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, 2025 – December 31, 2025**.

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 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% 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 BlueCrossNC.com/Shop-Plans/Medicare 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)		H3449-01	2 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:		\$55 copay	



Blue Medicare Medical Only (HMO-POS) H3449-012 **PCP** Any Other What You Should Know **Benefits** Office Setting **Diagnostic Tests and Procedures:** \$0 copay \$25 copay Lab Services: \$0 copay \$5 copay Lesser of MRI, CT and Other \$0 copay 20% of cost or **Nuclear Medicine:** \$150 copay Diagnostic **Diagnostic** Radiological Services/ PET: \$0 copay \$300 copay Services: Labs/ Imaging:* All Other Services: \$0 copay \$75 copay Lesser of **Therapeutic Radiological Services:** 20% of cost or \$0 copay \$60 copay X-rays: \$0 copay \$15 copay **Medicare-Covered** Exams to diagnose and treat \$25 copay **Hearing Exam:** hearing and balance issues. Hearing **Routine Hearing** One per year. Must use \$0 copay Services: Exam: designated providers. One per ear, per year. Must \$699-\$999 **Hearing Aids:** use designated providers. copay Medicare may pay for certain **Medicare-Covered** services when you're in a \$25 copay Dental Services:* hospital and need emergency or complicated dental procedures. Dental Services: \$2,000 yearly allowance for Comprehensive and services including oral exams, \$0 copav*** Preventive Dental:** cleanings, X-rays, fillings, extractions and dentures.

^{*}May require prior authorization.

^{**}Certain limits apply. Combined yearly allowance. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.

^{***}Must use designated providers.

Blue Medicare Medical Only (HMO-POS) H3449-012				
Benefits		What You Should Know		
	Routine Eye Exam:	One per calendar year.	\$0 copay	
	Vision 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	applies per day. Benefit period applied per admission.)	Days 6-90:	\$0 copay	
Services:	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$25 copay	
Skilled	(Cost share applies per day	Days 1–20:	\$0 copay	
Nursing	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$214 copay	
Facility:*	aurrission./	Days 61–100:	\$0 copay	
	Physical and Speech Langua	nge Therapy:	\$25 copay	
Outpatient Rehabilitation	Occupational Therapy:	\$25 copay		
Services:	Cardiac Rehab Services:		\$0 copay	
	Pulmonary Rehab Services:		\$15 copay	
Ambulance Services:*	Covers medically necessary gr	\$250 copay		
Transportation:	24 one-way rides to health-rela	\$0 copay		
Medicare	Part B Insulins: 30-day supp	ly.	\$35 copay	
Part B Drugs:	Chemotherapy and Other P	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.



Blue Medicare Medical Only (HMO-POS) Other Covered Benefits H3449-012				
Benefit	What You Should Kno	ow		
Podiatry Services:	Foot care.		\$25 copay	
	Durable Medical Equipment and Supplies:*		20% of cost	
Medical Equipment	Diabetic Shoes or Inserts:	20% of cost		
and Supplies:	Diabetes Supplies:*	Preferred Brands	\$0 copay	
	Diabetes Supplies.	Non-Preferred Brands**	20% of cost	
Fitness:		vith designated vendor on sses and select equipment;	\$0 copay	
Over-the-Counter Products Allowance:		ce. Must use participating nated catalog; no rollover.	\$0 copay	
Meals Benefit:	Two meals per day for 1	4 days post-discharge.	\$0 copay	
Support for Caregivers:	Support and resources caregivers.	for non-professional	\$0 copay	
In-Home Assistance:	60 hours per year.		\$0 copay	
Personal Emergency Response System:	Wearable device with f to emergency services		\$0 copay	
Home Safety Devices: [†]	Two devices per year.		\$0 copay	

^{*}May require prior authorization.

**With a medical exception.

†Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.

Plan Offering and Premium by County

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

Blue Medic	are Essential (H	IMO)	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
Blue Medic	are Essential (H	IMO)	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 Essential (HMO) i		TER		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) H3449-027 H3449-027			
Monthly Premium:	You must also continue to pay your Medicare Part B premium.		
Part B Premium Reduction:	Monthly reduction.		\$61 monthly
Annual Deductible:	This plan has no medical deductible.		\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.		\$8,300
Benefits	What You Should Know		
Inpatient Hospital Care:*	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
Outpatient Services:*	Outpatient Hospital: Per stay.		\$335 copay
	Ambulatory Surgical Center:		\$300 copay
	0		\$5 copay
Doctor Visit:	Primary:	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:			\$45 copay

Blue Medic	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	\$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.	\$4	5 copay	
Hearing Services:	Routine Hearing Exam:	One per year. Must use designated providers.	\$0	\$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.	a gency or \$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.



Blue Medicar	e Essential (HMO)	What You Should Know	H3449-027-001 H3449-027-002
	Routine Eye Exam:	One per calendar year.	\$0 copay
	Vision 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 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.	\$40 copay
		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21-60:	\$214 copay
i donity.	approa por darmosion,	Days 61–100:	\$0 copay
	Physical and Speech La	nguage Therapy:	\$25 copay
Outpatient	Occupational Therapy:		\$25 copay
Rehabilitation Services:	Cardiac Rehab Services	\$0 copay	
	Pulmonary Rehab Services:		\$15 copay

Blue Medicare	H3449-027-001 H3449-027-002	
Benefits	What You Should Know	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:		Not covered
Medicare Part B	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		
Voorly	Tiers 1, 2 and 6: \$0	iers 3, 4 and 5 : \$590		
Yearly Deductible Stage:	This is the set amount that you pay before your plan begins to pay its sha of the cost. Your deductible does not apply to covered insulin products an most adult Part D vaccines.			
Initial Coverage Stage:		deductible. You generally stay in this costs reach \$2,000 . The amount you pay on the next page.***		
Catastrophic Coverage Stage:	stage, you pay nothing for your co	drug costs reach \$2,000. During this vered Part D drugs. Once you are in the will stay in this payment stage until the		

^{*}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.



Blue Medicare Essential (HMO)

H3449-027-001 H3449-027-002

R		Preferred Retail Pharmacies		Preferred Mail Order	(Non-Pi	ndard referred) nacies
		1 month 30-day supply	3 months 90-day supply	3 months 90-day supply	1 month 30-day supply*	3 months 90-day supply
Preferred 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 Brack (Tier 3)	and Drugs:	\$45 copay	\$135 copay	\$90 copay	\$47 copay	\$141 copay
Non-Preferre	ed Drugs:	49% of cost	49% of cost	49% of cost	49% of cost	49% of cost
Specialty Tie (Tier 5)	er Drugs:**	25% of cost	N/A	N/A	25% of cost	N/A
Select Care (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
	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

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

^{*}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.

Blue Medicare Essential (HMO) H3449-027-				
Other Covered Benefits				
Benefit	What You Should Kn	ow		
Podiatry Services:	Foot care.		\$45 copay	
	Durable Medical Equi and Supplies:*	ipment	20% of cost	
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:		20% of cost	
and Supplies.	Diabetes Supplies:*	Preferred Brands	\$0 copay	
		Non-Preferred Brands**	20% of cost	
Fitness:	\$112/month to spend w memberships, classes no rollover.	vith designated vendor on gyr and select equipment;	n \$0 copay	
Meals Benefit:	Two meals per day for post-discharge.	14 days	\$0 copay	
Support for Caregivers:	Support and resources non-professional careg	\$0 copay		
Personal Emergency Response System:	Wearable device with to emergency services	\$0 copay		
Home Safety Devices: [†]	Two devices per year.		\$0 copay	

^{*}May require prior authorization.
**With a medical exception.

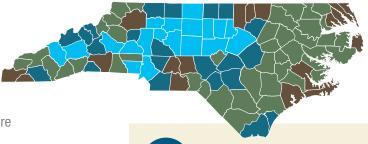
[†] Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.



Plan Offerings and Premiums by County

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

Blue Medicare Essential Plus (HMO-POS)		H3449-023-001	Monthly Pre	mium: \$0	
Alamance Buncombe Burke Catawba	Chatham Davidson Davie	Durham Forsyth Gaston	Guilford Haywood Iredell	Mecklenburg Orange Randolph	Rockingham Wake Yadkin
Blue Medicar	e Essential Plu	s (HMO-POS)	H3449-023-002	Monthly Pre	mium: \$0
Alexander Brunswick Cabarrus Caswell	Cumberland Franklin Harnett Hoke	Johnston Macon Madison McDowell	Mitchell Moore New Hanover Person	Polk Rowan Stokes Surry	Union Yancey
Blue Medicar	e Essential Plu	s"(HMO-POS)	H3449-023-004	Monthly Pre	mium: \$0
Anson Camden Carteret	Cherokee Clay Craven	Currituck Dare Granville	Montgomery Onslow Pasquotank	Perquimans Rutherford Stanly	Vance Warren Wilkes
Blue Medicar	e Essential Plu	s"(HMO-POS)	H3449-023-005	Monthly Pre	mium: \$0
Alleghany Ashe Avery Beaufort Bertie Bladen Caldwell	Chowan Cleveland Columbus Duplin Edgecombe Gates Graham	Greene Halifax Henderson Hertford Hyde Jackson Jones	Lee Lenoir Lincoln Martin Nash Northampton Pamlico	Pender Pitt Richmond Robeson Sampson Scotland Swain	Transylvania Tyrrell Washington Watauga Wayne 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.

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 Plus (HMO-POS) H3 H3 H3			
Monthly Premium:	You must also continue to pay your Medicare Part B premium.		\$0
Part B Premium Reduction:	Monthly reduction.		\$3 monthly
Deductible:	These plans have no medical deductible.		\$0
Annual Maximum Out-of-Pocket:	Does not include prescription drugs.	001: 002: 004: 005:	\$3,500 \$5,200
Benefits	What You Should Know		
Inpatient Hospital Care:*	Days 1–5:		\$400 copay
(Cost share applies per day. Benefit period applied	Days 6-90:	\$0 copay	
per admission.)	Days 91 and beyond:	\$0 copay	
Outpotiont Convinces*	Outpatient Hospital: Per stay.		\$400 copay
Outpatient Services:*	Ambulatory Surgical Center:	\$350 copay	
	Primary:		\$0 copay
Doctor Visit:	Specialist:		\$20 copay
	Openialist.	004: 005:	\$30 copay
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered	ed.	\$0 copay
Emergency Care:	If you are admitted to the hospital within 48 hour do not have to pay your share of the cost for eme care. Emergency services are covered worldwide	rgency	\$120 copay
Urgently Needed Services	:		\$55 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	\$0 copay	\$25 copay	
Diagnostic	Lab Services:	Lab Services:		
	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:	\$0 copay	\$75 copay
	Therapeutic Radiological 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	001: 002:	\$20 copay
Hearing		hearing and balance issues.	004: 005:	\$30 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:	\$20 copay
Dental	Dental Services:*	hospital and need emergency or complicated dental procedures.	004: 005:	\$30 copay
Services:	Comprehensive and Preventive Dental:	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.**		\$0 copay***

^{*}May require prior authorization.

^{**}Certain limits apply. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please see the Evidence of Coverage for more information.

^{***}Must use designated providers.

Blue Medicare Essential Plus (HMO-POS) H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005 H3449-023-005				
Donones			001: 002:	\$0 copay
	Routine Eye Exam:	One per calendar year.	004: 005:	\$0 copay
	Vision Allowance:	\$200 yearly allowance.		\$0 copay
Vision Services:	Medicare-Covered treatment of illnesses	For the diagnosis and	001: 002:	\$20 copay
Oct vices.		and injuries of the eye.	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
	Inpatient:* (Cost share applies per	Days 1–5:	\$350 copay	
Mental	day. Benefit period applied per admission.)	Days 6-90:		\$0 copay
Health Services:	Outpatient:	Individual and	001: 002:	\$20 copay
			002.	Ψ20 σοραγ
	(Mental health* and substance use.)	group sessions.	002: 004: 005:	\$30 copay
Skilled	(Mental health* and substance use.)		004:	
Skilled Nursing	(Mental health* and substance use.) (Cost share applies per day. Benefit period	group sessions.	004:	\$30 copay
	(Mental health* and substance use.) (Cost share applies per	group sessions. Days 1–20:	004:	\$30 copay
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:	\$30 copay \$0 copay \$214 copay
Nursing Facility:* Outpatient	(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:	\$30 copay \$0 copay \$214 copay \$0 copay
Nursing Facility:*	(Mental health* and substance use.) (Cost share applies per day. Benefit period applied per admission.) Physical and Speech Land	group sessions. Days 1–20: Days 21–60: Days 61–100: nguage Therapy:	004:	\$30 copay \$0 copay \$214 copay \$0 copay \$10 copay



Blue Medicare E	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.	\$300 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	
V 1	Tiers 1, 2 and 6: \$0 Tier	s 3, 4 and 5 : \$375	
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 destage until your out-of-pocket drug continuing this stage is shown in the chart on	osts reach \$2,000 . The amount you pay	
Catastrophic Coverage Stage:	Begins when your out-of-pocket do stage, you pay nothing for your cover Catastrophic Coverage Stage, you we the end of the calendar year.	red Part D drugs. Once you are in the	

^{*}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.

Blue Medicare Essential Plus (HMO-POS)

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

H3449-023-005

R		Preferred Retail Pharmacies		Preferred Mail Order	Standard (Non-Preferred) Pharmacies	
		1 month 30-day supply	3 months 90-day supply	3 months 90-day supply	1 month 30-day supply*	3 months 90-day supply
Preferred Ge (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-Preferro	ed Drugs:	49% of cost	49% of cost	49% of cost	49% of cost	49% of cost
Specialty Ti (Tier 5)	er Drugs:**	28% of cost	N/A	N/A	28% of cost	N/A
Select Care (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
iliaulilia.	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

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

^{*}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.



H32				H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005	
Other Covered Benefits					
Benefit	What You Shou	ld Kn	ow		
Podiatry Services:	Foot care.			001: 002:	\$20 copay
r canati y cor viocoi	r oot dare.			004: 005:	\$30 copay
	Durable Medica	al Equ	ipment and Supplie	es:*	20% of cost
Medical Equipment	Diabetic Shoes	or Ins	erts:		20% of cost
and Supplies:	Diabetes	Pref	erred Brands		\$0 copay
	Supplies:*	Supplies:* Non-Preferred Brands			20% of cost
Fitness:			vith designated vend sses and select equi		\$0 copay
	001: \$108 per qu	arter			
Over-the-Counter	002: \$82 per qu	arter	Must use participal locations or design	il \$0 copay	
Products Allowance:	004: \$83 per qu	arter	er catalog; no rollover.		φο σοραγ
	005: \$82 per qu	arter			
Meals Benefit:	Two meals per d	ay for	14 days post-dischar	ge.	\$0 copay
Support for Caregivers:	Support and resonant non-professional				\$0 copay
In-Home Assistance:	60 hours per yea	ar.			\$0 copay
Personal Emergency Response System:	Wearable device to emergency se				\$0 copay
Home Safety Devices: [†]	Two devices per	year.			\$0 copay

^{*}May require prior authorization.
**With a medical exception.

[†]Devices must be ordered from approved product list using designated provider.

Plan Offering and Premium by County

Alamance Forsyth Mecklenburg Rockingham Wake Counties where Blue Medicare Choice (HMO) is available: O26 Monthly Premium: \$0 Monthly Premium: \$0

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 Choice (HMO)		H3449-026
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	\$0
Part B Premium Reduction:	Monthly reduction.	\$2.50 monthly
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:	\$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:		\$55 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
Diagnostic	Lab Services:		\$0 copay	\$5 copay
	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	r Radiological Services:	PET:	\$0 copay	\$300 copay
lmaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiological Services: \$0 cop		\$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 h balance issues.	earing and	\$15 copay
Hearing Services:	Routine Hearing Exam:	One per year. Must use design	ated providers	. \$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.		\$699–\$999 copay
Dental Services:	Medicare-Covered Dental Services:*	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.		\$15 copay
Services:	Preventive Dental:	Oral exams, cleanings, X-rays a screenings.**	and	\$0 copay

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



Blue Medicar	e Choice [*] (HMO)		H3449-026
Benefits		What You Should Know	
	Routine Eye Exam:	One per calendar year.	\$0 copay
	Vision Allowance:	\$200 yearly allowance.	\$0 copay
Vision Services:	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	\$20 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.	\$15 copay
0		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$214 copay
r donity.	,	Days 61–100:	\$0 copay
	Physical and Speech Lang	guage Therapy:	\$10 copay
Outpatient Rehabilitation	Occupational Therapy:	\$10 copay	
Services:	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Service	\$20 copay	

Blue Medicare	Choice [®] (HMO) What You Should Know	H3449-026
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, Pro	R Part D, Prescription Drug Benefit Stages				
Voorly	Tiers 1, 2 and 6: \$0	Tiers 3, 4 and 5 : \$375			
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:		early deductible. You generally st drug costs reach \$2,000 . The amo rt on the next page.***			
Catastrophic Coverage Stage:	stage, you pay nothing for you	ocket drug costs reach \$2,000. Dur covered Part D drugs. Once you you will stay in this payment stag	are in the		

^{*}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.



Blue Medicare Choice (HMO)

H3449-026

R		Preferred Retail Pharmacies		Preferred Mail Order	(Non-Pi	ndard referred) nacies
		1 month 30-day supply	3 months 90-day supply	3 months 90-day supply	1 month 30-day supply*	3 months 90-day supply
Preferred Ge	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	and Drugs:	\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferr	ed Drugs:	44%	44%	44%	44%	44%
(Tier 4)		of cost	of cost	of cost	of cost	of cost
Specialty Ti (Tier 5)	er Drugs:**	28% of cost	N/A	N/A	28% 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	\$105 copay	\$35 copay	\$105 copay

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

^{*}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.

Blue Medicare Choice (H	H3449-026			
Other Covered Benefits				
Benefit	What You Shoul	d Know		
Podiatry Services:	Foot care.		\$15 copay	
	Durable Medical and Supplies:*	Durable Medical Equipment and Supplies:*		
Medical Equipment and Supplies:	uipment or Inserts:		20% of cost	
and oupplies.	Diabetes	Preferred Brands	\$0 copay	
	Supplies:*	Non-Preferred Brands**	20% of cost	
Fitness:	on gym members	\$112/month to spend with designated vendor on gym memberships, classes and select equipment; no rollover.		
Over-the-Counter Products Allowance:		wance. Must use participating designated catalog; no rollover.	\$0 copay	
Meals Benefit:	Two meals per da post-discharge.	Two meals per day for 14 days post-discharge.		
Support for Caregivers:	Support and resonance non-professional of	\$0 copay		
Personal Emergency Response System:	Wearable device with fast access to s0 copa emergency services.			
Home Safety Devices:	Two devices per y	year.	\$0 copay	

^{*}May require prior authorization.
**With a medical exception.

[†] Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.



Plan Offerings and Premiums by County

Blue Medica	are Enhanced (I	HMO-POS)	H3449-024-001	Monthly Pre	mium: \$19
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin
Blue Medica	are Enhanced (I	HMO-POS)	H3449-024-002	Monthly Pre	mium: \$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	Transylvani Union Yancey
Blue Medic	are Enhanced (I	HMO-POS)	H3449-024-003	Monthly Premium: \$40	
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 Washingto Watauga Wayne Wilson
Counties where B Enhanced (HMO-F					
Limanoeu (i liviO-l	ooj is avallable.	TO-	Blue Medicare En	hanced (HMO-P	OS) is

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) H3449-024-003 H3449-024-003						
			\$19			
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	002:	\$34			
		003:	\$40			
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:	\$3,700			
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			
Outpatient Services:*	Outpatient Hospital: Per stay.		\$335 copay			
Outpatient Services.	Ambulatory Surgical Center:	\$200 copay				
Doctor Visit:	Primary:		\$0 copay			
Doctor visit.	Specialist:		\$20 copay			
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered.	İ	\$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	:		\$55 copay			



Blue Medica	are Enhanced (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 Radiological Services: \$0 co			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.		\$20 copay
Hearing Services:	Routine Hearing Exam:	One per year. Must use desig providers.	\$0 copay	
	Hearing Aids:	One per ear, per year. Must use designated providers.		\$699–\$999 copay
Dental	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
Services:	Comprehensive and Preventive Dental:	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.**		\$0 copay***

^{*}May require prior authorization.

^{**}Certain limits apply. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please 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.

^{***}Must use designated providers.

Blue Medicare	H3449-024-001 H3449-024-002		
Benefits		What You Should Know	H3449-024-003
	Routine Eye Exam:	One per calendar year.	\$0 copay
	Vision Allowance:	\$300 yearly allowance.	\$0 copay
Vision Services:	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	\$20 copay
001110001	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.	\$20 copay
		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21-60:	\$214 copay
i donity.	,	Days 61–100:	\$0 copay
	Physical and Speech Lar	\$10 copay	
Outpatient Rehabilitation	Occupational Therapy:		\$10 copay
Services:	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Servi	ces:	\$20 copay



Blue Medicare En	H3449-024-001 H3449-024-002 H3449-024-003	
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	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	H3449-024-001 H3449-024-002 H3449-024-003		
Vacult	All Tiers: \$0			
Yearly Deductible Stage: This is the set amount that you pay before your plan begins to pay its soft the cost. Your deductible does not apply to covered insulin products most adult Part D vaccines.				
Initial Coverage Stage:	Begins after you pay your yearly deductible. You gene stage until your out-of-pocket drug costs reach \$2,000 . T 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, stage, you pay nothing for your covered Part D drugs. Or Catastrophic Coverage Stage, you will stay in this payment the end of the calendar year.	nce you are in the		

^{*}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.

Blue Medicare Enhanced (HMO-POS)

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

P _x		Preferred Retail Pharmacies		Preferred Mail Order	(Non-Pi	ndard referred) nacies
		1 month 30-day supply	3 months 90-day supply	3 months 90-day supply	1 month 30-day supply*	3 months 90-day supply
Preferred 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
Inculine:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
Insulins:	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

^{*}Long-term care pharmacy benefit is covered the same as Standard Retail Pharmacies for 31 days instead of 30 days. **Tier 5 drugs limited to 30-day supply.

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



Blue Medicare Enhanced (H	H3449-024-001 H3449-024-002 H3449-024-003						
Other Covered Benefits	Other Covered Benefits						
Benefit	What You Sh	nould Know					
Podiatry Services:	Foot care.		\$20 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:*	Non-Preferred Brands**	20% of cost				
Fitness:	on gym mem	\$112/month to spend with designated vendor on gym memberships, classes and select equipment; no rollover.					
Over-the-Counter Products Allowance:	participating r	\$95 quarterly allowance. Must use participating retail locations or designated catalog; no rollover.					
Meals Benefit:	2 meals per of 14 days post-		\$0 copay				
Support for Caregivers:		Support and resources for non-professional caregivers.					
In-Home Assistance:	60 hours per	\$0 copay					
Personal Emergency Response System:		Wearable device with fast access to emergency services.					
Home Safety Devices: [†]	Two devices p	oer year.	\$0 copay				

^{*}May require prior authorization.

^{**}With a medical exception.

[†] Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.