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

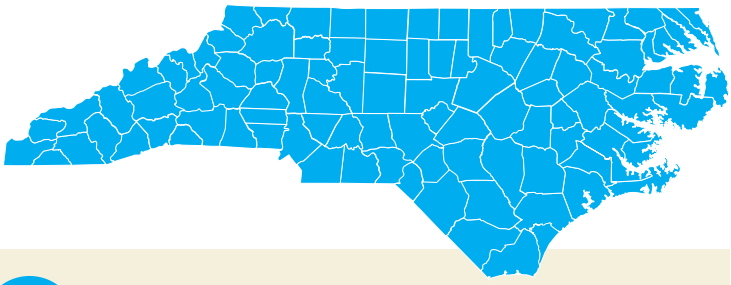
Summary of Benefits

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

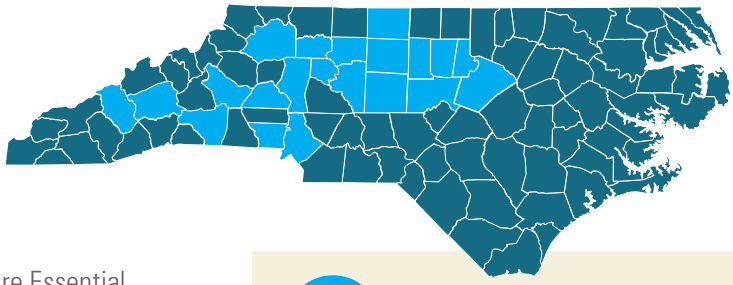
Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.

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 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

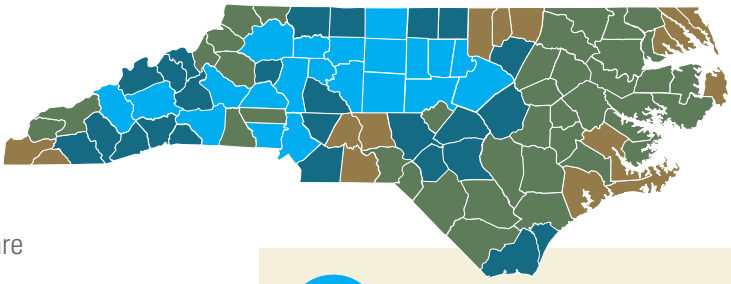
Alexander	Franklin	Johnston	Mitchell	Polk	Transylvania
Brunswick	Harnett	Macon	Moore	Rowan	Union
Cabarrus	Henderson	Madison	New Hanover	Stokes	Yancey
Caswell	Hoke	McDowell	Person	Surry	
Cumberland	Jackson				

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.

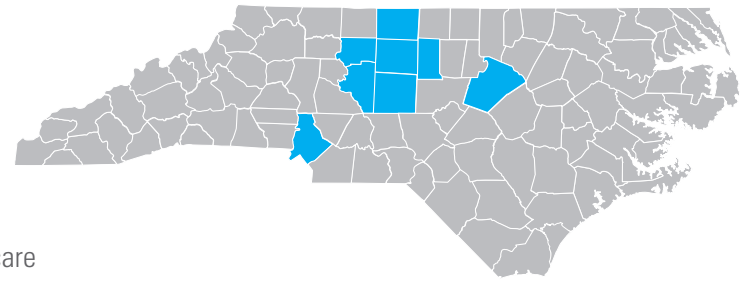
Summary of Benefits

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 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

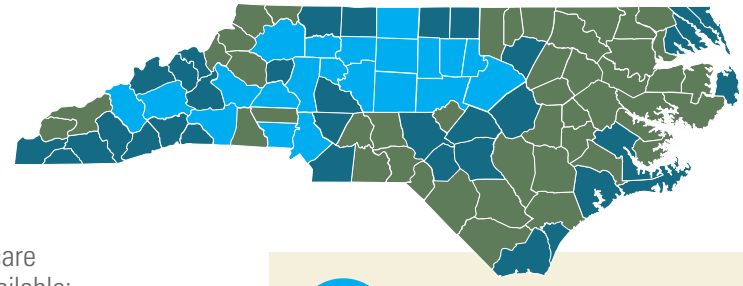
Alamance	Chatham	Forsyth	Iredell	Rockingham	Wilkes
Buncombe	Davidson	Gaston	Mecklenburg	Rutherford	Yadkin
Burke	Davie	Guilford	Orange	Wake	
Catawba	Durham	Haywood	Randolph		

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 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)

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

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)

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

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.