

# 2026 Summary of benefits

## Blue Medicare HMO<sup>SM</sup>

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare HMO plans for **January 1, 2026 – December 31, 2026**.

### 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 [BlueCrossNC.com/Members/Medicare/Forms-Library](https://BlueCrossNC.com/Members/Medicare/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 an 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% of preventive services and 40% of comprehensive services 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 **800-MEDICARE** (800-633-4227), TTY: 877-486-2048, 7 days a week, 24 hours a day. Or visit [Medicare.gov](https://www.Medicare.gov).
- For more details, call **800-665-8037** (TTY: 711), current members call **888-310-4110** (TTY: 711), 7 days a week, 8 a.m. – 8 p.m., visit [BlueCrossNC.com/Shop-Plans/Medicare](https://BlueCrossNC.com/Shop-Plans/Medicare) or contact your Blue Cross NC Authorized Independent Agent.

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MedicareRx  
Prescription Drug Coverage

# Summary of benefits

## Plan offerings and premiums by county

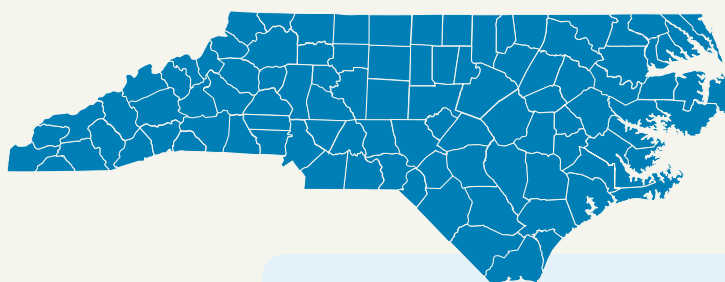
Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.

### Blue Medicare Medical Only<sup>SM</sup> (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

## Blue Medicare Medical Only<sup>SM</sup> (HMO-POS)

H3449-012

<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	<b>\$0</b>
<b>Part B Premium Reduction:</b>	Monthly reduction.	<b>\$35 monthly</b>
<b>Deductible:</b>	This plan has no medical deductible.	<b>\$0</b>
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.	<b>\$3,900</b>
Benefits		
What You Should Know		
<b>Inpatient Hospital Care:</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>	<b>\$295 copay</b>
	<b>Days 7–90:</b>	<b>\$0 copay</b>
	<b>Days 91 and beyond:</b>	<b>\$0 copay</b>
<b>Outpatient Services:</b>	<b>Outpatient Hospital: Per stay.</b>	<b>\$0–\$275 copay</b>
	<b>Ambulatory Surgical Center:</b>	<b>\$0–\$225 copay</b>
<b>Doctor Visit:</b>	<b>Primary:</b>	<b>\$0 copay</b>
	<b>Specialist:</b>	<b>\$25 copay</b>
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	<b>\$0 copay</b>
<b>Emergency Care:</b>	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.	<b>\$150 copay</b>
<b>Urgently Needed Services:</b>		<b>\$65 copay</b>

\*May require prior authorization.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Medical Only<sup>SM</sup> (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.		\$0 copay***
	Hearing Aids:	One per ear, per year.		\$499–\$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 combined 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% of preventive services and 40% of comprehensive services plus any 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 Evidence of Coverage for more information.

\*\*\*Must use designated providers.

# Summary of benefits

## Blue Medicare Medical Only<sup>SM</sup> (HMO-POS)

H3449-012

Benefits		What You Should Know	
Vision Services:	<b>Routine Eye Exam:</b>	One per calendar year.	\$0 copay
	<b>Vision Allowance:</b>	<b>\$300</b> yearly allowance.	\$0 copay
	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	\$25 copay
	<b>Glaucoma Screening and Diabetic Eye Exam:</b>	For people who are at high risk of glaucoma or have diabetes.	\$0 copay
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost
Mental Health Services:	<b>Inpatient:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–5:</b>	\$295 copay
		<b>Days 6–90:</b>	\$0 copay
	<b>Outpatient:*</b> (Mental health and substance use.)	Individual and group sessions.	\$25 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–20:</b>	\$0 copay
		<b>Days 21–100:</b>	\$218 copay
Outpatient Rehabilitation Services:	<b>Physical and Speech Language Therapy:</b>		\$25 copay
	<b>Occupational Therapy:</b>		\$25 copay
	<b>Cardiac Rehab Services:</b>		\$0 copay
	<b>Pulmonary Rehab Services:</b>		\$15 copay
<b>Ambulance Services:*</b>	Covers medically necessary ground and air ambulance services.		\$250 copay
<b>Transportation:</b>	12 one-way rides to health-related locations.		\$0 copay
Medicare Part B Drugs:	<b>Part B Insulins:</b>	30-day supply.	\$35 copay
	<b>Chemotherapy and Other Part B Drugs:**</b>		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

## Blue Medicare Medical Only<sup>SM</sup> (HMO-POS)

H3449-012

### Other Covered Benefits

#### Benefits

#### What You Should Know

#### Medicare-Covered 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 Brand

\$0 copay

Non-Preferred Brands\*\*

20% of cost

#### Fitness:

Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).

\$0 copay

#### Over-the-Counter Products Allowance:

\$100 quarterly allowance. Must use participating retail locations or designated catalog; no rollover.

\$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

#### In-Home Support Services:

60 hours per year. Hours do not rollover.

\$0 copay

#### Personal Emergency Response System:

Wearable device with fast access to emergency services.

\$0 copay

\*May require prior authorization.

\*\*With a medical exception.

# Summary of benefits

## Plan offerings and premiums by county

Blue Medicare Essential<sup>SM</sup> (HMO) is available in all 100 North Carolina counties.

### Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001

Monthly premium: \$0

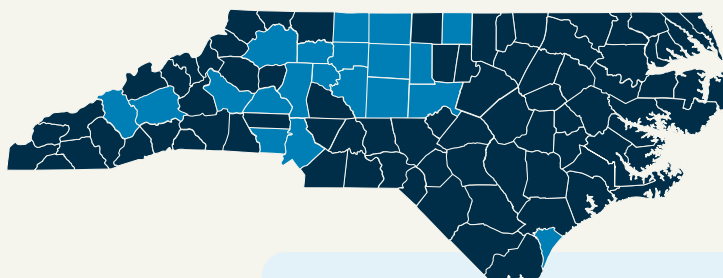
Alamance	Chatham	Gaston	Mecklenburg	Rockingham
Buncombe	Davidson	Guilford	New Hanover	Stokes
Burke	Davie	Haywood	Person	Wilkes
Catawba	Forsyth	Iredell	Randolph	Yadkin

### Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-002

Monthly premium: \$0

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

## Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001  
H3449-027-002

<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	<b>\$0</b>
<b>Part B Premium Reduction:</b>	Monthly reduction.	001: \$42.50 monthly 002: \$62.50 monthly
<b>Deductible:</b>	This plan has no medical deductible.	<b>\$0</b>
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.	<b>\$9,250</b>
<b>Benefits</b>	<b>What You Should Know</b>	
<b>Inpatient Hospital Care:</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>	<b>\$407 copay</b>
	<b>Days 7–90:</b>	<b>\$0 copay</b>
	<b>Days 91 and beyond:</b>	<b>\$0 copay</b>
<b>Outpatient Services:</b>	<b>Outpatient Hospital: Per stay.</b>	<b>\$0–\$335 copay</b>
	<b>Ambulatory Surgical Center:</b>	<b>\$0–\$300 copay</b>
<b>Doctor Visit:</b>	<b>Primary:</b>	001: \$5 copay 002: \$10 copay
	<b>Specialist:</b>	<b>\$45 copay</b>
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	<b>\$0 copay</b>
<b>Emergency Care:</b>	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.	<b>\$115 copay</b>
<b>Urgently Needed Services:</b>		<b>\$40 copay</b>

\*May require prior authorization.

# Summary of benefits

## Blue Medicare Essential<sup>SM</sup> (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.	001:	\$20 copay
			002:	\$25 copay
	Routine Hearing Exam:	One per year.		\$0 copay**
	Hearing Aids:	One per ear, per year.		\$499-\$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

## Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001  
H3449-027-002

Benefits		What you should know	
Vision Services:	<b>Routine Eye Exam:</b>	One per calendar year.	\$0 copay
	<b>Vision Allowance:</b>	\$100 yearly allowance.	\$0 copay
	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	\$25 copay
	<b>Glaucoma Screening and Diabetic Eye Exam:</b>	For people who are at high risk of glaucoma or have diabetes.	\$0 copay
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost
Mental Health Services:	<b>Inpatient:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–5:</b>	\$407 copay
		<b>Days 6–90:</b>	\$0 copay
	<b>Outpatient:*</b> (Mental health and substance use.)	Individual and group sessions.	\$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–20:</b>	\$0 copay
		<b>Days 21–100:</b>	\$218 copay
Outpatient Rehabilitation Services:	<b>Physical and Speech Language Therapy:</b>		\$25 copay
	<b>Occupational Therapy:</b>		\$25 copay
	<b>Cardiac Rehab Services:</b>		\$0 copay
	<b>Pulmonary Rehab Services:</b>		\$15 copay

\*May require prior authorization.

# Summary of benefits

## Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001  
H3449-027-002

### Benefits

### What you should know

<b>Ambulance Services:*</b>	Covers medically necessary ground and air ambulance services.	<b>\$275 copay</b>
<b>Transportation:</b>		<b>Not Covered</b>
<b>Medicare Part B Drugs:</b>	<b>Part B Insulins:</b> 30-day supply.	<b>\$35 copay</b>
	<b>Chemotherapy and Other Part B Drugs:**</b>	<b>0–20% of cost</b>



## Part D Drug Benefit Stages

H3449-027-001  
H3449-027-002

**Tiers 1, 2 and 6: \$0**

**Tiers 3, 4 and 5: \$615**

### Yearly Deductible Stage:

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 Stage:

#### **Begins after you pay your yearly deductible.**

You generally stay in this stage until your out-of-pocket drug costs reach **\$2,100**. The amount you pay in this stage is shown in the chart on the next page.\*\*\*

### Catastrophic Coverage Stage:

#### **Begins when your out-of-pocket drug costs reach \$2,100.**

During this stage, you pay nothing for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

\*May require prior authorization.

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

\*\*\*Your out-of-pocket drug costs include payments made in the Yearly Deductible Stage and the Initial Coverage Stage.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001  
H3449-027-002



### Preferred Retail Pharmacies



### Preferred Mail Order



### Standard (Non-Preferred) Pharmacies

Tiers		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
Tier 1 – Preferred Generic Drugs:		\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Tier 2 – Generic Drugs:		\$4 copay	\$12 copay	\$0 copay	\$20 copay	\$60 copay
Tier 3 – Preferred Brand Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 4 – Non-Preferred Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 5 – Specialty Tier Drugs:**		25% of cost	N/A	N/A	25% of cost	N/A
Tier 6 – Select Care Drugs:***		\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins:†	Tier 3:	\$35 copay	\$105 copay	\$105 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 Standard Retail Pharmacies for 31 days instead of 30 days.

\*\*Tier 5 drugs limited to 30-day supply.

\*\*\*Tier 6 drugs include vaccines and select generic medications used to treat high blood pressure, diabetes and high cholesterol.

†Cost-sharing for covered Part D insulins will not exceed the lesser of \$35 or 25% of the drug's cost for a one-month supply.

Note: Two-month (60-day) supplies may also be available. Standard Mail Order costs may differ.

# Summary of benefits

## Blue Medicare Essential<sup>SM</sup> (HMO)

H3449-027-001  
H3449-027-002

### Other Covered Benefits

#### Benefits

#### What you should know

#### Medicare-Covered 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 Brand

\$0 copay

Non-Preferred Brands\*\*

20% of cost

#### Fitness:

Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).

\$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

\*May require prior authorization.

\*\*With a medical exception.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Plan offerings and premiums by county

Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS) is available in all 100 North Carolina counties.

### Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

H3449-023-001

Monthly premium: \$0

Alamance	Chatham	Forsyth	Haywood	New Hanover	Rockingham
Buncombe	Davidson	Gaston	Iredell	Person	Stokes
Burke	Davie	Guilford	Mecklenburg	Randolph	Yadkin
Catawba					

### Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

H3449-023-002

Monthly premium: \$0

Alexander	Durham	Macon	Mitchell	Polk	Union
Brunswick	Harnett	Madison	Moore	Rowan	Wake
Caswell	Hoke	McDowell	Orange	Surry	Yancey
Cumberland	Johnston				

### Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

H3449-023-004

Monthly premium: \$0

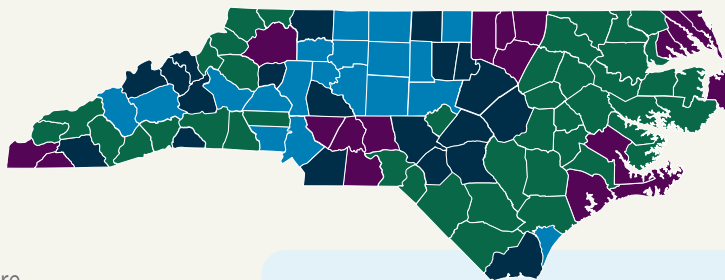
Anson	Cherokee	Currituck	Granville	Pasquotank	Vance
Cabarrus	Clay	Dare	Montgomery	Perquimans	Warren
Camden	Craven	Franklin	Onslow	Stanly	Wilkes
Carteret					

### Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

H3449-023-005

Monthly premium: \$0

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



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



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

# Summary of benefits

Blue Medicare Essential Plus <sup>SM</sup> (HMO-POS)		H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	\$0
<b>Deductible:</b>	This plan has no medical deductible.	\$0
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.	001: \$4,900
		002: \$5,400
		004: \$6,750
		005: \$7,450
Benefits	What You Should Know	
<b>Inpatient Hospital Care:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>	\$400 copay
	<b>Days 7–90:</b>	\$0 copay
	<b>Days 91 and beyond:</b>	\$0 copay
<b>Outpatient Services:*</b>	<b>Outpatient Hospital: Per stay.</b>	\$0–\$400 copay
	<b>Ambulatory Surgical Center:</b>	\$0–\$350 copay
<b>Doctor Visit:</b>	<b>Primary:</b>	\$0 copay
	<b>Specialist:</b>	001: \$20 copay
		002: \$25 copay
		004: \$30 copay
		005: \$40 copay
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay
<b>Emergency Care:</b>	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.	001, 002, 004: \$130 copay
		005: \$115 copay
<b>Urgently Needed Services:</b>		001, 002, 004: \$50 copay
		005: \$40 copay

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

# Summary of benefits

## Blue Medicare Essential Plus<sup>SM</sup> (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:	\$20 copay
			002:	\$25 copay
			004:	\$20 copay
			005:	\$25 copay
	Routine Hearing Exam:	One per year.		\$0 copay***
	Hearing Aids:	One per ear, per year.		\$499-\$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:	\$20 copay
			002:	\$25 copay
			004:	\$30 copay
			005:	\$40 copay
	Comprehensive and Preventive Dental:	\$1,500 combined 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% of preventive services and 40% of comprehensive services plus any 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 Evidence of Coverage for more information.

\*\*\*Must use designated providers.

# Summary of benefits

## Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

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

### Benefits

### What you should know


Vision Services:	Routine Eye Exam:	One per calendar year.	001: 002:	\$0 copay
			004: 005:	\$0 copay
	Vision Allowance:	\$200 yearly allowance.		\$0 copay
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	001:	\$20 copay
			002:	\$25 copay
			004: 005:	\$30 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:		\$400 copay
		Days 6–90:		\$0 copay
	Outpatient:* (Mental health and substance use.)	Individual and group sessions.	001:	\$20 copay
			002:	\$25 copay
			004:	\$30 copay
			005:	\$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20:		\$0 copay
		Days 21–100:		\$218 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:		001: 002:	\$15 copay
			004: 005:	\$20 copay
	Occupational Therapy:		001: 002:	\$15 copay
			004: 005:	\$20 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

Blue Medicare Essential Plus <sup>SM</sup> (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.	\$300 copay
Transportation:	12 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 Drug Benefit Stages		H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
	Tiers 1, 2 and 6: \$0	Tiers 3, 4 and 5: \$615
Yearly Deductible Stage:	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 Stage:	<b>Begins after you pay your yearly deductible.</b> You generally stay in this stage until your out-of-pocket drug costs reach <b>\$2,100</b> . The amount you pay in this stage is shown in the chart on the next page.***	
Catastrophic Coverage Stage:	<b>Begins when your out-of-pocket drug costs reach \$2,100.</b> During this stage, you pay nothing for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.	

\*May require prior authorization.  
 \*\*May require prior authorization. Based on Inflation Reduction Act mandates.  
 \*\*\*Your out-of-pocket drug costs include payments made in the Yearly Deductible Stage and the Initial Coverage Stage.  
 Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

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



Preferred  
Retail Pharmacies



Preferred  
Mail Order



Standard (Non-Preferred)  
Pharmacies

Tiers		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
Tier 1 – Preferred Generic Drugs:		\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Tier 2 – Generic Drugs:		\$4 copay	\$12 copay	\$0 copay	\$20 copay	\$60 copay
Tier 3 – Preferred Brand Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 4 – Non-Preferred Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 5 – Specialty Tier Drugs:**		25% of cost	N/A	N/A	25% of cost	N/A
Tier 6 – Select Care Drugs:***		\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins:†	Tier 3:	\$35 copay	\$105 copay	\$105 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 Standard Retail Pharmacies for 31 days instead of 30 days.

\*\*Tier 5 drugs limited to 30-day supply.

\*\*\*Tier 6 drugs include vaccines and select generic medications used to treat high blood pressure, diabetes and high cholesterol.

†Cost-sharing for covered Part D insulins will not exceed the lesser of \$35 or 25% of the drug's cost for a one-month supply.

Note: Two-month (60-day) supplies may also be available. Standard Mail Order costs may differ.

Note: This chart shows only a portion of the costs.

# Summary of benefits

## Blue Medicare Essential Plus<sup>SM</sup> (HMO-POS)

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

### Other Covered Benefits

#### Benefits

#### What you should know

#### Medicare-Covered Podiatry Services:

Foot care.

001: \$20 copay

002: \$25 copay

004: \$30 copay

005: \$40 copay

#### Medical Equipment and Supplies:

#### Durable Medical Equipment and Supplies:\*

20% of cost

#### Diabetic Shoes or Inserts:

20% of cost

#### Diabetes Supplies:\*

Preferred Brand

\$0 copay

Non-Preferred Brands\*\*

20% of cost

#### Fitness:

Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).

\$0 copay

#### Over-the-Counter Products Allowance:

001: \$49 per quarter

002: \$40 per quarter

004: \$30 per quarter

005: \$25 per quarter

Must use participating retail locations or designated catalog; no rollover.

\$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

#### In-Home Support Services:

60 hours per year. Hours do not rollover.

\$0 copay

#### Personal Emergency Response System:

Wearable device with fast access to emergency services.

\$0 copay

\*May require prior authorization.

\*\*With a medical exception.

# Summary of benefits

## Plan offerings and premiums by county

### Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026

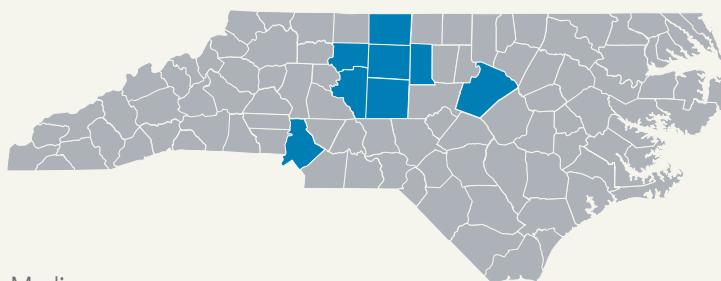
Monthly premium: \$0

Alamance  
Davidson

Forsyth  
Guilford

Mecklenburg  
Randolph

Rockingham  
Wake



026

Counties where Blue Medicare  
Choice (HMO) is available:

**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

## Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026

<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	<b>\$0</b>
<b>Deductible:</b>	This plan has no medical deductible.	<b>\$0</b>
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.	<b>\$4,200</b>
Benefits		What You Should Know
<b>Inpatient Hospital Care:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>	<b>\$350 copay</b>
	<b>Days 7–90:</b>	<b>\$0 copay</b>
	<b>Days 91 and beyond:</b>	<b>\$0 copay</b>
<b>Outpatient Services:*</b>	<b>Outpatient Hospital: Per stay.</b>	<b>\$0–\$295 copay</b>
	<b>Ambulatory Surgical Center:</b>	<b>\$0–\$275 copay</b>
<b>Doctor Visit:</b>	<b>Primary:</b>	<b>\$0 copay</b>
	<b>Specialist:</b>	<b>\$25 copay</b>
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	<b>\$0 copay</b>
<b>Emergency Care:</b>	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.	<b>\$150 copay</b>
<b>Urgently Needed Services:</b>		<b>\$65 copay</b>

\*May require prior authorization.

40 Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Choice<sup>SM</sup> (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.		\$25 copay
	Routine Hearing Exam:	One per year.		\$0 copay**
	Hearing Aids:	One per ear, per year.		\$499-\$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
	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

## Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026

Benefits		What you should know	
Vision Services:	<b>Routine Eye Exam:</b>	One per calendar year.	\$0 copay
	<b>Vision Allowance:</b>	\$200 yearly allowance.	\$0 copay
	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	\$25 copay
	<b>Glaucoma Screening and Diabetic Eye Exam:</b>	For people who are at high risk of glaucoma or have diabetes.	\$0 copay
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost
Mental Health Services:	<b>Inpatient:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–5:</b>	\$350 copay
		<b>Days 6–90:</b>	\$0 copay
	<b>Outpatient:*</b> (Mental health and substance use.)	Individual and group sessions.	\$25 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–20:</b>	\$0 copay
		<b>Days 21–100:</b>	\$218 copay
Outpatient Rehabilitation Services:	<b>Physical and Speech Language Therapy:</b>		\$15 copay
	<b>Occupational Therapy:</b>		\$15 copay
	<b>Cardiac Rehab Services:</b>		\$0 copay
	<b>Pulmonary Rehab Services:</b>		\$20 copay

\*May require prior authorization.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026

### Benefits

### What you should know

<b>Ambulance Services:*</b>	Covers medically necessary ground and air ambulance services.	<b>\$275 copay</b>
<b>Transportation:</b>		<b>Not Covered</b>
<b>Medicare Part B Drugs:</b>	<b>Part B Insulins:</b> 30-day supply.	<b>\$35 copay</b>
	<b>Chemotherapy and Other Part B Drugs:**</b>	<b>0–20% of cost</b>



## Part D Drug Benefit Stages

H3449-026

**Tiers 1, 2 and 6: \$0**

**Tiers 3, 4 and 5: \$615**

### Yearly Deductible Stage:

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 Stage:

**Begins after you pay your yearly deductible.**

You generally stay in this stage until your out-of-pocket drug costs reach **\$2,100**. The amount you pay in this stage is shown in the chart on the next page.\*\*\*

### Catastrophic Coverage Stage:

**Begins when your out-of-pocket drug costs reach \$2,100.**

During this stage, you pay nothing for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

\*May require prior authorization.

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

\*\*\*Your out-of-pocket drug costs include payments made in the Yearly Deductible Stage and the Initial Coverage Stage.

Note: This chart shows your portion of the costs.

# Summary of benefits

Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026



Preferred  
Retail Pharmacies



Preferred  
Mail Order



Standard (Non-Preferred)  
Pharmacies

Tiers		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
Tier 1 – Preferred Generic Drugs:		\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Tier 2 – Generic Drugs:		\$4 copay	\$12 copay	\$0 copay	\$20 copay	\$60 copay
Tier 3 – Preferred Brand Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 4 – Non-Preferred Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 5 – Specialty Tier Drugs:**		25% of cost	N/A	N/A	25% of cost	N/A
Tier 6 – Select Care Drugs:***		\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins:†	Tier 3:	\$35 copay	\$105 copay	\$105 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 Standard Retail Pharmacies for 31 days instead of 30 days.

\*\*Tier 5 drugs limited to 30-day supply.

\*\*\*Tier 6 drugs include vaccines and select generic medications used to treat high blood pressure, diabetes and high cholesterol.

†Cost-sharing for covered Part D insulins will not exceed the lesser of \$35 or 25% of the drug's cost for a one-month supply.

Note: Two-month (60-day) supplies may also be available. Standard Mail Order costs may differ.

# Summary of benefits

## Blue Medicare Choice<sup>SM</sup> (HMO)

H3449-026

### Other Covered Benefits

#### Benefits

#### What you should know

#### Medicare-covered 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 Brand

\$0 copay

Non-Preferred Brands\*\*

20% of cost

#### Fitness:

Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).

\$0 copay

#### Over-the-Counter Products Allowance:

\$25 quarterly allowance. Must use participating retail locations or designated catalog; no rollover.

\$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

\*May require prior authorization.

\*\*With a medical exception.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Plan offerings and premiums by county

Blue Medicare Enhanced<sup>SM</sup> (HMO-POS) is available in all 100 North Carolina counties.

### Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

H3449-024-001

Monthly premium: \$30

Alamance	Chatham	Gaston	Mecklenburg	Randolph	Wilkes
Buncombe	Davidson	Guilford	New Hanover	Rockingham	Yadkin
Burke	Davie	Haywood	Person	Stokes	
Catawba	Forsyth	Iredell			

### Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

H3449-024-002

Monthly premium: \$40

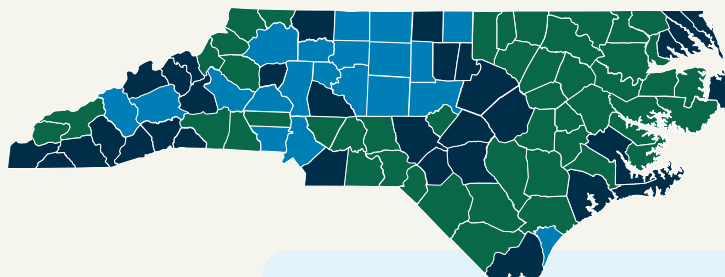
Alexander	Clay	Harnett	Madison	Pasquotank	Union
Brunswick	Craven	Henderson	McDowell	Perquimans	Wake
Camden	Cumberland	Hoke	Mitchell	Polk	Yancey
Carteret	Currituck	Jackson	Moore	Rowan	
Caswell	Dare	Johnston	Onslow	Surry	
Cherokee	Durham	Macon	Orange	Transylvania	

### Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

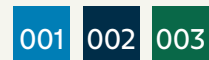
H3449-024-003

Monthly premium: \$47

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



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



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

## Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

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

<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	001:	\$30
		002:	\$40
		003:	\$47
<b>Deductible:</b>	This plan has no medical deductible.		\$0
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.		\$4,200
Benefits		What You Should Know	
<b>Inpatient Hospital Care:</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>		\$350 copay
	<b>Days 7–90:</b>		\$0 copay
	<b>Days 91 and beyond:</b>		\$0 copay
<b>Outpatient Services:</b>	<b>Outpatient Hospital: Per stay.</b>		\$0–\$335 copay
	<b>Ambulatory Surgical Center:</b>		\$0–\$200 copay
<b>Doctor Visit:</b>	<b>Primary:</b>		\$0 copay
	<b>Specialist:</b>		\$20 copay
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.		\$0 copay
<b>Emergency Care:</b>	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.		\$150 copay
<b>Urgently Needed Services:</b>			\$65 copay

\*May require prior authorization.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Enhanced<sup>SM</sup> (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
	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.	\$20 copay
	Routine Hearing Exam:	One per year.	\$0 copay***
	Hearing Aids:	One per ear, per year.	\$499-\$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.	\$20 copay
	Comprehensive and Preventive Dental:	\$2,000 combined 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% of preventive services and 40% of comprehensive services plus any 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 Evidence of Coverage for more information.

\*\*\*Must use designated providers.

# Summary of benefits

## Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

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

Benefits		What you should know	
Vision Services:	<b>Routine Eye Exam:</b>	One per calendar year.	\$0 copay
	<b>Vision Allowance:</b>	\$300 yearly allowance.	\$0 copay
	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	\$20 copay
	<b>Glaucoma Screening and Diabetic Eye Exam:</b>	For people who are at high risk of glaucoma or have diabetes.	\$0 copay
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost
Mental Health Services:	<b>Inpatient:</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–5:</b>	\$350 copay
		<b>Days 6–90:</b>	\$0 copay
	<b>Outpatient:</b> (Mental health and substance use.)	Individual and group sessions.	\$20 copay
Skilled Nursing Facility:	(Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–20:</b>	\$0 copay
		<b>Days 21–100:</b>	\$218 copay
Outpatient Rehabilitation Services:	<b>Physical and Speech Language Therapy:</b>		\$10 copay
	<b>Occupational Therapy:</b>		\$10 copay
	<b>Cardiac Rehab Services:</b>		\$0 copay
	<b>Pulmonary Rehab Services:</b>		\$20 copay

\*May require prior authorization.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

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

### Benefits

### What you should know

<b>Ambulance Services:*</b>	Covers medically necessary ground and air ambulance services.	<b>\$250 copay</b>
<b>Transportation:</b>	12 one-way rides to health-related locations.	<b>\$0 copay</b>
<b>Medicare Part B Drugs:</b>	<b>Part B Insulins:</b> 30-day supply.	<b>\$35 copay</b>
	<b>Chemotherapy and Other Part B Drugs:**</b>	<b>0–20% of cost</b>



## Part D Drug Benefit Stages

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

**Tiers 1, 2 and 6: \$0**

**Tiers 3, 4 and 5: \$100**

### Yearly Deductible Stage:

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 Stage:

#### **Begins after you pay your yearly deductible.**

You generally stay in this stage until your out-of-pocket drug costs reach **\$2,100**. The amount you pay in this stage is shown in the chart on the next page.\*\*\*

### Catastrophic Coverage Stage:

#### **Begins when your out-of-pocket drug costs reach \$2,100.**

During this stage, you pay nothing for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

\*May require prior authorization.

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

\*\*\*Your out-of-pocket drug costs include payments made in the Yearly Deductible Stage and the Initial Coverage Stage.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

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



Preferred  
Retail Pharmacies



Preferred  
Mail Order



Standard (Non-Preferred)  
Pharmacies

Tiers		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
Tier 1 – Preferred Generic Drugs:		\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Tier 2 – Generic Drugs:		\$4 copay	\$12 copay	\$0 copay	\$20 copay	\$60 copay
Tier 3 – Preferred Brand Drugs:		25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 4 – Non-Preferred Drugs:		31% of cost	31% of cost	31% of cost	31% of cost	31% of cost
Tier 5 – Specialty Tier Drugs:**		31% of cost	N/A	N/A	31% of cost	N/A
Tier 6 – Select Care Drugs:***		\$0 copay	\$0 copay	\$0 copay	\$1 copay	\$1 copay
Insulins:†	Tier 3:	\$35 copay	\$105 copay	\$105 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 Standard Retail Pharmacies for 31 days instead of 30 days.

\*\*Tier 5 drugs limited to 30-day supply.

\*\*\*Tier 6 drugs include vaccines and select generic medications used to treat high blood pressure, diabetes and high cholesterol.

†Cost-sharing for covered Part D insulins will not exceed the lesser of \$35 or 25% of the drug's cost for a one-month supply.

Note: Two-month (60-day) supplies may also be available. Standard Mail Order costs may differ.

Note: This chart shows your portion of the costs.

# Summary of benefits

## Blue Medicare Enhanced<sup>SM</sup> (HMO-POS)

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

### Other Covered Benefits

#### Benefits

#### What you should know

#### Medicare-covered Podiatry Services:

Foot care.

\$20 copay

#### Medical Equipment and Supplies:

#### Durable Medical Equipment and Supplies:\*

20% of cost

#### Diabetic Shoes or Inserts:

20% of cost

#### Diabetes Supplies:\*

Preferred Brand

\$0 copay

Non-Preferred Brands\*\*

20% of cost

#### Fitness:

Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).

\$0 copay

#### Over-the-Counter Products Allowance:

001: \$41 per quarter

002: \$41 per quarter

003: \$20 per quarter

Must use participating retail locations or designated catalog; no rollover.

\$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

#### In-Home Support Services:

60 hours per year. Hours do not rollover.

\$0 copay

#### Personal Emergency Response System:

Wearable device with fast access to emergency services.

\$0 copay

\*May require prior authorization.

\*\*With a medical exception.

Note: This chart shows your portion of the costs.