medicare Part B premium. | $0 |
| **Deductible:** | This plan has no medical deductible. | $0 |
| **Annual Maximum Out-of-Pocket Amount:** | Does not include prescription drugs. | $2,800 |

| Benefits | What You Should Know | |
|---|---|---|
| **Inpatient Hospital Care:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $295 copay |
| | **Days 6–90:** | $0 copay |
| | **Days 91 and beyond:** | $0 copay |
| **Outpatient Services:*** | **Outpatient Hospital:** Per stay. | $295 copay |
| | **Ambulatory Surgical Center:** | $275 copay |
| **Doctor Visit:** | **Primary:** | $0 copay |
| | **Specialist:** | $10 copay |
| **Preventive Care:** | Any additional preventive services approved by Medicare during the contract year will be covered. | $0 copay |
| **Emergency Care:** | If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. | $135 copay |
| **Urgently Needed Services:** | | $60 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO)

H3449-026

| Benefits | | What You Should Know | PCP Office | Any Other Setting |
|---|---|---|---|---|
| Diagnostic Services/ Labs/ Imaging:* | Diagnostic Tests and Procedures: | | $0 copay | $15 copay |
| | Lab Services: | | $0 copay | $5 copay |
| | Diagnostic Radiological Services: | MRI, CT and Other Nuclear Medicine: | $0 copay | Lesser of 20% of cost or $150 copay |
| | | PET: | $0 copay | $300 copay |
| | | All Other Services: | $0 copay | $75 copay |
| | Therapeutic Radiological Services: | | $0 copay | Lesser of 20% of cost or $60 copay |
| | X-rays: | | $0 copay | $15 copay |
| Hearing Services: | Medicare-Covered Hearing Exam: | Exams to diagnose and treat hearing and balance issues. | | $10 copay |
| | Routine Hearing Exam: | One per year. Must use designated providers. | | $0 copay |
| | Hearing Aids: | One per ear, per year. Must use designated providers. | | $699–$999 copay |
| Dental Services: | Medicare-Covered Dental Services:* | Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures. | | $10 copay |
| | Preventive Dental: | Oral exams, cleanings, X-rays and screenings.** | | $0 copay |

*May require prior authorization.
**Certain limits apply. Must use designated providers.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO) H3449-026

| Benefits | | What You Should Know | |
|---|---|---|---|
| **Vision Services:** | **Routine Eye and Contact Lens Exams:** | One of each per calendar year. | $10 copay |
| | **Prescription Eyewear Allowance:** | $200 yearly allowance. | $0 copay |
| | **Medicare-Covered Eye Exam:** | For the diagnosis and treatment of illnesses and injuries of the eye. | $10 copay |
| | **Glaucoma Screening and Diabetic Eye Exam:** | For people who are at high risk of glaucoma or have diabetes. | $0 copay |
| | **Eyewear After Cataract Surgery:** | One pair of eyeglasses or one pair of contact lenses. | 20% of cost |
| **Mental Health Services:** | **Inpatient:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $295 copay |
| | | **Days 6–90:** | $0 copay |
| | **Outpatient:** (Mental health* and substance use.) | Individual and group sessions. | $10 copay |
| **Skilled Nursing Facility:*** | (Cost share applies per day. Benefit period applied per admission.) | **Days 1–20:** | $0 copay |
| | | **Days 21–60:** | $203 copay |
| | | **Days 61–100:** | $0 copay |
| **Outpatient Rehabilitation Services:** | **Physical and Speech Language Therapy:** | | $10 copay |
| | **Occupational Therapy:** | | $10 copay |
| | **Cardiac Rehab Services:** | | $0 copay |
| | **Pulmonary Rehab Services:** | | $20 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO) — H3449-026

| Benefits | What You Should Know | |
|---|---|---|
| **Ambulance Services:*** | Covers medically necessary ground and air ambulance services. | $275 copay |
| **Transportation:** | | Not Covered |
| **Medicare Part B Drugs:**** | **Part B Insulins:** 30-day supply. | $35 copay |
| | **Chemotherapy and Other Part B Drugs:** | 0–20% of cost |

## Part D, Prescription Drug Benefit Stages — H3449-026

| | |
|---|---|
| **Annual Deductible:** | **All Tiers:** $0<br>This is the set amount that you pay before your plan begins to pay its share of the cost. Your deductible does not apply to covered insulin products and most adult Part D vaccines. |
| **Initial Coverage Limit (ICL):** | **Begins after you pay your yearly deductible.** You remain in this stage until your costs on covered drugs reach **$5,030**.[1] The amount you pay in this stage is shown in the chart on the next page. |
| **Coverage Gap:** | **Begins when your total year-to-date costs on covered drugs exceed $5,030.** In this stage, you'll pay **25%** of the cost for your drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$8,000**.[2] Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at Preferred pharmacies or a **$3** copayment at Standard (non-preferred) pharmacies. |
| **Catastrophic Coverage:** | **Begins when your total year-to-date costs on covered drugs exceed $8,000.** During this stage, your plan will pay the full cost for your covered Part D drugs. |

*May require prior authorization.
**May require prior authorization. Based on Inflation Reduction Act mandates.
1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
2 Total year-to-date includes drug costs that only you have paid.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO)

H3449-026

| Prescription Drug Initial Coverage Limit (ICL) | Preferred Retail Pharmacies | | Preferred Mail Order | Standard (Non-Preferred) Pharmacies | |
|---|---|---|---|---|---|
| | 1-month 30-day supply | 3-months 90-day supply | 3-months 90-day supply | 1-month 30-day supply* | 3-months 90-day supply |
| **Preferred Generic Drugs:** (Tier 1) | $0 copay | $0 copay | $0 copay | $15 copay | $45 copay |
| **Generic Drugs:** (Tier 2) | $6 copay | $18 copay | $0 copay | $20 copay | $60 copay |
| **Preferred Brand Drugs:** (Tier 3) | $45 copay | $135 copay | $90 copay | $47 copay | $141 copay |
| **Non-Preferred Drugs:** (Tier 4) | $99 copay | $297 copay | $198 copay | $100 copay | $300 copay |
| **Specialty Tier Drugs:** (Tier 5) | 33% of cost | N/A | N/A | 33% of cost | N/A |
| **Select Care Drugs:** (Tier 6) | $0 copay | $0 copay | $0 copay | $3 copay | $3 copay |
| **Insulins:** Tier 3: | $35 copay | $105 copay | $90 copay | $35 copay | $105 copay |
| **Insulins:** Tier 4: | $35 copay | $105 copay | $90 copay | $35 copay | $105 copay |

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.
Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Choice℠ (HMO) H3449-026

### Other Covered Benefits

| Benefit | What You Should Know | | |
|---|---|---|---|
| **Podiatry Services:** | Foot care. | | $10 copay |
| **Medical Equipment and Supplies:** | **Durable Medical Equipment and Supplies:*** | | 20% of cost |
| | **Diabetic Shoes or Inserts:** | | 20% of cost |
| | **Diabetes Supplies:*** | Preferred Brands | $0 copay |
| | | Non-Preferred Brands** | 20% of cost |
| **Healthy Aging and Exercise Program:** | Must use participating facilities. | | $0 copay*** |
| **Over-the-Counter Products Allowance:** | Must use participating retail locations. Funds do not roll over quarter-to-quarter. | | $85 quarterly |
| **Meals Benefit:** | Two meals per day for 14 days post-discharge. | | $0 copay |
| **Support for Caregivers:** | Support and resources for non-professional caregivers. | | $0 copay |
| **Personal Emergency Response System:** | Wearable device with fast access to emergency services. | | $0 copay |
| **Home Safety Devices:†** | Two devices per year. | | $0 copay |

*May require prior authorization.
**With a medical exception.
***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
† Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## Plan Offerings and Premiums by County

### Blue Medicare Enhanced℠ (HMO-POS) H3449-024-001 — Monthly Premium: $19

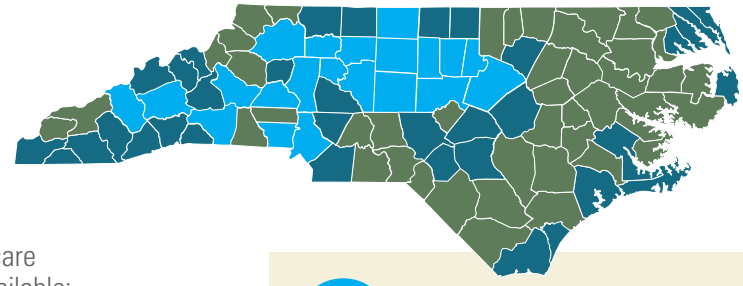
| | | | | | |
|---|---|---|---|---|---|
| Alamance | Chatham | Forsyth | Iredell | Rockingham | Wilkes |
| Buncombe | Davidson | Gaston | Mecklenburg | Rutherford | Yadkin |
| Burke | Davie | Guilford | Orange | Wake | |
| Catawba | Durham | Haywood | Randolph | | |

### Blue Medicare Enhanced℠ (HMO-POS) H3449-024-002 — Monthly Premium: $34

| | | | | | |
|---|---|---|---|---|---|
| Alexander | Clay | Henderson | Mitchell | Person | Transylvania |
| Brunswick | Craven | Hoke | Moore | Polk | Union |
| Cabarrus | Cumberland | Jackson | New Hanover | Rowan | Yancey |
| Camden | Currituck | Johnston | Onslow | Stokes | |
| Carteret | Dare | Macon | Pasquotank | Surry | |
| Caswell | Franklin | Madison | Perquimans | | |
| Cherokee | Harnett | McDowell | | | |

### Blue Medicare Enhanced℠ (HMO-POS) H3449-024-003 — Monthly Premium: $45

| | | | | | |
|---|---|---|---|---|---|
| Alleghany | Chowan | Greene | Martin | Robeson | Warren |
| Anson | Cleveland | Halifax | Montgomery | Sampson | Washington |
| Ashe | Columbus | Hertford | Nash | Scotland | Watauga |
| Avery | Duplin | Hyde | Northampton | Stanly | Wayne |
| Beaufort | Edgecombe | Jones | Pamlico | Swain | Wilson |
| Bertie | Gates | Lee | Pender | Tyrrell | |
| Bladen | Graham | Lenoir | Pitt | Vance | |
| Caldwell | Granville | Lincoln | Richmond | | |



Counties where Blue Medicare Enhanced (HMO-POS) is available:

001 002 003

**Blue Medicare Enhanced (HMO-POS) is available in all 100 North Carolina counties.**

**Please note:** To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

H3449-024-001
H3449-024-002
H3449-024-003

| | | | |
|---|---|---|---|
| **Monthly Premium:** | You must also continue to pay your Medicare Part B premium. | 001: | $19 |
| | | 002: | $34 |
| | | 003: | $45 |
| **Deductible:** | These plans have no medical deductible. | | $0 |
| **Annual Maximum Out-of-Pocket Amount:** | Does not include prescription drugs. | 001: | $3,150 |
| | | 002: | $3,150 |
| | | 003: | $3,400 |

| Benefits | What You Should Know | |
|---|---|---|
| **Inpatient Hospital Care:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $335 copay |
| | **Days 6–90:** | $0 copay |
| | **Days 91 and beyond:** | $0 copay |
| **Outpatient Services:*** | **Outpatient Hospital:** Per stay. | $295 copay |
| | **Ambulatory Surgical Center:** | $200 copay |
| **Doctor Visit:** | **Primary:** | $0 copay |
| | **Specialist:** | $15 copay |
| **Preventive Care:** | Any additional preventive services approved by Medicare during the contract year will be covered. | $0 copay |
| **Emergency Care:** | If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. | $135 copay |
| **Urgently Needed Services:** | | $60 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

H3449-024-001
H3449-024-002
H3449-024-003

| Benefits | What You Should Know | | PCP Office | Any Other Setting |
|---|---|---|---|---|
| **Diagnostic Services/ Labs/ Imaging:*** | **Diagnostic Tests and Procedures:** | | $0 copay | $25 copay |
| | **Lab Services:** | | $0 copay | $5 copay |
| | **Diagnostic Radiological Services:** | **MRI, CT and Other Nuclear Medicine:** | $0 copay | Lesser of 20% of cost or $150 copay |
| | | **PET:** | $0 copay | $300 copay |
| | | **All Other Services:** | $0 copay | $75 copay |
| | **Therapeutic Radiological Services:** | | $0 copay | Lesser of 20% of cost or $60 copay |
| | **X-rays:** | | $0 copay | $15 copay |
| **Hearing Services:** | **Medicare-Covered Hearing Exam:** | Exams to diagnose and treat hearing and balance issues. | | $15 copay |
| | **Routine Hearing Exam:** | One per year. Must use designated providers. | | $0 copay |
| | **Hearing Aids:** | One per ear, per year. Must use designated providers. | | $699–$999 copay |
| **Dental Services:** | **Medicare-Covered Dental Services:*** | Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures. | | $15 copay |
| | **Comprehensive and Preventive Dental:** | **$2,000** yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.** | | $0 copay*** |

*May require prior authorization.
**Certain limits apply. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please see the Evidence of Coverage for more information.
***Must use designated providers.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

H3449-024-001
H3449-024-002
H3449-024-003

| Benefits | | What You Should Know | |
|---|---|---|---|
| **Vision Services:** | **Routine Eye and Contact Lens Exams:** | One of each per calendar year. | $15 copay |
| | **Prescription Eyewear Allowance:** | $300 yearly allowance. | $0 copay |
| | **Medicare-Covered Eye Exam:** | For the diagnosis and treatment of illnesses and injuries of the eye. | $15 copay |
| | **Glaucoma Screening and Diabetic Eye Exam:** | For people who are at high risk of glaucoma or have diabetes. | $0 copay |
| | **Eyewear After Cataract Surgery:** | One pair of eyeglasses or one pair of contact lenses. | 20% of cost |
| **Mental Health Services:** | **Inpatient:*** (Cost share applies per day. Benefit period applied per admission.) | **Days 1–5:** | $300 copay |
| | | **Days 6–90:** | $0 copay |
| | **Outpatient:** (Mental health* and substance use.) | Individual and group sessions. | $15 copay |
| **Skilled Nursing Facility:*** | (Cost share applies per day. Benefit period applied per admission.) | **Days 1–20:** | $0 copay |
| | | **Days 21–60:** | $203 copay |
| | | **Days 61–100:** | $0 copay |
| **Outpatient Rehabilitation Services:** | **Physical and Speech Language Therapy:** | | $10 copay |
| | **Occupational Therapy:** | | $10 copay |
| | **Cardiac Rehab Services:** | | $0 copay |
| | **Pulmonary Rehab Services:** | | $20 copay |

*May require prior authorization.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

H3449-024-001
H3449-024-002
H3449-024-003

| Benefits | What You Should Know | |
|---|---|---|
| **Ambulance Services:*** | Covers medically necessary ground and air ambulance services. | $250 copay |
| **Transportation:** | 24 one-way rides to health-related locations. | $0 copay |
| **Medicare Part B Drugs:**** | **Part B Insulins:** 30-day supply. | $35 copay |
| | **Chemotherapy and Other Part B Drugs:** | 0–20% of cost |

## Part D, Prescription Drug Benefit Stages

H3449-024-001
H3449-024-002
H3449-024-003

| | |
|---|---|
| **Annual Deductible:** | **All Tiers:** $0<br>This is the set amount that you pay before your plan begins to pay its share of the cost. Your deductible does not apply to covered insulin products and most adult Part D vaccines. |
| **Initial Coverage Limit (ICL):** | **Begins after you pay your yearly deductible.** You remain in this stage until your costs on covered drugs reach **$5,030**.[1] The amount you pay in this stage is shown in the chart on the next page. |
| **Coverage Gap:** | **Begins when your total year-to-date costs on covered drugs exceed $5,030.** In this stage, you'll pay **25%** of the cost for your drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$8,000**.[2] Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at Preferred pharmacies or a **$1** copayment at Standard (non-preferred) pharmacies. |
| **Catastrophic Coverage:** | **Begins when your total year-to-date costs on covered drugs exceed $8,000.** During this stage, your plan will pay the full cost for your covered Part D drugs. |

*May require prior authorization.
**May require prior authorization. Based on Inflation Reduction Act mandates.
1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
2 Total year-to-date includes drug costs that only you have paid.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

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| Prescription Drug Initial Coverage Limit (ICL) | Preferred Retail Pharmacies | | Preferred Mail Order | Standard (Non-Preferred) Pharmacies | |
|---|---|---|---|---|---|
| | 1-month 30-day supply | 3-months 90-day supply | 3-months 90-day supply | 1-month 30-day supply* | 3-months 90-day supply |
| **Preferred Generic Drugs:** (Tier 1) | $0 copay | $0 copay | $0 copay | $15 copay | $45 copay |
| **Generic Drugs:** (Tier 2) | $6 copay | $18 copay | $0 copay | $20 copay | $60 copay |
| **Preferred Brand Drugs:** (Tier 3) | $45 copay | $135 copay | $90 copay | $47 copay | $141 copay |
| **Non-Preferred Drugs:** (Tier 4) | $99 copay | $297 copay | $198 copay | $100 copay | $300 copay |
| **Specialty Tier Drugs:** (Tier 5) | 33% of cost | N/A | N/A | 33% of cost | N/A |
| **Select Care Drugs:** (Tier 6) | $0 copay | $0 copay | $0 copay | $1 copay | $1 copay |
| **Insulins:** Tier 3: | $35 copay | $105 copay | $90 copay | $35 copay | $105 copay |
| **Insulins:** Tier 4: | $35 copay | $105 copay | $105 copay | $35 copay | $105 copay |

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.
Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.
Note: This chart shows your portion of the costs.

# Summary of Benefits

## BlueMedicare Enhanced℠ (HMO-POS)

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### Other Covered Benefits

| Benefit | What You Should Know | | |
|---|---|---|---|
| **Podiatry Services:** | Foot care. | | $15 copay |
| **Medical Equipment and Supplies:** | **Durable Medical Equipment and Supplies:*** | | 20% of cost |
| | **Diabetic Shoes or Inserts:** | | 20% of cost |
| | **Diabetes Supplies:*** | Preferred Brands | $0 copay |
| | | Non-Preferred Brands** | 20% of cost |
| **Healthy Aging and Exercise Program:** | Must use participating facilities. | | $0 copay*** |
| **Over-the-Counter Products Allowance:** | Must use participating retail locations. Funds do not roll over quarter-to-quarter. | 001: | $105 quarterly |
| | | 002: | $105 quarterly |
| | | 003: | $95 quarterly |
| **Meals Benefit:** | 2 meals per day for 14 days post-discharge. | | $0 copay |
| **Support for Caregivers:** | Support and resources for non-professional caregivers. | | $0 copay |
| **In-Home Assistance:** | 60 hours per year. | | $0 copay |
| **Personal Emergency Response System:** | Wearable device with fast access to emergency services. | | $0 copay |
| **Home Safety Devices:†** | Two devices per year. | | $0 copay |

*May require prior authorization.
**With a medical exception.
***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
† Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.