### **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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#### **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 P	remium: \$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	



**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.



Blue Medicare 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:*	Days 1–5:	\$295 copay		
(Cost share applies per day. Benefit period applied	Days 6–90:	\$0 copay		
per admission.)	Days 91 and beyond:	\$0 copay		
Outpatient Services:*	Outpatient Hospital: Per stay.	\$275 copay		
Outpatient Services.	Ambulatory Surgical Center:	\$225 copay		
Doctor Visit:	Primary:	\$0 copay		
Doctor visit.	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		



Blue Medicare Medical Only**(HMO-POS) H3449-012				
Benefits	What You Should Kr	What You Should Know		
	Diagnostic Tests and	l Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
Imaging:*		All Other Services:	ther Services: \$0 copay	\$75 copay
	Therapeutic Radiolo	gical Services:	\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.	\$25 copay	
Hearing Services:	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.		
	Comprehensive and Preventive Dental:**	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.	\$0 copay***	

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>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.

<sup>\*\*\*</sup>Must use designated providers.



BlueMedicare	Medical Only (нмо-роз		H3449-012
Benefits		What You Should Know	
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$25 copay
	Prescription Eyewear Allowance:	\$300 yearly allowance.	\$0 copay
Vision Services:	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
	Inpatient:* (Cost share	Days 1–5:	\$295 copay
Mental Health Services:	applies per day. Benefit period applied per admission.)	Days 6-90:	\$0 copay
	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$25 copay
Skilled	(Coat abara applica par day	Days 1–20:	\$0 copay
Nursing	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay
Facility:*	auriission./	Days 61–100:	\$0 copay
	Physical and Speech Langua	\$25 copay	
Outpatient Rehabilitation	Occupational Therapy:		\$25 copay
Services:	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 Insulins: 30-day supply.		\$35 copay
Part B	Tart billisums. 30-day supp	. 7 .	, , , , , , , , , , , , , , , , , , , ,

<sup>\*</sup>May require prior authorization.

\*\*May require prior authorization. Based on Inflation Reduction Act mandates.

Note: This chart shows your portion of the costs.



Blue Medicare Medica	H3449-012					
Other Covered Benefits						
Benefit	What You Should Kn	ow				
Podiatry Services:	Foot care.		\$25 copay			
	Durable Medical Equi and Supplies:*	ipment	20% of cost			
Medical Equipment	Diabetic Shoes or Inserts:		20% of cost			
and Supplies:	Diabetes Supplies:*	Preferred Brands	\$0 copay			
		Non-Preferred Brands**	20% of cost			
Healthy Aging and Exercise Program:	Must use participating	Must use participating facilities.				
Over-the-Counter Products Allowance:		Must use participating retail locations. Funds do not roll over quarter-to-quarter.				
Meals Benefit:	Two meals per day for 1 post-discharge.	4 days	\$0 copay			
Support for Caregivers:		Support and resources for non-professional caregivers.				
In-Home Assistance:	60 hours per year.	\$0 copay				
Personal Emergency Response System:	Wearable device with to emergency services	\$0 copay				
Home Safety Devices:	Two devices per year.		\$0 copay			

<sup>\*</sup>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.



#### **Plan Offering and Premium by County**

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

<b>Blue</b> Medicare Essential (HMO)		l <sup>™</sup> (HMO)	H3449-027-001	Monthly Pre	mium: \$0
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin
<b>Blue</b> Med	icare Essentia	l <sup>™</sup> (HMO)	H3449-027-002	Monthly Pre	mium: \$0
Alexander Alleghany Anson Ashe Avery Beaufort Bertie Bladen Brunswick Cabarrus Caldwell Camden Carteret Caswell	Cherokee Chowan Clay Cleveland Columbus Craven Cumberland Currituck Dare Duplin Edgecombe Franklin Gates Graham	Granville Greene Halifax Harnett Henderson Hertford Hoke Hyde Jackson Johnston Jones Lee Lenoir Lincoln	Macon Madison Martin McDowell Mitchell Montgomery Moore Nash New Hanover Northampton Onslow Pamlico Pasquotank Pender	Perquimans Person Pitt Polk Richmond Robeson Rowan Sampson Scotland Stanly Stokes Surry Swain Transylvania	Tyrrell Union Vance Warren Washington Watauga Wayne Wilson Yancey
Counties where E (HMO) is available	Blue Medicare Essential e:	100		Essential (HMO) Carolina countie	

**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.



Blue Medicare Essential (HMO) H3449-				
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	<b>)</b> .	\$0	
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs		\$8,300	
Benefits	What You Should Know			
Inpatient Hospital Care:*	Days 1–5:		\$335 copay	
(Cost share applies per day. Benefit period applied	Days 6–90:	\$0 copay		
per admission.)	Days 91 and beyond:		\$0 copay	
	Outration the suitable Day store	001:	\$295 copay	
Outpatient Services:*	Outpatient Hospital: Per stay.	002:	\$345 copay	
	Ambulatory Surgical Center:		\$275 copay	
	Primary:	001:	\$5 copay	
Doctor Visit:		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	



<b>Blue</b> Medi		H3449-027-001 H3449-027-002		
Benefits		What You Should Know	PCP Office	Any Other Setting
	Diagnostic Tests ar	nd Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
lmaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiol	ogical Services:	\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.	\$45 copay	
Hearing Services:	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.	\$4	5 copay
	Preventive Dental:	Oral exams, cleanings, X-rays and screenings.**	\$0 copay	

<sup>\*</sup>May require prior authorization.

\*\*Certain limits apply. Must use designated providers.

Note: This chart shows your portion of the costs.



Blue Medica	are Essential <sup>™</sup> (HMO)	What You Should Know	H3449-027-001 H3449-027-002
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$25 copay
	Prescription Eyewear Allowance:	\$100 yearly allowance.	\$0 copay
Vision Services:	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
	Inpatient:* (Cost share applies per	Days 1–5:	\$300 copay
Mental Health	day. Benefit period applied per admission.)	Days 6–90:	\$0 copay
Services:	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$40 copay
Olella I		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay
1 00		Days 61–100:	\$0 copay
	Physical and Speech Language Therapy:		\$25 copay
Outpatient Rehabilitation	Occupational Therapy:		\$25 copay
Services:	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Services:		\$15 copay



Blue Medicar Benefits	re Essential <sup>™</sup> (HMO)  What You Should Know	H3449-027-001 H3449-027-002
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:		Not covered
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

R Part D, Pre	escription Drug Benefit Stages	H3449-027-001 H3449-027-002		
	<b>Tiers 1, 2, 3 and 6</b> : \$0 <b>Tiers 4 and 5</b> : \$375			
Annual Deductible:	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):	<b>Begins after you pay your yearly deductible.</b> 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:	<b>Begins when your total year-to-date costs on cover</b> \$5,030. In this stage, you'll pay 25% of the cost for you dispensing and administration fees, until your total yea \$8,000.2 Tier 6 drugs are fully covered in the Coverage copayment at Preferred pharmacies or a \$3 copayment (non-preferred) pharmacies.	ur drugs, excluding r-to-date costs reach Gap; there's a <b>\$0</b>		
Catastrophic Coverage:	<b>Begins when your total year-to-date costs on cover \$8,000.</b> During this stage, your plan will pay the full corport D drugs.	_		

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>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.

<sup>2</sup> Total year-to-date includes drug costs that only you have paid. Note: This chart shows your portion of the costs.



#### Blue Medicare Essential (HMO)

H3449-027-001 H3449-027-002

	iption Drug Coverage ICL)		d Retail nacies	Preferred Mail Order	(Non-Pr	dard referred) nacies
		<b>1-month</b> 30-day supply	<b>3-months</b> 90-day supply	<b>3-months</b> 90-day supply	<b>1-month</b> 30-day supply*	<b>3-months</b> 90-day supply
Preferred G	eneric Drugs:	\$0	\$0	\$0	\$15	\$45
(Tier 1)		copay	copay	copay	copay	copay
Generic Dru	gs:	\$6	\$18	\$0	\$20	\$60
(Tier 2)		copay	copay	copay	copay	copay
Preferred Bi	rand Drugs:	\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferr	ed Drugs:	\$99	\$297	\$198	\$100	\$300
(Tier 4)		copay	copay	copay	copay	copay
Specialty Ti (Tier 5)	er Drugs:	27% of cost	N/A	N/A	27% of cost	N/A
Select Care	Drugs:	\$0	\$0	\$0	\$3	\$3
(Tier 6)		copay	copay	copay	copay	copay
Insulins:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
ilisulliis.	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

<sup>\*</sup>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.



Blue Medicare Esser	H3449-027-001 H3449-027-002					
Other Covered Benefits						
Benefit	What You Should Kn	ow				
Podiatry Services:	Foot care.		\$45 copay			
	Durable Medical Equi and Supplies:*	pment	20% of cost			
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:		20% of cost			
and Supplies.	Dichetee Supplies:*	Preferred Brands	\$0 copay			
	Diabetes Supplies:*	Non-Preferred Brands**	20% of cost			
Healthy Aging and Exercise Program:	Must use participating t	facilities.	\$0 copay***			
Meals Benefit:	Two meals per day for post-discharge.	Two meals per day for 14 days post-discharge.				
Support for Caregivers:		Support and resources for non-professional caregivers.				
Personal Emergency Response System:	Wearable device with to emergency services		\$0 copay			
Home Safety Devices: <sup>†</sup>	Two devices per year.		\$0 сорау			

<sup>\*</sup>May require prior authorization.
\*\*With a medical exception.

<sup>\*\*\*</sup>This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.

**<sup>†</sup>** Devices must be ordered from approved product list using designated provider.



#### **Plan Offerings and Premiums by County**

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

BlueMedi	care Essentia	l Plus⁵(HMO-P¢	OS) <b>H3449-023-00</b>	1 Monthly Pr	emium: \$0
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin
<b>Blue</b> Medi	care Essentia	l Plus (HMO-PC	OS) <b>H3449-023-00</b>	2 Monthly Pr	emium: \$0
Alexander Brunswick Cabarrus Caswell Cumberland	Franklin Harnett Henderson Hoke Jackson	Johnston Macon Madison McDowell	Mitchell Moore New Hanover Person	Polk Rowan Stokes Surry	Transylvania Union Yancey
<b>Blue</b> Medi	care Essentia	I Plus <sup>™</sup> (HMO-P¢	OS) <b>H3449-023-00</b> 4	4 Monthly Pr	emium: \$0
Anson Camden	Cherokee Clay	Currituck Dare	Montgomery Onslow	Perquimans Stanly	Vance Warren
Carteret	Craven	Granville	Pasquotank		
Carteret			Pasquotank DS) <b>H3449-023-00</b> !	Monthly Pr	emium: \$0
Carteret			·	Richmond Robeson Sampson Scotland Swain Tyrrell	emium: \$0 Washingtor Watauga Wayne Wilson
Blue Media Alleghany Ashe Avery Beaufort Bertie Bladen	Chowan Cleveland Columbus Duplin Edgecombe Gates Graham	Greene Halifax Hertford Hyde Jones Lee	Lincoln Martin Nash Northampton Pamlico Pender Pitt	Richmond Robeson Sampson Scotland Swain	Washingtor Watauga Wayne

**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.



Blue Medicare Essen	ntial Plus <sup>™</sup> (нмо-роѕ)	H3 H3	3449-023-001 3449-023-002 3449-023-004 3449-023-005
Monthly Premium:	You must also continue to pay your Medicare Part B premium.		\$0
Deductible:	These plans have no medical deductible.		\$0
Annual Maximum	Does not include prescription drugs.	001: 002:	\$3,500
Out-of-Pocket:	, , ,	004: 005:	\$4,900
Benefits	What You Should Know		
Inpatient Hospital Care:*	Days 1–5:		\$335 copay
(Cost share applies per day. Benefit period applied	Days 6-90:		\$0 copay
per admission.)	Days 91 and beyond:	\$0 copay	
Outpotiont Somiogo:*	Outpatient Hospital: Per stay.		\$295 copay
Outpatient Services:*	Ambulatory Surgical Center:		\$275 copay
	Primary:		\$0 copay
Doctor Visit:	Specialist:		\$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	s:		\$60 copay



#### Blue Medicare 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 Tests and Procedures:		\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic Services/	Diagnostic Dayled and a second			Lesser of 20% of cost or \$150 copay
Labs/ Imaging:*	Radiological Services:	PET:	\$0 copay	\$300 copay
imaging.		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiolog	gical Services:	\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:	X-rays:		\$15 copay
	Medicare-Covered	Exams to diagnose and treat	001: 002:	\$15 copay
Hearing	Hearing Exam:	hearing and balance issues.	004: 005:	\$25 copay
Services:	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
	Medicare-Covered	Medicare may pay for certain services when you're in a	001: 002:	\$15 copay
Dental	Dental Services:*	hospital and need emergency or complicated dental procedures.	004: 005:	\$25 copay
Services:	Comprehensive and Preventive Dental:	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.**		\$0 copay***

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>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.

<sup>\*\*\*</sup>Must use designated providers.



Blue Medica  Benefits	#3449-023-001 #3449-023-002 #3449-023-004 What You Should Know #3449-023-005					
	Routine Eye and	One of each per	001: 002:	\$15 copay		
	Contact Lens Exams:	calendar year.	004: 005:	\$25 copay		
	Prescription Eyewear Allowance	\$300 yearly allowance.		\$0 copay		
Vision Services:	Medicare-Covered	For the diagnosis and treatment of illnesses	001: 002:	\$15 copay		
Sei vices.	Eye Exam:	and injuries of the eye.	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:			20% of cost		
	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:		\$300 copay		
Mental		Days 6–90:		\$0 copay		
Health		Individual and	001:	4		
Services:	Outpatient: (Mental health* and		002:	\$15 copay		
	<b>Outpatient:</b> (Mental health* and substance use.)	Individual and group sessions.	002: 004: 005:	\$15 copay \$25 copay		
Services:	(Mental health* and substance use.)		004:			
Services: Skilled Nursing	(Mental health* and substance use.)  (Cost share applies per day. Benefit period	group sessions.	004:	\$25 copay		
Services:	(Mental health* and substance use.)  (Cost share applies per	group sessions.  Days 1–20:	004:	\$25 copay \$0 copay		
Services: Skilled Nursing	(Mental health* and substance use.)  (Cost share applies per day. Benefit period	group sessions.  Days 1–20:  Days 21–60:  Days 61–100:	004:	\$25 copay \$0 copay \$203 copay		
Services:  Skilled Nursing Facility:*	(Mental health* and substance use.)  (Cost share applies per day. Benefit period applied per admission.)	group sessions.  Days 1–20:  Days 21–60:  Days 61–100:	004:	\$25 copay \$0 copay \$203 copay \$0 copay		
Services:  Skilled Nursing Facility:*	(Mental health* and substance use.)  (Cost share applies per day. Benefit period applied per admission.)  Physical and Speech Lar	group sessions.  Days 1–20:  Days 21–60:  Days 61–100:  nguage Therapy:	004:	\$25 copay \$0 copay \$203 copay \$0 copay \$10 copay		



Blue Medicare Benefits	Essential Plus (HMO-POS)  What You Should Know	H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
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	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0-20% of cost

R Part D, Pre	escription Drug Benefit Stages	H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
	Tiers 1, 2, 3 and 6: \$0 Tiers 4 and 5:	\$150
Annual Deductible:	This is the set amount that you pay before you share of the cost. Your deductible does not approducts and most adult Part D vaccines.	
Initial Coverage Limit (ICL):	Begins after you pay your yearly deductible until your costs on covered drugs reach \$5,030 this stage is shown in the chart on the next page.	.1 The amount you pay in
Coverage Gap:	<b>Begins when your total year-to-date costs o \$5,030.</b> In this stage, you'll pay <b>25</b> % of the cost excluding dispensing and administration fees, costs reach <b>\$8,000</b> . <sup>2</sup> Tier 6 drugs are fully cove there's a <b>\$0</b> copayment at Preferred pharmacies Standard (non-preferred) pharmacies.	et of your drugs, until your total year-to-date red in the Coverage Gap;
Catastrophic Coverage:	<b>Begins when your total year-to-date costs o \$8,000.</b> During this stage, your plan will pay the Part D drugs.	<u> </u>
. ,	Part D drugs.	

<sup>\*</sup>May require prior authorization.
\*\*May require prior authorization. Based on Inflation Reduction Act mandates.

<sup>1</sup> 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.



#### Blue Medicare 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	
		<b>1-month</b> 30-day supply	<b>3-months</b> 90-day supply	<b>3-months</b> 90-day supply	<b>1-month</b> 30-day supply*	<b>3-months</b> 90-day supply
Preferred Ge (Tier 1)	eneric Drugs:	\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Generic Drug (Tier 2)	gs:	\$6 copay	\$18 copay	\$0 copay	\$20 copay	\$60 copay
Preferred Bra (Tier 3)	and Drugs:	\$45 copay	\$135 copay	\$90 copay	\$47 copay	\$141 copay
Non-Preferre	ed Drugs:	\$99 copay	\$297 copay	\$198 copay	\$100 copay	\$300 copay
Specialty Tie (Tier 5)	er Drugs:	30% of cost	N/A	N/A	30% of cost	N/A
Select Care I (Tier 6)	Drugs:	\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
mounns.	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

<sup>\*</sup>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.



Other Covered Benefits         Benefit       What You Should Know         Podiatry Services:       Foot care.         Foot care.       001: 002: 002: 002: 002: 004: 005: 005: 005: 005: 005: 005: 005
Podiatry Services: Foot care.  Foot care.  Durable Medical Equipment  20% of cost
Durable Medical Equipment 30% of cost
and Supplies:*
Medical Diabetic Shoes or Equipment Inserts:
and Supplies:  Diabetes  Preferred Brands \$0 copay
Supplies:* Non-Preferred Brands** 20% of cost
Healthy Aging and Exercise Program:  Must use participating facilities.  \$0 copay***
001: \$120 quarterl
Over-the-Counter Must use participating retail locations.  002: \$95 quarterly
Products Allowance: Funds do not roll over quarter-to-quarter. 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: <sup>†</sup> Two devices per year. \$0 copay

<sup>\*</sup>May require prior authorization.

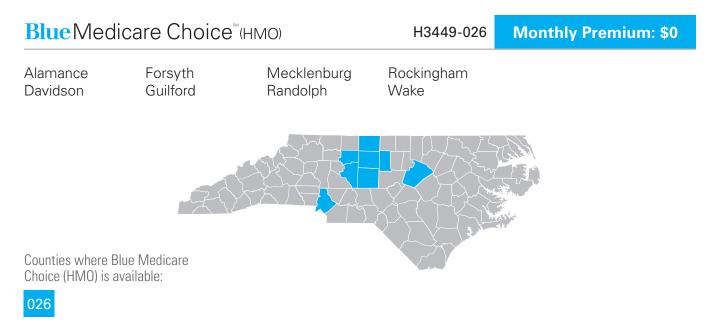
\*\*With a medical exception.

\*\*\*This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.

**<sup>†</sup>** Devices must be ordered from approved product list using designated provider.



#### **Plan Offering and Premium by County**



**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.



<b>Blue</b> Medicare Choice <sup>™</sup> (H	MO)	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:*	Days 1–5:	\$295 copay
(Cost share applies per day. Benefit period applied	Days 6–90:	\$0 copay
per admission.)	Days 91 and beyond:	\$0 copay
Outpatient Services:*	Outpatient Hospital: Per stay.	\$295 copay
Outpatient Services.	Ambulatory Surgical Center:	\$275 copay
Doctor Visit:	Primary:	\$0 copay
Doctor Visit.	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



#### **Blue** Medicare Choice (HMO)

H3449-026

Benefits		What You Should Know	PCP Office	Any Other Setting
	Diagnostic Tests ar	nd Procedures:	\$0 copay	\$15 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
lmaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiol	ogical Services:	\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat halance issues.	nearing and	\$10 copay
Hearing Services:	Routine Hearing Exam:	One per year. Must use desig	nated providers	. \$0 сорау
	Hearing Aids:	One per ear, per year. Must us providers.	se designated	\$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
Services:	Preventive Dental:	Oral exams, cleanings, X-rays screenings.**	and	\$0 copay

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



<b>Blue</b> Medica	are Choice <sup>®</sup> (HMO)		H3449-026
Benefits		What You Should Know	
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$10 copay
	Prescription Eyewear Allowance:	\$200 yearly allowance.	\$0 copay
Vision Services:	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
	Inpatient:* (Cost share applies per	Days 1–5:	\$295 copay
Mental Health	day. Benefit period applied per admission.)	Days 6-90:	\$0 copay
Services:	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$10 copay
OL:U. A		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21-60:	\$203 copay
i domey.		Days 61–100:	\$0 copay
	Physical and Speech Lang	uage Therapy:	\$10 copay
Outpatient Rehabilitation	Occupational Therapy:		\$10 copay
Services:	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Service	es:	\$20 copay



Blue Medicare  Benefits	H3449-026	
Delicits	What You Should Know	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:		Not Covered
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

R Part D, Pre	escription Drug Benefit Stages H3449-026			
	All Tiers: \$0			
Annual Deductible:	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):	<b>Begins after you pay your yearly deductible.</b> 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:	<b>Begins when your total year-to-date costs on covered drugs exceed \$5,030.</b> 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 <b>\$8,000</b> . <sup>2</sup> Tier 6 drugs are fully covered in the Coverage Gap; there's a <b>\$0</b> copayment at Preferred pharmacies or a <b>\$3</b> copayment at Standard (non-preferred) pharmacies.			
Catastrophic Coverage:	<b>Begins when your total year-to-date costs on covered drugs exceed \$8,000.</b> During this stage, your plan will pay the full cost for your covered Part D drugs.			

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>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.

<sup>2</sup> Total year-to-date includes drug costs that only you have paid. Note: This chart shows your portion of the costs.



### **Blue** Medicare Choice (HMO)

H3449-026

	iption Drug Coverage ICL)		d Retail nacies	Preferred Mail Order	Standard (Non-Preferred) Pharmacies	
		<b>1-month</b> 30-day supply	<b>3-months</b> 90-day supply	<b>3-months</b> 90-day supply	<b>1-month</b> 30-day supply*	<b>3-months</b> 90-day supply
Preferred Go	eneric Drugs:	\$0	\$0	\$0	\$15	\$45
(Tier 1)		copay	copay	copay	copay	copay
Generic Dru	gs:	\$6	\$18	\$0	\$20	\$60
(Tier 2)		copay	copay	copay	copay	copay
Preferred Br	rand Drugs:	\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferred Drugs:		\$99	\$297	\$198	\$100	\$300
(Tier 4)		copay	copay	copay	copay	copay
Specialty Tier Drugs: (Tier 5)		33% of cost	N/A	N/A	33% of cost	N/A
Select Care	Drugs:	\$0	\$0	\$0	\$3	\$3
(Tier 6)		copay	copay	copay	copay	copay
Insulins:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
	Tier 4:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay

<sup>\*</sup>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.



Blue Medicare Choice	H3449-026						
Other Covered Benefits	Other Covered Benefits						
Benefit	What You Should	d Know					
Podiatry Services:	Foot care.		\$10 copay				
	Durable Medical and Supplies:*	Equipment	20% of cost				
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:						
ана вариев.	Diabetes Supplies:*	Preferred Brands	\$0 copay				
		Non-Preferred Brands**	20% of cost				
Healthy Aging and Exercise Program:	Must use participa	ting facilities.	\$0 copay***				
Over-the-Counter Products Allowance:		ating retail locations. over quarter-to-quarter.	\$85 quarterly				
Meals Benefit:	Two meals per day post-discharge.	/ for 14 days	\$0 copay				
Support for Caregivers:	Support and resou non-professional c	\$0 copay					
Personal Emergency Response System:	Wearable device v emergency service	\$0 copay					
Home Safety Devices:	Two devices per y	ear.	\$0 copay				

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>With a medical exception.

<sup>\*\*\*</sup>This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.

**<sup>†</sup>** Devices must be ordered from approved product list using designated provider.



#### **Plan Offerings and Premiums by County**

Blue Medicare Enhanced (HMO-POS)		J <sup>™</sup> (HMO-POS)	H3449-024-001	Monthly Prem	ium: \$19	
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin	
<b>Blue</b> Medic	are Enhanced	(HMO-POS)	H3449-024-002	Monthly Prem	ium: \$34	
Alexander Brunswick Cabarrus Camden Carteret Caswell Cherokee	Clay Craven Cumberland Currituck Dare Franklin Harnett	Henderson Hoke Jackson Johnston Macon Madison McDowell	Mitchell Moore New Hanover Onslow Pasquotank Perquimans	Person Polk Rowan Stokes Surry	Transylvania Union Yancey	
<b>Blue</b> Medic	are Enhanced	J <sup>™</sup> (HMO-POS)	H3449-024-003	Monthly Prem	ium: \$45	
Alleghany Anson Ashe Avery Beaufort Bertie Bladen Caldwell	Chowan Cleveland Columbus Duplin Edgecombe Gates Graham Granville	Greene Halifax Hertford Hyde Jones Lee Lenoir Lincoln	Martin Montgomery Nash Northampton Pamlico Pender Pitt Richmond	Robeson Sampson Scotland Stanly Swain Tyrrell Vance	Warren Washington Watauga Wayne Wilson	
Counties where Blue Medicare						
Enhanced (HMO-PO)	S) is available:		Blue Medicare En available in all 10		•	

**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.



Blue Medicare Enhanced (HMO-POS)						
			\$19			
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	002:	\$34			
		003:	\$45			
Deductible:	These plans have no medical deductible.		\$0			
		001:	\$3,150			
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	002:	\$3,150			
		003:	\$3,400			
Benefits	What You Should Know					
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied	Days 1–5:		\$335 copay			
	Days 6-90:	\$0 copay				
per admission.)	Days 91 and beyond:		\$0 copay			
Outpatient Services:*	Outpatient Hospital: Per stay.		\$295 copay			
Outpatient Services.	Ambulatory Surgical Center:	\$200 copay				
Doctor Visit:	Primary:		\$0 copay			
Doctor Visit.	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			



BlueMedi	care Enhanced <sup>™</sup> (⊦	HMO-POS)		H3449-024-001 H3449-024-002 H3449-024-003
Benefits		What You Should Know	PCP Office	Any Other Setting
	Diagnostic Tests and	Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
lmaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiolog	\$0 copay	Lesser of 20% of cost or \$60 copay	
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat balance issues.	\$15 copay	
Hearing Services:	Routine Hearing Exam:	One per year. Must use desig providers.	\$0 copay	
	Hearing Aids:	One per ear, per year. Must u 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 s including oral exams, cleaning fillings, extractions and dentu	\$0 copay***	

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>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.

<sup>\*\*\*</sup>Must use designated providers.



Blue Medicare Enhanced (HMO-POS)				
Benefits		What You Should Know	H3449-024-003	
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$15 copay	
	Prescription Eyewear Allowance:	\$300 yearly allowance.	\$0 copay	
Vision Services:	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	
	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$300 copay	
Mental Health		Days 6-90:	\$0 copay	
Services:	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$15 copay	
01:11		Days 1–20:	\$0 copay	
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay	
i domey.	.,	Days 61–100:	\$0 copay	
	Physical and Speech La	\$10 copay		
Outpatient Rehabilitation Services:	Occupational Therapy:	\$10 copay		
	Cardiac Rehab Services	\$0 copay		
	Pulmonary Rehab Servi	\$20 copay		



Blue Medicare  Benefits	H3449-024-001 H3449-024-002 H3449-024-003		
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$250 copay	
Transportation:	<b>Transportation:</b> 24 one-way rides to health-related locations.		
Medicare Part B Insulins: 30-day supply. Part B		\$35 copay	
Drugs:**	Chemotherapy and Other Part B Drugs:	0-20% of cost	

R Part D, Pre	H3449-024-001 H3449-024-002 H3449-024-003			
	All Tiers: \$0			
Annual Deductible:	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):	<b>Begins after you pay your yearly deductible.</b> You remain your costs on covered drugs reach \$5,030.1 The amount your shown in the chart on the next page.	•		
Coverage Gap:	<b>Begins when your total year-to-date costs on covered of</b> \$5,030. In this stage, you'll pay 25% of the cost for your dr dispensing and administration fees, until your total year-to-\$8,000.2 Tier 6 drugs are fully covered in the Coverage Gap copayment at Preferred pharmacies or a \$1 copayment at (non-preferred) pharmacies.	ugs, excluding date costs reach o; there's a <b>\$0</b>		
Catastrophic Coverage:	<b>Begins when your total year-to-date costs on covered c \$8,000.</b> During this stage, your plan will pay the full cost for Part D drugs.	_		

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>May require prior authorization. Based on Inflation Reduction Act mandates.

<sup>1</sup> Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.

<sup>2</sup> Total year-to-date includes drug costs that only you have paid.



#### Blue Medicare Enhanced (HMO-POS)

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

	iption Drug Coverage ICL)	Preferred Retail Pharmacies		Preferred Mail Order	Standard (Non-Preferred) Pharmacies	
		<b>1-month</b> 30-day supply	<b>3-months</b> 90-day supply	<b>3-months</b> 90-day supply	<b>1-month</b> 30-day supply*	<b>3-months</b> 90-day supply
Preferred Go (Tier 1)	eneric Drugs:	\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Generic Dru (Tier 2)	gs:	\$6 copay	\$18 copay	\$0 copay	\$20 copay	\$60 copay
Preferred Br (Tier 3)	and Drugs:	\$45 copay	\$135 copay	\$90 copay	\$47 copay	\$141 copay
Non-Preferr (Tier 4)	ed Drugs:	\$99 copay	\$297 copay	\$198 copay	\$100 copay	\$300 copay
Specialty Ti (Tier 5)	er Drugs:	33% of cost	N/A	N/A	33% of cost	N/A
Select Care (Tier 6)	Drugs:	\$0 copay	\$0 copay	\$0 copay	\$1 copay	\$1 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

<sup>\*</sup>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.



Blue Medicare Enhanced Other Covered Benefits	H3449-024-001 H3449-024-002 H3449-024-003			
Benefit Series Benefit	What You Sh	nould Know		
Podiatry Services:	Foot care.			\$15 copay
	Durable Med and Supplies	lical Equipment s:*		20% of cost
Medical Equipment	Diabetic Sho	es or Inserts:		20% of cost
and Supplies:	Diabetes	Preferred Brands		\$0 copay
	Supplies:*	Supplies:* Non-Preferred Brands		20% of cost
Healthy Aging and Exercise Program:	Must use par	Must use participating facilities.		
	Must use participating retail locations. Funds do not roll 002:		001:	\$105 quarterly
Over-the-Counter Products Allowance:			002:	\$105 quarterly
	over quarter t	over quarter-to-quarter. — 00		
Meals Benefit:	2 meals per o 14 days post-			\$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: <sup>†</sup>	Two devices (	oer year.		\$0 copay

<sup>\*</sup>May require prior authorization.

<sup>\*\*</sup>With a medical exception.

<sup>\*\*\*</sup>This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.

**<sup>†</sup>** Devices must be ordered from approved product list using designated provider.