

BlueMedicare HMO<sup>SM</sup>

# 2016 Summary of Benefits

(Contract H3449, Plans 005, 012, 013, and 016)

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January 1, 2016 - December 31, 2016

Medicare<sup>Rx</sup>  
Prescription Drug Coverage <sup>Rx</sup>

Y0079\_7234 CMS Accepted 08312015  
U5047h, 8/15

PAGE 1 of 36

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BlueCross BlueShield  
of North Carolina

Smart choices for Medicare

# Section I - Introduction to Summary of benefits

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This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Medicare HMO plans**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Medicare HMO plans** cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

## Sections in this booklet

- Things to know about **Blue Medicare HMO plans**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-800-665-8037 (TTY / TDD 1-800-922-3140)**.

## Things to know about Blue Medicare HMO plans

### Hours of operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

### Blue Medicare HMO plans phone numbers and website

- If you are a member of this plan, call toll-free **1-888-310-4110 (TTY / TDD 1-888-451-9957)**.
- If you are not a member of this plan, call toll-free **1-800-665-8037 (TTY / TDD 1-800-922-3140)**.
- Our website: <http://www.bcbsnc.com/medicare>

# Section I - Introduction to **Summary of benefits** (continued)

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## **Who can join?**

To join **Blue Medicare HMO plans**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for **Blue Medicare HMO Medical Only (HMO)** includes the following counties in North Carolina: Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Cabarrus, Caldwell, Carteret, Caswell, Catawba, Chatham, Chowan, Cleveland, Columbus, Cumberland, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Gates, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Johnston, Jones, Lee, Lincoln, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Nash, New Hanover, Northampton, Onslow, Orange, Pamlico, Pender, Perquimans, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Sampson, Scotland, Stanly, Stokes, Surry, Transylvania, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, Yadkin, and Yancey.

Our service area for **Blue Medicare HMO Essential (HMO)** includes the following counties in North Carolina: Alamance, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Wake, Wilkes, and Yadkin.

Our service area for **Blue Medicare HMO Standard (HMO)** includes the following counties in North Carolina: Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Cabarrus, Caldwell, Carteret, Caswell, Catawba, Chatham, Chowan, Cleveland, Columbus, Cumberland, Duplin, Durham, Edgecombe, Franklin, Gaston, Gates, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Johnston, Jones, Lee, Lincoln, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Nash, New Hanover, Northampton, Onslow, Orange, Pamlico, Pender, Perquimans, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Sampson, Scotland, Stanly, Transylvania, Tyrrell, Union, Vance, Warren, Washington, Watauga, Wayne, Wilson, and Yancey.

Our service area for **Blue Medicare HMO Enhanced (HMO)** includes the following counties in North Carolina: Alexander, Alleghany, Ashe, Avery, Beaufort, Bertie, Bladen, Buncombe, Caldwell, Carteret, Catawba, Chatham, Chowan, Cleveland, Columbus, Cumberland, Durham, Edgecombe, Franklin, Gaston, Gates, Granville, Greene, Guilford, Halifax, Haywood, Henderson, Hertford, Hyde, Johnston, Jones, Lee, Madison, Martin, Nash, New Hanover, Northampton, Orange, Pender, Person, Polk, Robeson, Rockingham, Sampson, Scotland, Vance, Warren, Watauga, Wayne, and Yancey.

## Section I - Introduction to **Summary of benefits** (continued)

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### **Which doctors, hospitals and pharmacies can I use?**

**Blue Medicare HMO plans** have a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider directory at our website (<http://www.bcbsnc.com/medicare>).

You can see our plan's pharmacy directory at our website (<https://www.myprime.com/MyRx/MyPrime/MedicareD/pharmacy/BCBSNC>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

### **What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is covered by Original Medicare*.** Some of the extra benefits are outlined in this booklet.

Some **Blue Medicare HMO plans** cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [www.bcbsnc.com/content/medicare/formulary-home.htm](http://www.bcbsnc.com/content/medicare/formulary-home.htm).
- Or, call us and we will send you a copy of the formulary.

## Section I - Introduction to **Summary of benefits** (continued)

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### **How will I determine my drug costs?**

Our plan groups each medication into one of five "tiers" or six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible, if applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about these plans' benefits or costs, please contact Blue Cross and Blue Shield of North Carolina for details.

## Section II – Summary of Benefits

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</b>		
<b>How much is the monthly premium?</b>	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$76.90 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	This plan does not have a deductible.	\$195 per year for Part D prescription drugs.
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$6,700 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$6,700 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

\$38.40 per month. In addition, you must keep paying your Medicare Part B premium.

\$64.70 per month. In addition, you must keep paying your Medicare Part B premium.

This plan does not have a deductible.

This plan does not have a deductible.

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

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

Your yearly limit(s) in this plan:

- \$4,700 for services you receive from in-network providers.

Your yearly limit(s) in this plan:

- \$3,950 for services you receive from in-network providers.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</b>		
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
	Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.	
<b>COVERED MEDICAL AND HOSPITAL BENEFITS</b>		
<p><b>NOTE:</b></p> <ul style="list-style-type: none"> <li>▪ <b>SERVICES WITH A <sup>1</sup>MAY REQUIRE PRIOR AUTHORIZATION.</b></li> </ul>		
<b>OUTPATIENT CARE AND SERVICES</b>		
<b>Acupuncture</b>	Not covered	Not covered
<b>Ambulance<sup>1</sup></b>	\$250 copay Covers medically necessary ambulance services	\$250 copay Covers medically necessary ambulance services
<b>Chiropractic Care</b>	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay

Blue Medicare HMO Standard (HMO) (H3449, Plan 013)	Blue Medicare HMO Enhanced (HMO) (H3449, Plan 005)
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.	
Not covered	Not covered
\$250 copay Covers medically necessary ambulance services	\$150 copay Covers medically necessary ambulance services
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Dental Services<sup>1</sup></b>	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$50 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$50 copay
<b>Diabetes Supplies and Services</b>	Diabetes monitoring supplies: You pay nothing  Diabetes self-management training: You pay nothing  Therapeutic shoes or inserts: 20% of the cost  Covers supplies such as: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors	Diabetes monitoring supplies: You pay nothing  Diabetes self-management training: You pay nothing  Therapeutic shoes or inserts: 20% of the cost  Covers supplies such as: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
<b>Diagnostic Tests, Lab and Radiology Services and X-Rays</b> (Costs for these services may vary based on place of service) <sup>1</sup>	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost  Diagnostic tests and procedures: 20% of the cost  Lab services: 20% of the cost  Outpatient x-rays: 20% of the cost  Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost  If the doctor provides you services in addition to the Outpatient Diagnostics Procedures, Therapeutic Radiology, Tests, Lab Services, a separate doctor visit copay may apply	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost  Diagnostic tests and procedures: 20% of the cost  Lab services: 20% of the cost  Outpatient x-rays: 20% of the cost  Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost  If the doctor provides you services in addition to the Outpatient Diagnostics Procedures, Therapeutic Radiology, Tests, Lab Services, a separate doctor visit copay may apply

Blue Medicare HMO Standard (HMO) (H3449, Plan 013)	Blue Medicare HMO Enhanced (HMO) (H3449, Plan 005)
<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$50 copay</p>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$40 copay</p>
<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Covers supplies such as: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors</p>	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: 20% of the cost</p> <p>Covers supplies such as: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors</p>
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## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Doctor's Office Visits</b>	Primary care physician visit: \$35 copay  Specialist visit: \$50 copay	Primary care physician visit: \$35 copay  Specialist visit: \$50 copay
<b>Durable Medical Equipment</b> <i>(wheelchairs, oxygen, etc.)<sup>1</sup></i>	20% of the cost	20% of the cost
<b>Emergency Care</b>	\$75 copay  If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.  Emergency services are covered worldwide.	\$75 copay  If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.  Emergency services are covered worldwide.
<b>Foot Care</b> <i>(podiatry services)</i>	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues: \$50 copay  In general, supplemental routine hearing exams and hearing aids not covered.	Exam to diagnose and treat hearing and balance issues: \$50 copay  In general, supplemental routine hearing exams and hearing aids not covered.

Blue Medicare HMO Standard (HMO) (H3449, Plan 013)	Blue Medicare HMO Enhanced (HMO) (H3449, Plan 005)
<p>Primary care physician visit: \$15 copay</p> <p>Specialist visit: \$50 copay</p>	<p>Primary care physician visit: You pay nothing</p> <p>Specialist visit: \$40 copay</p>
<p>20% of the cost</p>	<p>20% of the cost</p>
<p>\$75 copay</p> <p>If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>Emergency services are covered worldwide.</p>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>Emergency services are covered worldwide.</p>
<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay</p>	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay</p>
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## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Home Health Care<sup>1</sup></b>	<p>You pay nothing</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Part-time or intermittent skilled nursing and home health aide services</li> <li>▪ Physical therapy, occupational therapy, and speech therapy</li> <li>▪ Medical and social services</li> <li>▪ Medical equipment and supplies</li> </ul>	<p>You pay nothing</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Part-time or intermittent skilled nursing and home health aide services</li> <li>▪ Physical therapy, occupational therapy, and speech therapy</li> <li>▪ Medical and social services</li> <li>▪ Medical equipment and supplies</li> </ul>
<b>Mental Health Care<sup>1</sup></b>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>A benefit period starts anew for each Medicare-approved admission.</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>A benefit period starts anew for each Medicare-approved admission.</p>

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

You pay nothing  
Covered services include, but are not limited to:

- Part-time or intermittent skilled nursing and home health aide services
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

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A benefit period starts anew for each Medicare-approved admission.

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Mental Health Care<sup>1</sup></b> (continued)	<ul style="list-style-type: none"> <li>▪ \$260 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> </ul> Outpatient group therapy visit: \$40 copay Outpatient individual therapy visit: \$40 copay	<ul style="list-style-type: none"> <li>▪ \$260 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> </ul> Outpatient group therapy visit: \$40 copay Outpatient individual therapy visit: \$40 copay
<b>Outpatient Rehabilitation<sup>1</sup></b>	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Occupational therapy visit: \$40 copay Physical therapy and speech and language therapy visit: \$40 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Occupational therapy visit: \$40 copay Physical therapy and speech and language therapy visit: \$40 copay
<b>Outpatient Substance Abuse<sup>1</sup></b>	Group therapy visit: \$40 copay Individual therapy visit: \$40 copay	Group therapy visit: \$40 copay Individual therapy visit: \$40 copay
<b>Outpatient Surgery<sup>1</sup></b>	Ambulatory surgical center: \$195 copay Outpatient hospital: \$195 copay	Ambulatory surgical center: \$195 copay Outpatient hospital: \$195 copay
<b>Over-the-Counter Items</b>	Not Covered	Not Covered
<b>Prosthetic Devices</b> <i>(braces, artificial limbs, etc.)<sup>1</sup></i>	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost

Blue Medicare HMO Standard (HMO) (H3449, Plan 013)	Blue Medicare HMO Enhanced (HMO) (H3449, Plan 005)
<ul style="list-style-type: none"> <li>▪ \$260 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>	<ul style="list-style-type: none"> <li>▪ \$250 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>
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<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>	<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>
<p>Ambulatory surgical center: \$195 copay</p> <p>Outpatient hospital: \$195 copay</p>	<p>Ambulatory surgical center: \$125 copay</p> <p>Outpatient hospital: \$125 copay</p>
<p>Not Covered</p>	<p>Not Covered</p>
<p>Prosthetic devices: 20% of the cost</p> <p>Related medical supplies: 20% of the cost</p>	<p>Prosthetic devices: 20% of the cost</p> <p>Related medical supplies: 20% of the cost</p>

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Renal Dialysis</b>	20% of the cost	20% of the cost
<b>Transportation</b>	Not covered	Not covered
<b>Urgently Needed Services</b>	\$65 copay	\$65 copay
<b>Vision Services</b>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service</p> <p>Routine eye exam (for up to 1): \$40 copay</p> <p>Our plan pays up to \$100 for routine eye exams.</p> <p>Eyeglasses or contact lenses after cataract surgery: 20% of the cost</p> <p>One routine eye exam every 12 months</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service</p> <p>Routine eye exam (for up to 1): \$40 copay</p> <p>Our plan pays up to \$100 for routine eye exams.</p> <p>Eyeglasses or contact lenses after cataract surgery: 20% of the cost</p> <p>One routine eye exam every 12 months</p>
<b>Preventive Care</b>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> </ul>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> </ul>

Blue Medicare HMO Standard (HMO) (H3449, Plan 013)	Blue Medicare HMO Enhanced (HMO) (H3449, Plan 005)
20% of the cost	20% of the cost
Not covered	Not covered
\$65 copay	\$40 copay
<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service</p> <p>Routine eye exam (for up to 1): \$40 copay</p> <p>Our plan pays up to \$100 for routine eye exams.</p> <p>Eyeglasses or contact lenses after cataract surgery: 20% of the cost</p> <p>One routine eye exam every 12 months</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service</p> <p>Routine eye exam (for up to 1): \$40 copay</p> <p>Our plan pays up to \$100 for routine eye exams.</p> <p>Eyeglasses or contact lenses after cataract surgery: 20% of the cost</p> <p>One routine eye exam every 12 months</p>
<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> </ul>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> </ul>

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>OUTPATIENT CARE AND SERVICES (continued)</b>		
<b>Preventive Care (continued)</b>	<ul style="list-style-type: none"> <li>▪ Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>▪ "Welcome to Medicare" preventive visit (one-time)</li> <li>▪ Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> <li>▪ Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>▪ "Welcome to Medicare" preventive visit (one-time)</li> <li>▪ Yearly "Wellness" visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Hospice</b>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p> <p>Hospice is covered outside of our plan. Please contact us for more details.</p>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p> <p>Hospice is covered outside of our plan. Please contact us for more details.</p>

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
  
- Obesity screening and counseling
  
- Prostate cancer screenings (PSA)
  
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
  
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
  
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
  
- Obesity screening and counseling
  
- Prostate cancer screenings (PSA)
  
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
  
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
  
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Hospice is covered outside of our plan. Please contact us for more details.

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Hospice is covered outside of our plan. Please contact us for more details.

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care<sup>1</sup></b>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>▪ \$295 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> <li>▪ You pay nothing per day for days 91 and beyond</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>A benefit period starts anew for each Medicare-approved admission.</p>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>▪ \$295 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> <li>▪ You pay nothing per day for days 91 and beyond</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>A benefit period starts anew for each Medicare-approved admission.</p>
<b>Inpatient Mental Health Care</b>	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>▪ You pay nothing per day for days 1 through 20</li> <li>▪ \$75 copay per day for days 21 through 49</li> <li>▪ \$100 copay per day for days 50 through 100</li> </ul> <p>A benefit period starts anew for each Medicare-approved admission.</p>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>▪ You pay nothing per day for days 1 through 20</li> <li>▪ \$75 copay per day for days 21 through 49</li> <li>▪ \$100 copay per day for days 50 through 100</li> </ul> <p>A benefit period starts anew for each Medicare-approved admission.</p>

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

Our plan covers an unlimited number of days for an inpatient hospital stay.

- \$295 copay per day for days 1 through 6
- You pay nothing per day for days 7 through 90
- You pay nothing per day for days 91 and beyond

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

A benefit period starts anew for each Medicare-approved admission.

Our plan covers an unlimited number of days for an inpatient hospital stay.

- \$275 copay per day for days 1 through 6
- You pay nothing per day for days 7 through 90
- You pay nothing per day for days 91 and beyond

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

A benefit period starts anew for each Medicare-approved admission.

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Our plan covers up to 100 days in a SNF.

- You pay nothing per day for days 1 through 20
- \$75 copay per day for days 21 through 49
- \$100 copay per day for days 50 through 100

A benefit period starts anew for each Medicare-approved admission.

Our plan covers up to 100 days in a SNF.

- You pay nothing per day for days 1 through 20
- \$75 copay per day for days 21 through 49
- \$100 copay per day for days 50 through 100

A benefit period starts anew for each Medicare-approved admission.

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)																								
<b>PRESCRIPTION DRUG BENEFITS</b>																										
<b>How much do I pay?</b>	<p>For Part B drugs such as chemotherapy drugs: 20% of the cost</p> <p>Other Part B drugs: 20% of the cost</p> <p>Our plan does not cover Part D prescription drugs.</p>	<p>For Part B drugs such as chemotherapy drugs: 20% of the cost</p> <p>Other Part B drugs: 20% of the cost</p>																								
<b>Initial Coverage</b>		<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p><b>Preferred Retail Cost-Sharing</b></p> <table border="1" data-bbox="914 1171 1619 1854"> <thead> <tr> <th data-bbox="914 1171 1092 1276">Tier</th> <th data-bbox="1092 1171 1268 1276">One-month supply</th> <th data-bbox="1268 1171 1446 1276">Two-month supply</th> <th data-bbox="1446 1171 1619 1276">Three-month supply</th> </tr> </thead> <tbody> <tr> <td data-bbox="914 1276 1092 1388">Tier 1 (Preferred Generic)</td> <td data-bbox="1092 1276 1268 1388">\$3 copay</td> <td data-bbox="1268 1276 1446 1388">\$6 copay</td> <td data-bbox="1446 1276 1619 1388">\$9 copay</td> </tr> <tr> <td data-bbox="914 1388 1092 1486">Tier 2 (Generic)</td> <td data-bbox="1092 1388 1268 1486">\$6 copay</td> <td data-bbox="1268 1388 1446 1486">\$12 copay</td> <td data-bbox="1446 1388 1619 1486">\$18 copay</td> </tr> <tr> <td data-bbox="914 1486 1092 1598">Tier 3 (Preferred Brand)</td> <td data-bbox="1092 1486 1268 1598">\$40 copay</td> <td data-bbox="1268 1486 1446 1598">\$80 copay</td> <td data-bbox="1446 1486 1619 1598">\$120 copay</td> </tr> <tr> <td data-bbox="914 1598 1092 1745">Tier 4 (Non-Preferred Brand)</td> <td data-bbox="1092 1598 1268 1745">\$80 copay</td> <td data-bbox="1268 1598 1446 1745">\$160 copay</td> <td data-bbox="1446 1598 1619 1745">\$240 copay</td> </tr> <tr> <td data-bbox="914 1745 1092 1854">Tier 5 (Specialty Tier)</td> <td data-bbox="1092 1745 1268 1854">25% of the cost</td> <td data-bbox="1268 1745 1446 1854">25% of the cost</td> <td data-bbox="1446 1745 1619 1854">25% of the cost</td> </tr> </tbody> </table>	Tier	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay	Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay	Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay	Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay	Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost
Tier	One-month supply	Two-month supply	Three-month supply																							
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**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

For Part B drugs such as chemotherapy drugs:  
20% of the cost

Other Part B drugs: 20% of the cost

For Part B drugs such as chemotherapy drugs:  
20% of the cost

Other Part B drugs: 20% of the cost

You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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

**Preferred Retail Cost-Sharing**

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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

**Preferred Retail Cost-Sharing**

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)			
<b>PRESCRIPTION DRUG BENEFITS (continued)</b>					
<b>Initial Coverage</b> (continued)		<b>Standard Retail Cost-Sharing</b>			
		<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
		Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
		Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
		Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
		Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
		Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

**Standard Retail Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

**Standard Retail Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$5 copay	\$10 copay	\$15 copay

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)			
<b>PRESCRIPTION DRUG BENEFITS (continued)</b>					
<b>Initial Coverage</b> (continued)		<b>Preferred Mail Order Cost-Sharing</b>			
		<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
		Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
		Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
		Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
		Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
		Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

**Preferred Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

**Preferred Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
Tier 4 (Non-Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)			
<b>PRESCRIPTION DRUG BENEFITS (continued)</b>					
<b>Initial Coverage</b> (continued)		<b>Standard Mail Order Cost-Sharing</b>			
		<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
		Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
		Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
		Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
		Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
		Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost
		<p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>			

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

**Standard Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
Tier 5 (Specialty Tier)	25% of the cost	25% of the cost	25% of the cost

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

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

**Standard Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
Tier 4 (Non-Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$5 copay	\$10 copay	\$15 copay

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

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

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare HMO Medical Only (HMO) (H3449, Plan 012)	Blue Medicare HMO Essential (HMO) (H3449, Plan 016)
<b>PRESCRIPTION DRUG BENEFITS (continued)</b>		
<b>Coverage Gap</b> (continued)		
<b>Catastrophic Coverage</b>		<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copay for all other drugs.</li> </ul>

**Blue Medicare HMO  
Standard (HMO)  
(H3449, Plan 013)**

**Blue Medicare HMO  
Enhanced (HMO)  
(H3449, Plan 005)**

**Preferred Mail Order Cost-Sharing**

<b>Tier</b>	<b>Drugs Covered</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	All	\$3 copay	\$6 copay	\$9 copay

**Standard Mail Order Cost-Sharing**

<b>Tier</b>	<b>Drugs Covered</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	All	\$8 copay	\$16 copay	\$24 copay

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:

- 5% of the cost, or
- \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copay for all other drugs.

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:

- 5% of the cost, or
- \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copay for all other drugs.



## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-665-8037. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-665-8037. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-665-8037。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-665-8037。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-665-8037. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-665-8037. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-665-8037. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-665-8037. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-665-8037 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

## Multi-language Interpreter Services *(continued)*

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-665-8037. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-665-8037. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-665-8037 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-665-8037. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-665-8037. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-665-8037. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-665-8037. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため、無料の通訳サービスがあります。通訳をご用命になるには、1-800-665-8037にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

Blue Cross and Blue Shield of North Carolina (BCBSNC) is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.