2024 MEDICARE ADVANTAGE PLANS

CORE HMO

BlueCross BlueShield Nebraska

MEDICARE

Carry the Card that Carries You Through

Through tests and treatments, trials and triumphs, we're there with you. For over 85 years, we have ensured access to the doctors you trust, coverage for the care you need and support from a company based right here in Nebraska.

TABLE OF CONTENTS

QUESTIONS? WE'RE HERE FOR YOU!

For more information about our plan choices, call toll-free **844-291-6880 (TTY 711)**, email **GetStarted@NebraskaBlue.com** or visit **Medicare.NebraskaBlue.com**.

MEDICARE ADVANTAGE

A smart choice for your Medicare coverage.

What are Medicare Advantage plans?

Medicare Advantage plans (Medicare Part C) are health plans approved by Medicare and run by private insurance companies, like Blue Cross and Blue Shield of Nebraska (BCBSNE). They include Part A (hospital insurance), Part B (medical insurance) and in many cases, Part D (prescription drug) coverage. They may also include extra benefits and services like routine care and wellness programs.

MEDICARE PART C: Medicare Advantage

Part A + Part B + Part D + Routine Care + Wellness Programs

Why choose a BCBSNE Medicare Advantage plan vs. Original Medicare?

With our Medicare Advantage plans you get:

- **Convenience:** All of your coverage from a single health plan.
- **Prescriptions:** Part D prescription drug coverage is included.
- **Benefits:** Access to additional benefits, such as routine care, dental, hearing, vision, wellness, telehealth services and over-the-counter (OTC) benefits.
- **Financial protection:** Medicare Advantage plans limit your maximum out-of-pocket expense on copayments and coinsurance for Medicare-covered or eligible medical services.

More Americans are choosing Medicare Advantage

Medicare Advantage plans continue to grow in popularity each year. According to the Centers for Medicare & Medicaid Services (CMS), as of May 2023 more than 31.6 million individuals nationwide were enrolled in a Medicare Advantage plan.

It's the only card you need

We have a contract with Original Medicare, so when you enroll in our Medicare Advantage plans, BCBSNE provides your benefits, not Original Medicare. You'll only need to show your BCBSNE ID card for care. You should put your red, white and blue Medicare card away for safekeeping.

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OUR MEDICARE ADVANTAGE PLANS

Enjoy more coverage than Original Medicare, with predictable costs.

Our Medicare Advantage insurance plans are available in 76 counties throughout Nebraska. These plans are partially funded by the federal government. This ensures your premiums are kept affordable, while you enjoy all the coverage of Medicare Parts A and B – plus prescription drug benefits. With coverage from BCBSNE, you'll have predictable, easy-to-budget costs for doctor office visits, prescription drugs and more. Each plan offers a different level of benefits and out-of-pocket costs, so you can choose the one that suits your needs.

Medicare Advantage Core HMO

- $0 monthly premium
- $0 medical deductible
- $0 24/7 nurse line copay
- No cost deductible for all drug tiers
- Open access – referrals are not required to see a specialist
- Additional benefits such as dental, hearing, vision, OTC, telehealth services and travel benefits

AVAILABLE IN: Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cass, Cedar, Chase, Clay, Colfax, Cuming, Custer, Dawson, Deuel, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler and York counties.

Convenient care that can save you money.

Preventive Care Coverage

All plans provide coverage for important preventive care including:

Preventive Benefits	• Bone density test • Glaucoma testing • Diabetes prevention program • Hepatitis C screening
Immunizations	• COVID-19 • Flu • Pneumococcal • Hepatitis B
Welcome to Medicare Visit	• Medicare will cover a one-time "Welcome to Medicare" routine exam within the first 12 months that you are enrolled in Part B coverage
Routine Exam	• Physical exam, one every calendar year
Health Screenings	• Mammograms • Prostate cancer screening • Colonoscopy • Pap smear

Prescription Coverage

Yes, prescription drug coverage is included. As a member, your drugs cost less at in-network pharmacies. Plus, we offer a mail-order program for convenient home delivery of your medications.

The amount of assistance you get will determine your total monthly plan premium. These premiums include coverage for both medical services and prescription drugs. They do not include any Medicare Part B premium you may need to pay. For more information, please refer to the Summary of Benefits on page 24.

Many people are eligible for these savings on prescription drugs and don't even know it.

For more information, or to see if you qualify, contact:

- **800-Medicare (800-633-4227)**. TTY users call **877-486-2048** (24 hours a day/seven days a week).
- Your state Medicaid office, or the Social Security Administration at **800-772-1213**. TTY users should call **800-325-0778**, between 8 a.m. and 7 p.m., Monday through Friday.

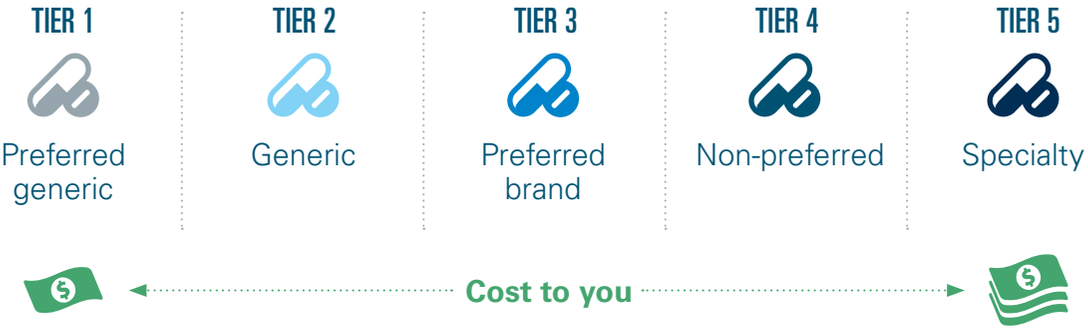
Frequently used benefits	Medicare Advantage Core HMO In-network
Premium	$0 monthly premium
Maximum out of pocket for Medicare-covered medical services	$3,900 annually
Medical deductible	$0
Referrals required	No
Office visits or telehealth: primary care	$0 copay
Office visits or telehealth: specialists	$40 copay
24/7 Nurse line	$0 copay
Dental*	$1,425 annual maximum reimbursement benefit for covered services
VSP vision benefits	$10 copay for a routine eye exam $200 plan coverage limit for eyewear every 12 months
Medicare-covered vision services	$0 copay for a glaucoma screening $40 copay for Medicare-covered exams $0 copay for Medicare-covered eyewear after each cataract surgery
Supplemental hearing* Routine hearing exam Hearing aid fitting and evaluation Hearing aid allowance per ear	$10 copay (one per year) $0 copay (once every three years) $500 (once every three years)
Medicare-covered hearing Hearing exam with a primary care provider Hearing exam with a specialist	$0 copay $40 copay
Urgent care within the U.S. Emergency care within the U.S. Emergency and urgent care outside the U.S.	$60 copay $120 copay $120 copay, $50,000 lifetime maximum
Outpatient ambulatory surgical center Outpatient hospital services	$300 copay $395 copay
Ambulance services (ground and air)	$350 copay
Inpatient acute hospital care	$400 copay per day for days 1-4 $0 copay for days 5+
Skilled nursing facility (in a Medicare-certified skilled nursing facility)	Days 1-20: $0 copay Days 21-53: $196 copay Days 54-100: $0 copay
Durable medical equipment	20% coinsurance
Diabetic supplies and services*	0%-20%; no cost-share for preferred brands
Preventive services (services include but are not limited to the list on page 7)	$0 copay
Chiropractic care*	$20 copay for Medicare-covered services and routine care $0 copay annually for one set of X-rays; up to three views
Acupuncture services	$20 copay for Medicare-covered services
Over-the-Counter (OTC) benefit	$50 quarterly allowance; allowance balance does not roll over to next quarter

*Not a complete description of benefits. Please see Summary of Benefits on page 24 for full details.

Vision Service Plan (VSP) is an independent company providing supplemental vision care products for Blue Cross and Blue Shield of Nebraska.

PRESCRIPTION DRUG COVERAGE

BCBSNE Medicare Advantage plans include prescription drug coverage that's **easy to use and understand**. With a wide selection of in-network pharmacies and the option to have prescriptions delivered directly to your front door, access to your prescriptions is designed to be as convenient as possible. Copays are affordable too, with a $0, 90-day mail order copay option on generic drugs. No matter where you live in the 76-county service area (listed on page 6), you can count on copayments and coinsurance as outlined in the charts below.



$0 CORE HMO PLAN

	Medicare Advantage Core HMO		
Drug Tiers	Rx Deductible	Copayment/Coinsurance	
		30-Day Supply: In-network Pharmacy	90-Day Supply: Mail Order**
TIER 1 (Preferred generic)[1]	$0	$4	$0
TIER 2 (Generic)		$14	$0
TIER 3 (Preferred brand)		$47	$141
TIER 4 (Non-preferred)		$100	$300
TIER 5 (Specialty)		33%	N/A

Members won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier

	Medicare Advantage Core HMO
Initial coverage limit	You pay copays and coinsurance until your total yearly drug costs reach $5,030
Gap coverage	Generic Drugs – 25% copay of the plan's cost Brand Name Drugs – 25% copay of the plan's cost
Catastrophic coverage	Amount you pay after paying $8,000 $0 cost share for all medications except excluded drugs

1 Includes coverage for generic Viagra (Sildenafil)

** Mail order extended based on 90-day supply.

BENEFITS BEYOND ORIGINAL MEDICARE

Taking Medicare to the next level.

When you buy a health insurance plan, it's nice to know that dental, vision, hearing and more are covered.

Dental Coverage

Our dental plans cover preventive and comprehensive services not typically covered by Original Medicare. Coverage includes **reimbursement from the dentist of your choice:**

- A services include: oral exams, routine cleanings, X-rays, fluoride treatment and more
- B services include: restorative dental services
- C services include: crowns, root canals, dentures and more

Vision Care

Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses or contact lenses. Our additional vision benefits through a VSP provider complements Original Medicare coverage by adding routine eye exams and an eyewear allowance every 12 months.

Hearing Benefit

To help lower your out-of-pocket costs, our covered services also include a routine hearing exam once every 12 months, related hearing tests furnished as part of a covered hearing exam and an allowance every three years towards the cost of hearing aids.

Enhanced Chiropractic Care

We've got your back by saving you money with our enhanced chiropractic benefit. Chiropractic care is most often used to treat neuro-musculoskeletal complaints, including but not limited to back pain, neck pain, headaches and pain in the joints of the arms or legs. Chiropractors take a drug-free, hands-on approach to health care that includes patient examination, diagnosis and treatment.

- $20 copay for office visit
- $0 copay for first set of routine X-rays

Over-the-Counter (OTC) Allowance

While you don't need a prescription for your OTC medications, they are an important part of your health and wellness. Medicare Advantage plans from BCBSNE offer a quarterly allowance on common OTC medications such as vitamins, pain relievers, cold remedies and more.

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TRAVEL BENEFITS

Traveling outside of Nebraska? You're covered coast to coast and beyond.

No matter where your plans might take you, you're covered when you travel with a Medicare Advantage plan from BCBSNE. The best part is **no pre-notification of travel plans is required**.

If you need any covered services when you're traveling outside of Nebraska, you can access care using the nationwide network of Blue Plan providers available through the Blue Cross Blue Shield Association (BCBSA). The travel benefits of your Medicare Advantage plan allow you to receive certain covered services from participating providers. Participating providers are those who accept Medicare and are considered an in-network provider with the local Blue Cross and Blue Shield Plan.

Members of BCBSNE Medicare Advantage plans can enjoy benefits and low costs at home and away. You can travel with confidence.

- Opens up possibilities for treatment by specialty centers throughout the United States.
- Coverage follows you when you leave Nebraska.
- No need to notify us of your travel plans – we've got you covered!

For more information, please refer to the Summary of Benefits on page 24.

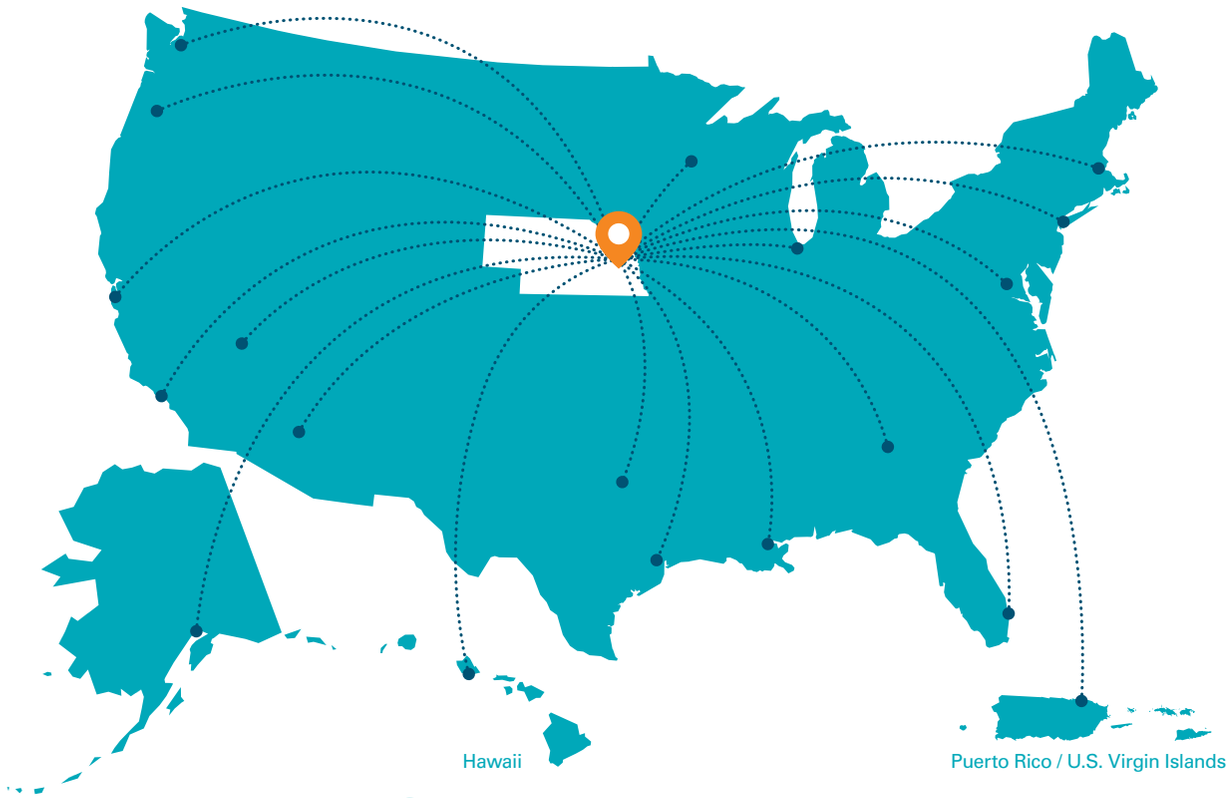
Worldwide emergency and urgent care coverage.

Traveling abroad? We've got you covered there too!

You can access emergency or urgently needed care whenever and wherever you may need it. With Blue Cross Blue Shield Global® Core, worldwide coverage is just another way we give you the confidence that comes with being a member. Through the Blue Cross Blue Shield Global Core program, you have access to medical assistance services, doctors and hospitals in more than 200 countries and territories around the world.

TRAVEL BENEFITS

Nationwide coverage area



Robust travel coverage

Product	Travel within the NE service area	Travel outside of NE and inside the U.S.	Travel outside the U.S.
Core HMO	In-network providers are covered with a $3,900 maximum out of pocket; Limited out-of-network coverage for emergency care ($120 copay) and urgent care ($60 copay)	Covered at in-network costs with a $3,900 maximum out of pocket	Emergency $120 copay Urgent care $120 copay Lifetime maximum $50,000

Emergency and urgent care is covered statewide, nationally and globally.

For more information, please refer to the Summary of Benefits on page 24.

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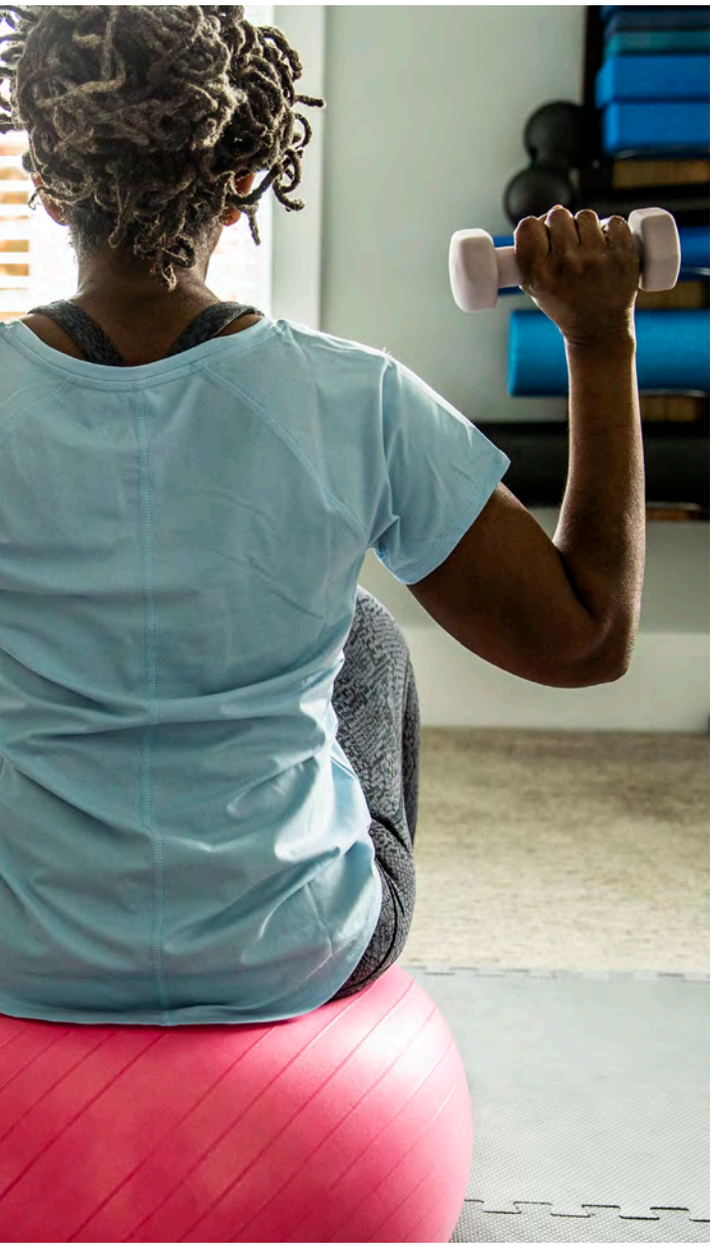
SILVERSNEAKERS® FITNESS PROGRAM

Stay active the way you want, at your convenience.

Stay fit with Tivity Health's SilverSneakers. SilverSneakers allows you to take control of your health with exercise classes and social activities. Your SilverSneakers membership gives you access to gyms and fitness locations nationwide, in addition to virtual classes you can take from the comfort of your own home. This program is designed specifically for older adults and is available at no additional cost to you.



SilverSneakers includes:

Access to 15,000+ locations nationwide

- Use the exercise equipment and other basic amenities like pools and saunas
- Take SilverSneakers classes
- Receive guidance and assistance from helpful staff at network locations
- Participate in social activities
- Take advantage of all the same benefits when you travel*

Online and in-home programming

- ***SilverSneakers Steps Kit*** is an at-home kit available if you can't get to a location
- SilverSneakers LIVE™ virtual classes throughout the week
- SilverSneakers On-Demand™ videos available 24/7
- Online tools to assess your health and track your activity
- Fitness and meal planning advice, including healthy recipes

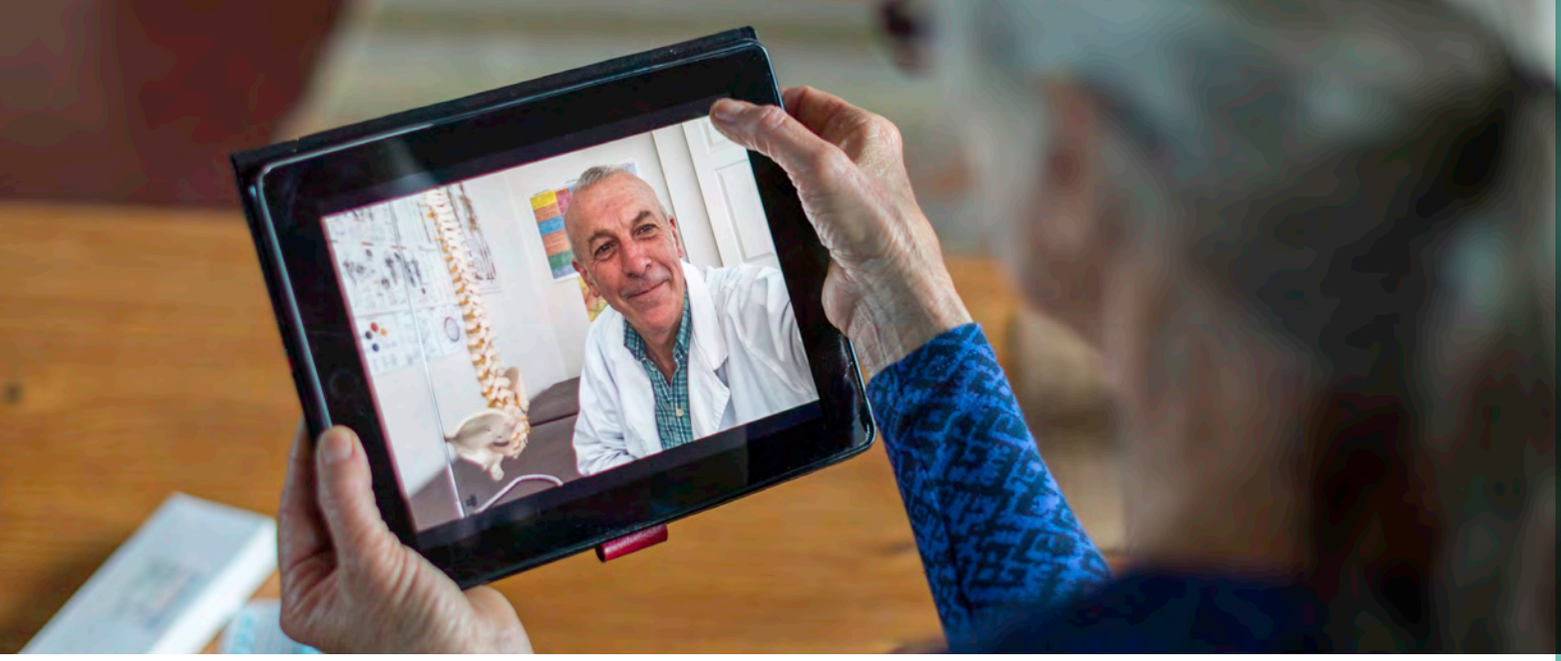
Community engagement with SilverSneakers FLEX™

- Activities at parks, recreation centers and other local venues
- Classes such as dance, tai chi, yoga and walking groups
- Online activity locator

To learn more or to find a gym near you, visit **SilverSneakers.com**.

SilverSneakers® by Tivity Health

*Limitations and exclusions apply.



HELPING YOU STAY HEALTHY

Virtual resources and doctor visits.

If you have basic health questions, virtual appointments can often be the answer.

Sometimes a call with a nurse or a video conference with your doctor can help keep you healthy without having to visit the office. With your Medicare Advantage plan from BCBSNE, nurse line and telehealth services are covered.

- $0 copay for 24/7 nurse line calls
- Office visit copays applied to some services through telehealth

Help with surgical decisions.

Welvie® is an independent company contracted by BCBSNE to provide surgery decision support services to our members.

Welvie provides a surgery decision support program. Designed by surgeons, Welvie walks you through the entire surgery decision-making process, from diagnosis to recovery.

Care management and behavioral health services.

If you have a condition, we're here to help.

Our health care management services help you stay healthy, enhance your quality of life and support recovery. If you have a qualifying health condition, your personal care management nurse will build a specialized care plan for you. For emotional or mental distress, including depression and drug or alcohol abuse, a specialized case manager will work with you to get the right care and services arranged.

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WHEN TO ENROLL

You may enroll in a Medicare Advantage plan during specific times of the year.

Initial Coverage Election Period

You can enroll when you first become eligible for Medicare (three months before the month you turn age 65 until three months after the month you turn age 65). This is called the Initial Coverage Election Period (ICEP). If you did not elect Medicare Part B when you were first eligible, you can still enroll in a Medicare Advantage plan. You will have a three-month period to enroll, which begins three months before your Medicare Part B effective date.

Annual Enrollment Period (Oct. 15 - Dec. 7)

If you are eligible for Medicare, you can enroll in or switch plans during the Annual Enrollment Period. For example, you can switch from Original Medicare to a Medicare Advantage plan. Your coverage will be effective on Jan. 1 of the following year.

Medicare Advantage Open Enrollment Period (Jan. 1 - March 31)

After the Annual Enrollment Period, individuals enrolled in a Medicare Advantage plan will have an additional three months where you can switch to another Medicare Advantage plan or return to Original Medicare coverage.

Special Enrollment Period

In certain situations, you may be able to join, switch or drop a Medicare Advantage plan at other times during the year. Some of these situations include:

- If you move out of your plan's service area
- If you have both Medicare and Medicaid
- If you qualify for Extra Help paying for your Part D prescription drugs
- If you live in an institution (such as a nursing home)
- If you lose your employer coverage

HOW TO ENROLL

Medicare can be complex. Enrolling in our plans is easy.

Sign up for our Medicare Advantage plans online, by phone or by mail.
You'll need your red, white and blue Medicare card.

STEP 1: Confirm your eligibility

- Must have Medicare Part A and Part B
- Reside in the plan's service area:

  Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cass, Cedar, Chase, Clay, Colfax, Cuming, Custer, Dawson, Deuel, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler and York counties.

- Continue to pay Medicare Part B premium (in addition to your Medicare Advantage plan premium)

STEP 2: Choose a plan that best fits your needs

As you consider your health care needs and estimate your costs, answering these questions can help ensure you choose wisely:

- How often do I see my primary care physician or specialist?
- How many times have I been in the hospital in the recent years?
- What level of prescription coverage do I need?

STEP 3: Enroll in one of three ways

MAIL: Complete the enclosed application and mail it to us

ONLINE: Visit **NebraskaBlue.com/EnrollMedicare** to enroll online

PHONE: Call **844-291-6880 (TTY 711)**

- From Oct. 1 to March 31, you can call us seven days a week, 8 a.m. to 9 p.m. CT
- From April 1 to Sept. 30, you can call us Monday through Friday, 8 a.m. to 9 p.m. CT

No payment is needed when you enroll. We'll send a letter to confirm your intent to join the plan. This usually happens within 30 days. Once enrolled, you'll receive a member ID card and Welcome Kit with information about how to use your benefits.

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GLOSSARY

Annual Enrollment Period – The Annual Enrollment Period (AEP) is for individuals on Medicare who have not yet joined a plan or are already enrolled in a plan and want to switch, with coverage effective Jan. 1.

Benefit Period – The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.

Blue Cross Blue Shield Global Core – A program that allows for reimbursement of funds used for urgent and emergency care obtained when traveling outside of the United States.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Copayment – A fixed dollar amount you pay for health care, such as an office visit, medical test or prescription drug.

Deductible – The amount you must pay before your plan begins to pay its share.

Drug Tiers – Drugs on a formulary are usually grouped into tiers. The tier that your medication is in determines your portion of the drug cost.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Formulary – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Gap Coverage – After your total prescription drug costs reach the initial coverage limit of your prescription drug plan and before they reach the maximum out-of-pocket costs.

Initial Coverage Election Period (ICEP) – The period during which an individual is newly eligible for a Medicare Advantage plan. Normally, this period begins three months before the individual's first entitlement to both Medicare Part A and Part B and ends three months after the month of eligibility. For most individuals, this means the ICEP begins three months before you turn age 65 and ends three months after the month in which you turn 65. However, for individuals who defer their enrollment into Part B (because, for example, they've continued to work), the ICEP is only the three months immediately preceding entitlement to Part B.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Medicare Part A – Helps cover hospital, skilled nursing facility, hospice care and home health care.

Medicare Part B – Helps cover doctor services, outpatient care, durable medical equipment (DME) and some preventive services.

Medicare Part C – Insurance plan offered by private companies that include Medicare Parts A and B, plus may cover some additional services such as vision, hearing, dental and certain health/wellness programs. Most Medicare Advantage plans offer prescription drug coverage. (Medicare Part D).

Medicare Part D – Medicare Part D is prescription drug coverage, and helps cover the cost of many outpatient prescription drugs. If you enroll in a Medicare Advantage plan this drug coverage is usually included into the plan, otherwise it is offered through insurance companies as a separate plan.

Open Access – Open access health plans do not have a Primary Care Physician (PCP) requirement, which means referrals are not required.

Open Enrollment Period – A set time after AEP (Jan. 1 - March 31) where individuals have an additional three months when they can make one switch from their current Medicare Advantage plan to another Medicare Advantage plan or back to Original Medicare.

Out-of-Pocket Maximum – The most you will spend for copays, coinsurance and deductibles in any given year.

Pharmacy Network – Network pharmacy that offers covered Part D drugs to members of our plan that may have lower cost-sharing levels than at other network pharmacies.

Preferred Provider Organization or PPO – A PPO allows you to visit any health provider you'd like. You often pay more to see doctors outside the preferred provider network. Referrals aren't usually necessary to see specialists.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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OTHER IMPORTANT INFORMATION

Blue Cross and Blue Shield of Nebraska is an HMO plan with a Medicare contract. Enrollment in a Blue Cross and Blue Shield of Nebraska Medicare Advantage plan depends on contract renewal.

This information is not a complete description of benefits. Call **888-488-9850 (TTY 711)** for more information.

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross Blue Shield Association.

NOTES

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APPENDIX

Summary of Benefits
Non-Discrimination Notice
Multi-Language Notice

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO

2024

SUMMARY OF BENEFITS

Jan. 1, 2024 – Dec. 31, 2024

This information is not a complete description of the benefits. Call 1-888-488-9850/TTY 711 for more information. A complete list of services is available in the *Evidence of Coverage*. You may review the *Evidence of Coverage* online or by calling Customer Service (The website and phone numbers are printed on the back cover of this booklet).

To join Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

There are two service areas for the **Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO** plan: Metro and Central. **Metro** includes these counties in Nebraska: Cass, Dodge, Douglas, Lancaster, Otoe, Sarpy, Saunders and Washington. **Central** includes these counties in Nebraska: Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cedar, Chase, Clay, Colfax, Cuming, Custer, Dawson, Deuel, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Saline, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler and York.

Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

For more detailed information about our providers and our provider directory, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **Medicare.NebraskaBlue.com**.

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Premiums	Core HMO Metro	Core HMO Central	What You Should Know
Monthly Plan Premium	You pay $0		You must continue to pay your Medicare Part B premium.
Medical Benefits	**Core HMO Metro**	**Core HMO Central**	**What You Should Know**
Deductible	You pay $0		These plans do not have a Medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,900 annually		If you reach the limit for Medicare-covered services on out-of-pocket costs, and you keep getting Medicare-covered hospital and medical services we will pay the full cost for the rest of the year. You will still need to pay your monthly plan premiums, Medicare Part B premiums, and cost-sharing for your Part D drugs.
Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO Metro and Core HMO Central As a supplemental benefit, medical services are covered at in-network cost shares outside of the service area and within the U.S. and territories. With limited exceptions, there is no medical coverage for services provided by an out-of-network provider within the service area. Please contact the plan for assistance in locating a provider outside of the service area.			

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Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Inpatient Hospital Coverage	The copays for Medicare-covered hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for Medicare-covered inpatient hospital stay.		Services may require prior authorization.
	You pay a $400 copay per day for days 1 through 4. You pay a $0 copay for additional days.		
Outpatient Hospital Coverage	You pay a $395 copay for Medicare-covered outpatient hospital surgical services.		Services may require prior authorization. We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Ambulatory Surgical Center (ASC) Services	You pay a $300 copay for Medicare-covered ambulatory surgical center services.		Services may require prior authorization.
Doctor Visits • Primary Care Providers • Specialists	You pay a $0 copay, in-person and by telehealth. You pay a $40 copay, in-person and by telehealth.		

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Preventive Care	There is no coinsurance, copayment, or deductible for the following Medicare-covered and supplemental preventive services.		Any additional preventive services approved by Medicare during the contract year will be covered.
	Our plan covers many preventive services, including, but not limited to: • Abdominal aortic aneurysm screening • Annual physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screenings (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Immunizations (COVID-19, flu, pneumonia and Hepatitis B) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit		
Emergency Care	**Within the U.S.** You pay a $120 copay. The emergency room copay will be waived if you are admitted to the hospital within 3 days for the same condition. **Outside of the U.S.** You pay a $120 copay. $50,000 lifetime limit inclusive of emergency, urgent care and transportation outside of the U.S.		

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Urgently Needed Services	**Within the U.S.** You pay a $60 copay, in-person and telehealth services. **Outside of the U.S.** You pay a $120 copay. $50,000 lifetime limit inclusive worldwide emergency, urgent care and transportation		
Diagnostic Services/Labs/ Imaging			Services may require prior authorization.
• Diagnostic radiology service (e.g., MRI)	You pay a $195 copay for Medicare-covered diagnostic radiology services.		For Medicare-covered diagnostic tests and procedures: the minimum cost sharing applies to procedures performed in a professional office setting, the maximum applies to procedures performed in an outpatient setting.
• Lab services	You pay a $0 copay for Medicare-covered lab services.		
• Diagnostic tests and procedures	You pay a $30-395 copay for Medicare-covered diagnostic tests and procedures.		
• Outpatient X-rays	You pay a $25 copay for Medicare-covered X-rays.		
• Therapeutic radiology services	You pay 20% of the approved amount for Medicare-covered therapeutic radiology services.		
Hearing Services			
• Medicare-covered	You pay a $0 copay when seen by a Primary Care Provider and a $40 copay when seen by a Specialist.		
• Routine hearing exam	You pay a $10 copay.		One routine hearing exam per year is covered.
• Hearing aid	$500 allowance per ear toward one new standard (analog or basic digital) hearing aid every three years		
• Hearing aid fitting and evaluation	You pay a $0 copay once every three years.		

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Dental Services • Medicare-covered	You pay a $40 copay.		Preventive and Comprehensive Dental Services are covered as a member-reimbursed benefit. Dental forms can be downloaded at **Medicare.NebraskaBlue.com/MedicareAdvantage/Resources**.
• Supplemental Preventive and Comprehensive Dental Services	The Dental Services benefit provides a combined Preventive and Comprehensive $1,425 max benefit every plan year. The Preventive Dental Services benefit provides oral exams, routine cleanings, fluoride treatment and X-rays. Emergency Dental exams are covered as Preventive Dental Services oral exams. The Comprehensive Dental Services benefit provides diagnostic services, restorative services, endodontics, periodontics, extractions and prosthodontics. Preventive and comprehensive dental services must be provided by a licensed dental provider.		
Vision Services • Medicare-covered	You pay a $40 copay.		One routine eye exam per year is covered. Routine eye exams must be provided by a VSP provider to be considered in-network. One pair of eyeglasses or contact lenses after each cataract surgery that includes the insertion of an intraocular lens is covered. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)
• Supplemental eyewear when provided by a VSP provider www.VSP.com	$200 plan coverage limit every year for elective contact lenses or eyeglass frames through a VSP provider. Standard lenses for glasses are covered in full.		
• Routine eye exam when provided by a VSP provider	You pay a $10 copay.		
• Medicare-covered Eyeglasses or contact lenses after cataract surgery	You pay a $0 copay.		
• Medicare-covered Glaucoma Screening	You pay a $0 copay.		

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Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Mental Health Services	The copays for Medicare-covered inpatient psychiatric hospital care benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. Our plan covers 90 days for a benefit period.		In addition to the 90 days of coverage in each benefit period, the beneficiary receives 100 lifetime reserve days for inpatient hospital psychiatric stays. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.
• Inpatient visit	You pay a $420 copay per day for days 1 through 4. You pay a $0 copay per day for days 5 through 90. You pay a $0 copay for days 91 through 190 until the lifetime limitation is exhausted.		
• Outpatient therapy visit	You pay a $40 copay for Medicare-covered outpatient group/individual therapy visit, in-person and by telehealth.		
Skilled Nursing Facility (SNF)	The copays for Medicare-covered hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. Our plan covers 100 days for a benefit period.		Services may require prior authorization.
	You pay a $0 copay per day for days 1 through 20. You pay a $196 copay per day for days 21 through 53. You pay a $0 copay per day for days 54 through 100.		
Physical Therapy	You pay a $40 copay for a Medicare-covered physical therapy visit.		
Ambulance (Air and Ground)	**In the U.S., including the District of Columbia and Puerto Rico:** You pay a $350 copay for each Medicare-covered, one-way ground or air ambulance trip. **Outside the U.S.:** You pay a $120 copay for worldwide emergency transportation, one-way ground or air ambulance trip. $50,000 lifetime limit for worldwide coverage inclusive of emergency, urgent care and transportation.		Non-emergency ambulance trips may require prior authorization.

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Transportation	Not covered		
Medicare Part B Drugs	You pay 0%-20% of the cost for Medicare Part B chemotherapy drugs and other Medicare Part B drugs. You may pay less than 20% coinsurance for certain Medicare Part B drugs if their prices have increased higher than the rate of inflation. The specific drugs and potential savings change every quarter. You pay $35 for Medicare Part B Insulins.		Some drugs may require prior authorization and/or step therapy.
Chiropractic Care • Manual manipulation of the spine to correct a subluxation • Routine office visits • One set of X-rays (up to 3 views) when performed by a chiropractor.	You pay a $20 copay for each Medicare-covered visit. You pay a $20 copay for routine care visits. You pay a $0 copay for one annual set of X-rays.		You are covered for unlimited routine chiropractic visits.
Foot Care (podiatry services) • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	You pay a $40 copay for Medicare-covered visits, in-person and by telehealth.		Medicare-covered podiatry benefits are for medically necessary foot care.
Home Health Care	You pay a $0 copay.		A doctor must certify that you need home health services and will order home health services to be provided by a home health agency.
Hospice	You pay a $0 copay for hospice care from a Medicare-certified hospice program.		Hospice is covered outside of our plan. Please contact Customer Service for more details (phone numbers are on the back of this booklet).

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Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetes supplies (e.g., monitoring, shoes or inserts)	You pay 20% of the approved amount for Medicare-covered durable medical equipment. You pay 20% of the approved amount for Medicare-covered prosthetics. You pay 20% of the approved amount for Medicare-covered Diabetic Therapeutic Shoes or Inserts. You pay a $0 copay for Medicare-covered diabetes self-management training. You pay 20% coinsurance for Medicare-covered blood glucose monitors, blood glucose test strips, lancet devices, and lancets, but for Contour/Breeze/Ascensia brand blood glucose monitors, blood glucose test strips, lancet devices, and lancets you pay $0 copay. You pay a $0 copay for Medicare-covered solutions and urine/ketone tests.		Medical equipment/supplies may require prior authorization.
Outpatient Substance Abuse • Outpatient therapy visit	You pay a $40 copay for Medicare-covered group/individual therapy visit, in-person and by telehealth.		
Outpatient Surgery • Ambulatory surgical center • Outpatient hospital	You pay a $300 copay for Medicare-covered outpatient surgical services. You pay a $395 copay for Medicare-covered outpatient surgical services.		Services may require prior authorization.
Rehabilitation Services • Pulmonary • Cardiac • Intensive cardiac • Occupational, speech and language therapy	You pay a $15 copay for each Medicare-covered pulmonary visit. You pay a $35 copay for each Medicare-covered cardiac visit. You pay a $60 copay for each Medicare-covered intensive cardiac visit. You pay a $40 copay for each Medicare-covered therapy visit.		
Renal Dialysis	You pay 20% of the approved amount for each Medicare-covered renal dialysis service.		

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Wellness Programs (e.g., fitness)	You pay a $0 copay. Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.*		Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at **SilverSneakers.com** or 1-866-678-0828, 8 a.m. to 8 p.m. ET, Monday through Friday. TTY users call 711. If a member is unable to access a facility, they may receive a fitness kit delivered in the mail.
Acupuncture	You pay a $20 copay for up to 20 Medicare-covered acupuncture treatments annually.		Services may require prior authorization. Treatment must be discontinued if the patient is not improving or is regressing.
Nurse Hotline	You pay a $0 copay for calls to the Nurse Hotline.		Available 24 hours a day, 7 days a week.
Telehealth • Urgently needed services • Visits with a Primary Care Physician • Visits with a specialist • Individual and group mental health and psychiatric services • Podiatry services • Opioid treatment • Individual and group outpatient substance abuse services • Kidney disease education services • Other Health Care Professionals	You pay a $60 copay. You pay a $0 copay. You pay a $40 copay. You pay a $40 copay for each Medicare-covered individual and group mental health and psychiatric service. You pay a $40 copay for each Medicare-covered podiatry visit. You pay a $40 copay for each Medicare-covered opioid treatment visit. You pay a $40 copay for each Medicare-covered individual and group substance abuse service. You pay a $0 copay for Medicare-covered kidney disease education services. You pay a $0-$40 copay.		Telehealth visits are medical visits delivered to you by a provider that uses compliant technology capabilities. Not all medical conditions can be treated through Telehealth visits. The Telehealth doctor will identify if you need to see an in-person doctor for treatment. If you choose to receive one of these services via Telehealth, then you must use a provider that currently offers the service via Telehealth.

* Tivity Health™ is an independent company not associated with the Blue Cross Blue Shield Association. Blue Cross Blue Shield of Nebraska contracts with Tivity Health to offer the SilverSneakers fitness program benefit. SilverSneakers® is a registered trademark of Tivity Health, Inc.

Medical Benefits	Core HMO Metro	Core HMO Central	What You Should Know
Over-the-Counter (OTC) items	$50 quarterly allowance. The quarterly allowance balance does not rollover into the next quarter.		Members may obtain authorized OTC items using a prepaid card and from a vendor at retail locations and via mail, phone and website. Members may access their OTC benefit through a program that delivers to their home.

Blue Cross Blue Shield Nebraska – Core HMO Metro and Core HMO Central

Outpatient Prescription Drugs – Short-Term Supply*				
PHASE 1: Deductible Stage	$0 as there is no Part D Deductible			
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
	In-Network Retail Rx 30-day supply	**Mail-Order Rx 30-day supply**	**Long Term Care Rx 31-day supply**	
TIER 1 Preferred generic	You pay $4.	You pay $4.	You pay $4.	Cost-sharing may change 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 at 1-855-457-1349 or access our *Evidence of Coverage* online at Medicare.NebraskaBlue.com/MedicareAdvantage.
TIER 2 Generic	You pay $14.	You pay $14.	You pay $14.	
TIER 3 Preferred brand	You pay $47.	You pay $47.	You pay $47.	
TIER 4 Non-preferred	You pay $100.	You pay $100.	You pay $100.	
TIER 5 Specialty	You pay 33%.	You pay 33%.	You pay 33%.	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.			
PHASE 4: Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and mail order) reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

* You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

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Blue Cross Blue Shield Nebraska – Core HMO Metro and Core HMO Central

Outpatient Prescription Drugs – Long-Term Supply*					
PHASE 1: Deductible Stage	$0 as there is no Part D Deductible				
PHASE 2: Initial Coverage Stage	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.				
	In-Network Retail Rx 60-day supply	**Mail-Order Rx 60-day supply**	**In-Network Retail Rx 90-day supply**	**Mail-Order Rx 90-day supply**	
TIER 1 Preferred generic	You pay $8.	You pay $8.	You pay $12.	You pay $0.	Cost-sharing may change 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 at 1-855-457-1349 or access our *Evidence of Coverage* online at Medicare.NebraskaBlue.com/MedicareAdvantage.
TIER 2 Generic	You pay $28.	You pay $28.	You pay $42.	You pay $0.	
TIER 3 Preferred brand	You pay $94.	You pay $94.	You pay $141.	You pay $141.	
TIER 4 Non-preferred	You pay $200.	You pay $200.	You pay $300.	You pay $300.	
TIER 5 Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	
PHASE 3: Coverage Gap Stage	You pay 25% for generic and brand drugs.				
PHASE 4: Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and mail order) reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.				

* You won't pay more than $70 for a 60-day supply of each covered insulin product regardless of the cost-sharing tier. You won't pay more than $105 for a 90-day supply of each covered insulin product regardless of the cost-sharing tier.

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Nebraska does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Nebraska:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Customer Service at 1-888-488-9850, TTY 711.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001
1-888-488-9850, TTY: 711
Fax: 1-402-392-4130
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

BlueCross BlueShield Nebraska

P.O. Box 3248
1919 Aksarben Drive

Omaha, NE 68180-0001
NebraskaBlue.com

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-488-9850 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-488-9850 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-488-9850 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-488-9850 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-488-9850 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-488-9850 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-488-9850 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-488-9850 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-488-9850 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-488-9850 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-488-9850 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية .

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-488-9850 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-488-9850 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-488-9850 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-488-9850 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-488-9850 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-488-9850 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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Need more information?

For more information, please call us at the phone number below or visit us at **Medicare.NebraskaBlue.com**.

If you are a member of this plan, call toll-free **1-888-488-9850 (TTY users should call 711)**.

If you are not a member of this plan, call toll-free **1-844-899-6060 (TTY users should call 711)**.

From Oct. 1 to March 31, you can call us 7 days a week, 8 a.m. to 9 p.m. CT.

From April 1 to Sept. 30, you can call us Monday through Friday, 8 a.m. to 9 p.m. CT.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **Medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. **TTY users should call 1-877-486-2048**.

This document is available in other formats, such as large print by calling the customer service phone number.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Blue Shield Nebraska Medicare Advantage Core HMO 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.

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

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NOTES

QUESTIONS? WE'RE HERE FOR YOU!

For more information about our plan choices, call toll-free **844-291-6880 (TTY 711)**, email **GetStarted@NebraskaBlue.com** or visit **Medicare.NebraskaBlue.com**.

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Is a BCBSNE Medicare Advantage plan right plan for you?

Find out for yourself.

Visit us in person

Blue Cross Centre:
1919 Aksarben Drive
Omaha, NE 68106

Give us a call

Call **844-291-6880 (TTY 711)**

- From Oct. 1 to March 31, you can call us seven days a week, 8 a.m. to 9 p.m. CT
- From April 1 to Sept. 30, you can call us Monday through Friday, 8 a.m. to 9 p.m. CT
- Reserve a seat at an informational meeting in your area. Visit **Medicare.NebraskaBlue.com/Seminars** for a listing of all events. For accommodations of persons with special needs at meetings, call **844-291-6880 (TTY 711)**.
- Arrange a personal consultation with a local BCBSNE agent.

Visit us online

Visit **Medicare.NebraskaBlue.com** to learn more about our plans.

BlueCross BlueShield Nebraska

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