2021 Summary of Benefits

BlueMedicare HMO℠

MedicareRx Prescription Drug Coverage

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare HMO plans for **January 1, 2021 – December 31, 2021**.

Plans:
Medical Only (HMO): H3449-012
Essential (HMO): H3449-025
Essential Plus (HMO): H3449-023-001, H3449-023-002, H3449-023-004, H3449-023-005
Choice (HMO): H3449-026
Enhanced (HMO): H3449-024-001, H3449-024-002, H3449-024-003

Notes:

- 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.
- 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 NC is an HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.
- The benefits information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. For more details, contact Blue Cross NC at **1-888-247-4142** (TTY: 711), access online at ***BlueCrossNC.com/Medicare*** or call your Blue Cross NC Authorized Agent.

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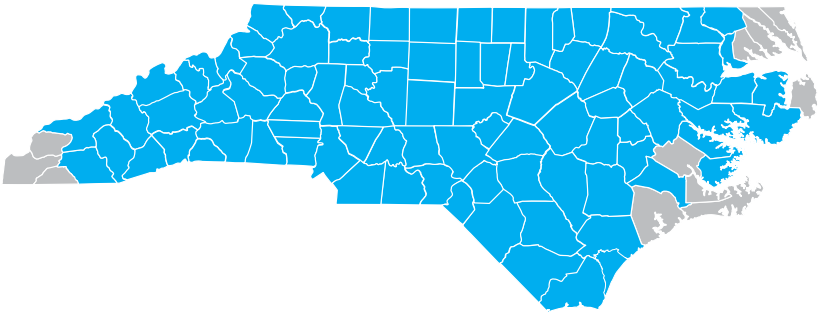
Summary of Benefits

Plan Offering and Premium By County:

BlueMedicare Medical Only℠ (HMO) H3449-012 **Monthly Premium: $0**

Alamance	Catawba	Granville	Lenoir	Pender	Swain
Alexander	Chatham	Greene	Lincoln	Person	Transylvania
Alleghany	Chowan	Guilford	Macon	Pitt	Tyrrell
Anson	Cleveland	Halifax	Madison	Polk	Union
Ashe	Columbus	Harnett	Martin	Randolph	Vance
Avery	Cumberland	Haywood	McDowell	Richmond	Wake
Beaufort	Davidson	Henderson	Mecklenburg	Robeson	Warren
Bertie	Davie	Hertford	Mitchell	Rockingham	Washington
Bladen	Duplin	Hoke	Montgomery	Rowan	Watauga
Brunswick	Durham	Hyde	Moore	Rutherford	Wayne
Buncombe	Edgecombe	Iredell	Nash	Sampson	Wilkes
Burke	Forsyth	Jackson	New Hanover	Scotland	Wilson
Cabarrus	Franklin	Johnston	Northampton	Stanly	Yadkin
Caldwell	Gaston	Jones	Orange	Stokes	Yancey
Caswell	Gates	Lee	Pamlico	Surry	



Counties where Blue Medicare Only (HMO) is available.

Please note: To join Blue Medicare HMO plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Summary of Benefits

BlueMedicare Medical Only℠ (HMO)

		H3449-012
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	$0
Deductible:	This plan has no medical deductible.	$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	$4,400
Benefits		
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$335 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	**Ambulatory Surgical Center:**	$225 copay
	Outpatient Hospital:	$325 copay
Doctor Visit:	**Primary:**	$20 copay
	Specialist:	$40 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.	$90 copay
Urgently Needed Services:		$65 copay

* May require prior authorization.

Summary of Benefits

BlueMedicare Medical Only℠ (HMO)

Benefits			H3449-012
Diagnostic Services/ Labs/Imaging:		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	$0–$300 copay
Hearing Services:	**Medicare-Covered Hearing Exam:**	Exams to diagnose and treat hearing and balance issues.	$40 copay
	Routine Hearing Exam:	One per year. Must use designated providers.	$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.	$699–$999 copay
Dental Services:	**Medical-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$40 copay
	Preventive Dental:	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	$300
Vision Services:	**Routine Eye Exam:**	Once every 12 months.	$25 copay
	Routine Eyewear:	Yearly allowance.	$100
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$25 copay
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost

* May require prior authorization.

Summary of Benefits

BlueMedicare Medical Only℠ (HMO)

Benefits			H3449-012
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$300 copay
		Days 7–90:	$0 copay
	Outpatient: (Mental health* and substance abuse)	Individual and group sessions	$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**	$0 copay
		Days 21–60:	$184 copay
		Days 61–100:	$0 copay
Outpatient Rehabilitation Services:		**Occupational, Physical and Speech Language Therapy:**	$40 copay
		Cardiac and Pulmonary Rehab Services:	$30 copay
Ambulance Services:*		Covers medically necessary ground and air ambulance services.	$250 copay
Transportation:			Not covered
Medicare Part B Drugs:*			20% of cost
Podiatry Services:		Foot care	$40 copay
Medical Equipment and Supplies:		**Durable Medical Equipment and Supplies:***	20% of cost
		Diabetic Shoes or Inserts:	20% of cost
		Diabetes Supplies:*	$0 copay
Healthy Aging and Exercise Program:		Participating facilities	$0 copay

* May require prior authorization.

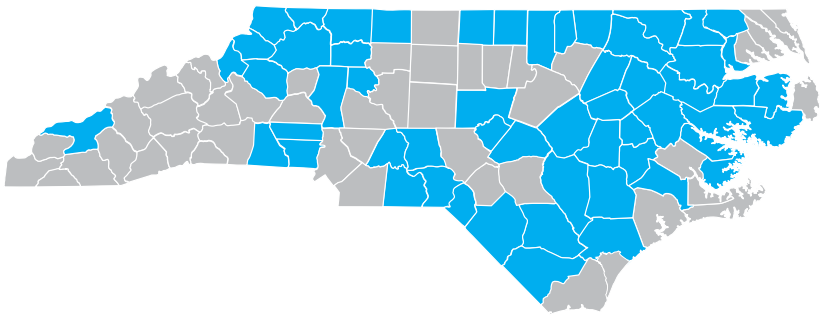
Summary of Benefits

Plan Offering and Premium By County:

Blue Medicare Essential℠ (HMO) H3449-025

Monthly Premium: $0

Alleghany	Chatham	Granville	Lee	Pitt	Tyrrell
Anson	Chowan	Greene	Lenoir	Richmond	Vance
Ashe	Cleveland	Halifax	Lincoln	Robeson	Warren
Avery	Columbus	Harnett	Martin	Sampson	Washington
Beaufort	Davie	Hertford	Montgomery	Scotland	Watauga
Bertie	Duplin	Hyde	Nash	Stanly	Wayne
Bladen	Edgecombe	Iredell	Northampton	Stokes	Wilkes
Caldwell	Gaston	Johnston	Pamlico	Surry	Wilson
Caswell	Gates	Jones	Pender	Swain	Yadkin



Counties where Blue Medicare Essential (HMO) is available.

Please note: To join Blue Medicare HMO plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Summary of Benefits

BlueMedicare Essential℠ (HMO)

		H3449-025
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	$0
Annual Deductible:	This plan has no medical deductible.	$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	$6,700
Benefits		
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$335 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	**Ambulatory Surgical Center:**	$275 copay
	Outpatient Hospital:	$335 copay
Doctor Visit:	**Primary:**	$10 copay
	Specialist:	$50 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.	$90 copay
Urgently Needed Services:		$65 copay

* May require prior authorization.

Summary of Benefits

BlueMedicare Essential℠ (HMO)

Benefits			H3449-025
Diagnostic Services/ Labs/Imaging:		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	$0–$300 copay
Hearing Services:	**Medicare-Covered Hearing Exam:**	Exams to diagnose and treat hearing and balance issues.	$50 copay
	Routine Hearing Exam:	One per year. Must use designated providers.	$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.	$699–$999 copay
Dental Services:	**Medical-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$50 copay
	Preventive Dental:	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	$250
Vision Services:	**Routine Eye Exam:**	Once every 12 months.	$25 copay
	Routine Eyewear:	Yearly allowance.	$100
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$25 copay
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost

* May require prior authorization.

Summary of Benefits

BlueMedicare Essential℠ (HMO)

Benefits			H3449-025
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$300 copay
		Days 7–90:	$0 copay
	Outpatient: (Mental health* and substance abuse)	Individual and group sessions	$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**	$0 copay
		Days 21–60:	$184 copay
		Days 61–100:	$0 copay
Outpatient Rehabilitation Services:		**Occupational, Physical and Speech Language Therapy:**	$40 copay
		Cardiac and Pulmonary Rehab Services:	$30 copay
Ambulance Services:*		Covers medically necessary ground and air ambulance services.	$275 copay
Transportation:			Not covered
Medicare Part B Drugs:*			20% of cost

To find other covered benefits, **see the bottom of page 31.**
For prescription drug coverage information, **see pages 30–31.**

* May require prior authorization.

Summary of Benefits — Prescription Drug Coverage

Blue Medicare Essential℠ (HMO) H3449-025

Part D, Prescription Drug Benefit Stages

Annual Deductible:	This is the set amount that you pay before your plan begins to pay its share of the cost. **Tiers 1, 2, 3 and 6:** $0 **Tiers 4 and 5:** $375
Initial Coverage Limit (ICL):	**Begins after you pay your yearly deductible.** You remain in this stage until your total year-to-date costs on covered drugs reach **$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)
Coverage Gap:	**Begins when your total year-to-date costs on covered drugs exceed $4,130.** In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at preferred pharmacies or a **$3** copayment at non-preferred pharmacies.
Catastrophic Coverage:	**Begins when your total year-to-date costs on covered drugs exceed $6,550.** During this stage, you pay the greater of **$3.70** or **5%** of the cost for generic drugs, and the greater of **$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, **see pages 17–20.**

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Essential℠ (HMO) H3449-025

	Preferred Pharmacies		Preferred Mail Order	Non-Preferred Pharmacies	
	1-month 30-day supply	3-months 90-day supply	3-months 90-day supply	1-month 30-day supply*	3-months 90-day supply
Preferred Generic Drugs (Tier 1)	$3 copay	$9 copay	$0 copay	$15 copay	$45 copay
Generic Drugs (Tier 2)	$10 copay	$30 copay	$0 copay	$20 copay	$60 copay
Preferred Brand Drugs (Tier 3)	$37 copay	$111 copay	$74 copay	$47 copay	$141 copay
Non-Preferred Drugs (Tier 4)	36% of cost	36% of cost	36% of cost	38% of cost	38% of cost
Specialty Tier Drugs (Tier 5)	26% of cost	N/A	N/A	26% of cost	N/A
Select Care Drugs (Tier 6)	$0 copay	$0 copay	$0 copay	$3 copay	$3 copay

Other Covered Benefits H3449-025

Podiatry Services:	Foot care	$50 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	$0 copay
Healthy Aging and Exercise Program:	Participating facilities	$0 copay

* Long-term care pharmacy benefit is covered the same as retail non-preferred for 31 days instead of 30 days.

** May require prior authorization.

Note: Two-month (60-day) supplies may also be available.

Summary of Benefits

Plan Offerings and Premiums By County:

Blue Medicare Essential Plus℠ (HMO) H3449-023-001

Monthly Premium: $0

Alamance	Catawba	Forsyth	Mecklenburg	Rockingham
Buncombe	Davidson	Guilford	Orange	Rutherford
Burke	Durham	Haywood	Randolph	Wake

Blue Medicare Essential Plus℠ (HMO) H3449-023-002

Monthly Premium: $0

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

Blue Medicare Essential Plus℠ (HMO) H3449-023-004

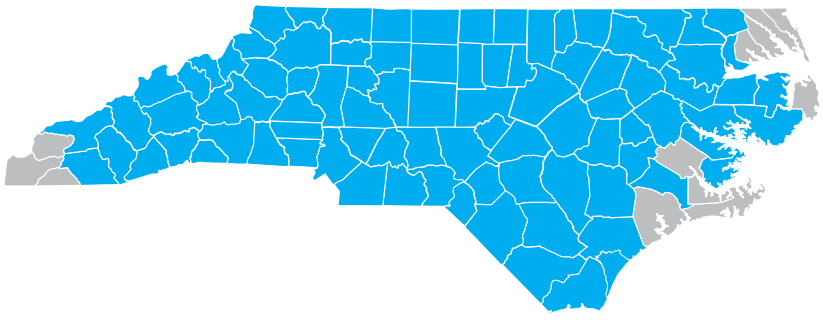
Monthly Premium: $19

Anson	Chatham	Johnston	Stanly	Surry	Warren
Caswell	Granville	Montgomery	Stokes	Vance	

Blue Medicare Essential Plus℠ (HMO) H3449-023-005

Monthly Premium: $39

Alleghany	Cleveland	Halifax	Lincoln	Robeson	Wilkes
Ashe	Columbus	Harnett	Martin	Sampson	Wilson
Avery	Davie	Hertford	Nash	Scotland	Yadkin
Beaufort	Duplin	Hyde	Northampton	Swain	
Bertie	Edgecombe	Iredell	Pamlico	Tyrrell	
Bladen	Gaston	Jones	Pender	Washington	
Caldwell	Gates	Lee	Pitt	Watauga	
Chowan	Greene	Lenoir	Richmond	Wayne	



Counties where Blue Medicare Essential Plus (HMO) is available.

Please note: To join Blue Medicare HMO plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Summary of Benefits

BlueMedicare Essential Plus℠ (HMO)		H3449-023-001	H3449-023-002	H3449-023-004	H3449-023-005
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	$0	$0	$19	$39
Deductible:	These plans have no medical deductible.	$0	$0	$0	$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	$4,200	$5,400	$6,700	$6,700
Benefits					
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$335 copay			
	Days 7–90:	$0 copay			
	Days 91 and beyond:	$0 copay			
Outpatient Services:*	**Ambulatory Surgical Center:**	$275 copay			
	Outpatient Hospital:	$335 copay			
Doctor Visit:	**Primary:**	$0 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.	$90 copay			
Urgently Needed Services:		$65 copay			

* May require prior authorization.

Summary of Benefits

BlueMedicare Essential Plus℠ (HMO) **Benefits**			H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
Diagnostic Services/ Labs/Imaging:		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	$0–$300 copay
Hearing Services:	**Medicare-Covered Hearing Exam:**	Exams to diagnose and treat hearing and balance issues.	$45 copay
	Routine Hearing Exam:	One per year. Must use designated providers.	$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.	$699–$999 copay
Dental Services:	**Medical-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$45 copay
	Preventive Dental:	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	$325
Vision Services:	**Routine Eye Exam:**	Once every 12 months.	$25 copay
	Routine Eyewear:	Yearly allowance.	$200
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$25 copay
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost

* May require prior authorization.

Summary of Benefits

BlueMedicare Essential Plus℠ (HMO)

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

Benefits			
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$300 copay
		Days 7–90:	$0 copay
	Outpatient: (Mental health* and substance abuse)	Individual and group sessions	$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**	$0 copay
		Days 21–60:	$184 copay
		Days 61–100:	$0 copay
Outpatient Rehabilitation Services:		**Occupational, Physical and Speech Language Therapy:**	$40 copay
		Cardiac and Pulmonary Rehab Services:	$30 copay
Ambulance Services:*		Covers medically necessary ground and air ambulance services.	$275 copay
Transportation:			Not covered
Medicare Part B Drugs:*			20% of cost

To find other covered benefits, **see the bottom of page 37.**
For prescription drug coverage information, **see pages 36–37.**

* May require prior authorization.

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Essential Plus℠ (HMO)

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

Part D, Prescription Drug Benefit Stages

Annual Deductible:	This is the set amount that you pay before your plan begins to pay its share of the cost. **Tiers 1, 2, 3 and 6:** $0 **Tiers 4 and 5:** $195
Initial Coverage Limit (ICL):	**Begins after you pay your yearly deductible.** You remain in this stage until your total year-to-date costs on covered drugs reach **$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)
Coverage Gap:	**Begins when your total year-to-date costs on covered drugs exceed $4,130.** In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at preferred pharmacies or a **$3** copayment at non-preferred pharmacies.
Catastrophic Coverage:	**Begins when your total year-to-date costs on covered drugs exceed $6,550.** During this stage, you pay the greater of **$3.70** or **5%** of the cost for generic drugs, and the greater of **$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, **see pages 17–20.**

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Essential Plus℠ (HMO)

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

	Preferred Pharmacies		Preferred Mail Order	Non-Preferred Pharmacies	
	1-month 30-day supply	3-months 90-day supply	3-months 90-day supply	1-month 30-day supply*	3-months 90-day supply
Preferred Generic Drugs (Tier 1)	$0 copay	$0 copay	$0 copay	$15 copay	$45 copay
Generic Drugs (Tier 2)	$10 copay	$30 copay	$0 copay	$20 copay	$60 copay
Preferred Brand Drugs (Tier 3)	$37 copay	$111 copay	$74 copay	$47 copay	$141 copay
Non-Preferred Drugs (Tier 4)	41% of cost	41% of cost	41% of cost	43% of cost	43% of cost
Specialty Tier Drugs (Tier 5)	29% of cost	N/A	N/A	29% of cost	N/A
Select Care Drugs (Tier 6)	$0 copay	$0 copay	$0 copay	$3 copay	$3 copay

Other Covered Benefits		H3449-023-001, H3449-023-002, H3449-023-004, H3449-023-005
Podiatry Services:	Foot care	$45 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	$0 copay
Healthy Aging and Exercise Program:	Participating facilities	$0 copay

* Long-term care pharmacy benefit is covered the same as retail non-preferred for 31 days instead of 30 days.

** May require prior authorization.

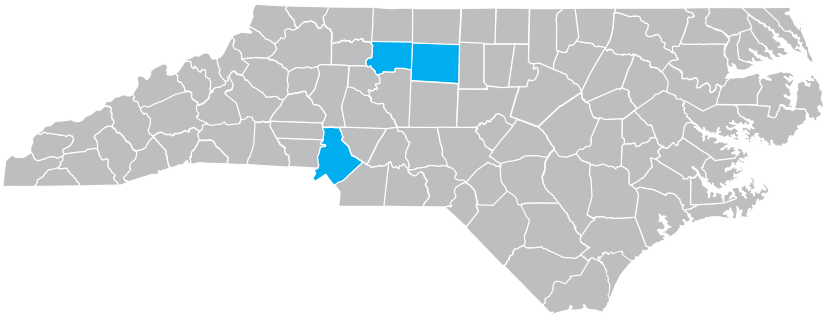
Note: Two-month (60-day) supplies may also be available.

Summary of Benefits

Plan Offering and Premium By County:

BlueMedicare Choice℠ (HMO) **H3449-026:** **Monthly Premium: $0**

Forsyth
Guilford
Mecklenburg



Counties where Blue Medicare Choice (HMO) is available.

Please note: To join Blue Medicare HMO plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Summary of Benefits

BlueMedicare Choice℠ (HMO)

		H3449-026
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	$0
Deductible:	These plans have no medical deductible.	$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	$3,900
Benefits		
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$335 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	**Ambulatory Surgical Center:**	$275 copay
	Outpatient Hospital:	$335 copay
Doctor Visit:	**Primary:**	Tier 1: $0 copay Others: $35 copay
	Specialist:	$40 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.	$90 copay
Urgently Needed Services:		$65 copay

* May require prior authorization.

Summary of Benefits

BlueMedicare Choice℠ (HMO)

Benefits			H3449-026
Diagnostic Services/ Labs/Imaging:		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	$0–$300 copay
Hearing Services:	**Medicare-Covered Hearing Exam:**	Exams to diagnose and treat hearing and balance issues.	$40 copay
	Routine Hearing Exam:	One per year. Must use designated providers.	$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.	$699–$999 copay
Dental Services:	**Medical-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$40 copay
	Preventive Dental:	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	$325
Vision Services:	**Routine Eye Exam:**	Once every 12 months.	$25 copay
	Routine Eyewear:	Yearly allowance.	$200
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$25 copay
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost

* May require prior authorization.

Summary of Benefits

BlueMedicare Choice℠ (HMO)

Benefits			H3449-026
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$300 copay
		Days 7–90:	$0 copay
	Outpatient: (Mental health* and substance abuse)	Individual and group sessions	$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**	$0 copay
		Days 21–60:	$184 copay
		Days 61–100:	$0 copay
Outpatient Rehabilitation Services:		**Occupational, Physical and Speech Language Therapy:**	$40 copay
		Cardiac and Pulmonary Rehab Services:	$30 copay
Ambulance Services:*		Covers medically necessary ground and air ambulance services.	$275 copay
Transportation:			Not covered
Medicare Part B Drugs:*			20% of cost

To find other covered benefits, **see the bottom of page 43.**
For prescription drug coverage information, **see pages 42–43.**

* May require prior authorization.

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Choice℠ (HMO) H3449-026

Part D, Prescription Drug Benefit Stages

Annual Deductible:	This is the set amount that you pay before your plan begins to pay its share of the cost. **All Tiers:** $0
Initial Coverage Limit (ICL):	**Begins after you pay your yearly deductible.** You remain in this stage until your total year-to-date costs on covered drugs reach **$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)
Coverage Gap:	**Begins when your total year-to-date costs on covered drugs exceed $4,130.** In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at preferred pharmacies or a **$3** copayment at non-preferred pharmacies.
Catastrophic Coverage:	**Begins when your total year-to-date costs on covered drugs exceed $6,550.** During this stage, you pay the greater of **$3.70** or **5%** of the cost for generic drugs, and the greater of **$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, **see pages 17–20.**

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Choice℠ (HMO) H3449-026

	Preferred Pharmacies		Preferred Mail Order	Non-Preferred Pharmacies	
	1-month 30-day supply	3-months 90-day supply	3-months 90-day supply	1-month 30-day supply*	3-months 90-day supply
Preferred Generic Drugs (Tier 1)	$0 copay	$0 copay	$0 copay	$15 copay	$45 copay
Generic Drugs (Tier 2)	$6 copay	$18 copay	$0 copay	$20 copay	$60 copay
Preferred Brand Drugs (Tier 3)	$37 copay	$111 copay	$74 copay	$47 copay	$141 copay
Non-Preferred Drugs (Tier 4)	45% of cost	45% of cost	45% of cost	50% of cost	50% of cost
Specialty Tier Drugs (Tier 5)	33% of cost	N/A	N/A	33% of cost	N/A
Select Care Drugs (Tier 6)	$0 copay	$0 copay	$0 copay	$3 copay	$3 copay

Other Covered Benefits H3449-026

Podiatry Services:	Foot care	$40 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	$0 copay
Healthy Aging and Exercise Program:	Participating facilities	$0 copay

* Long-term care pharmacy benefit is covered the same as retail non-preferred for 31 days instead of 30 days.

** May require prior authorization.

Note: Two-month (60-day) supplies may also be available.

Summary of Benefits

Plan Offerings and Premiums By County:

Blue Medicare Enhanced℠ (HMO) H3449-024-001:

Monthly Premium: $39

Alamance	Burke	Durham	Haywood	Randolph	Rutherford
Buncombe	Catawba	Guilford	Orange	Rockingham	Wake

Blue Medicare Enhanced℠ (HMO) H3449-024-002:

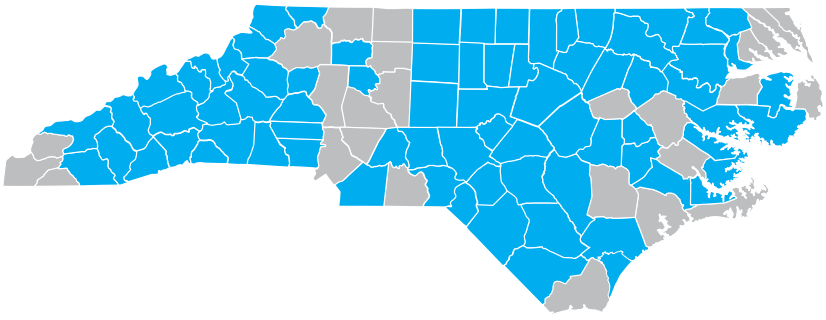
Monthly Premium: $49

Alexander	Henderson	Macon	Mitchell	Person	Union
Cumberland	Hoke	Madison	Moore	Polk	Yancey
Franklin	Jackson	McDowell	New Hanover	Transylvania	

Blue Medicare Enhanced℠ (HMO) H3449-024-003:

Monthly Premium: $75

Alleghany	Chatham	Granville	Lee	Pender	Vance
Ashe	Chowan	Greene	Lenoir	Richmond	Warren
Avery	Cleveland	Halifax	Lincoln	Robeson	Watauga
Beaufort	Columbus	Harnett	Martin	Sampson	Wayne
Bertie	Davie	Hertford	Montgomery	Scotland	Yadkin
Bladen	Edgecombe	Hyde	Nash	Stanly	
Caldwell	Gaston	Johnston	Northampton	Swain	
Caswell	Gates	Jones	Pamlico	Tyrrell	



Counties where Blue Medicare Enhanced (HMO) is available.

Please note: To join Blue Medicare HMO plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Summary of Benefits

BlueMedicare Enhanced℠ (HMO)			H3449-024-001	H3449-024-002	H3449-024-003
Monthly Premium:	You must also continue to pay your Medicare Part B premium.		$39	$49	$75
Deductible:	These plans have no medical deductible.		$0	$0	$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.		$3,900	$4,900	$5,500
Benefits					
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)		**Days 1–6:**	$335 copay		
		Days 7–90:	$0 copay		
		Days 91 and beyond:	$0 copay		
Outpatient Services:*		**Ambulatory Surgical Center:**	$200 copay		
		Outpatient Hospital:	$300 copay		
Doctor Visit:		**Primary:**	$0 copay		
		Specialist:	$40 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.		$90 copay		
Urgently Needed Services:			$65 copay		

* May require prior authorization.

Summary of Benefits

BlueMedicare Enhanced℠ (HMO)

Benefits			H3449-024-001 H3449-024-002 H3449-024-003
Diagnostic Services/ Labs/Imaging:		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	$0–$300 copay
Hearing Services:	**Medicare-Covered Hearing Exam:**	Exams to diagnose and treat hearing and balance issues.	$40 copay
	Routine Hearing Exam:	One per year. Must use designated providers.	$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.	$699–$999 copay
Dental Services:	**Medical-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$40 copay
	Preventive Dental:	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	$325
Vision Services:	**Routine Eye Exam:**	Once every 12 months.	$25 copay
	Routine Eyewear:	Yearly allowance.	$200
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$25 copay
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost

* May require prior authorization.

Summary of Benefits

BlueMedicare Enhanced℠ (HMO)

Benefits			H3449-024-001 H3449-024-002 H3449-024-003
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$300 copay
		Days 7–90:	$0 copay
	Outpatient: (Mental health* and substance abuse)	Individual and group sessions	$40 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**	$0 copay
		Days 21–60:	$184 copay
		Days 61–100:	$0 copay
Outpatient Rehabilitation Services:		**Occupational, Physical and Speech Language Therapy:**	$40 copay
		Cardiac and Pulmonary Rehab Services:	$30 copay
Ambulance Services:*		Covers medically necessary ground and air ambulance services.	$250 copay
Transportation:			Not covered
Medicare Part B Drugs:*			20% of cost

To find other covered benefits, **see the bottom of page 49.**
For prescription drug coverage information, **see pages 48–49.**

* May require prior authorization.

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Enhanced℠ (HMO)

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

Part D, Prescription Drug Benefit Stages

Annual Deductible:	This is the set amount that you pay before your plan begins to pay its share of the cost. **All Tiers:** $0
Initial Coverage Limit (ICL):	**Begins after you pay your yearly deductible.** You remain in this stage until your total year-to-date costs on covered drugs reach **$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)
Coverage Gap:	**Begins when your total year-to-date costs on covered drugs exceed $4,130.** In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **$0** copayment at preferred pharmacies or a **$1** copayment at non-preferred pharmacies.
Catastrophic Coverage:	**Begins when your total year-to-date costs on covered drugs exceed $6,550.** During this stage, you pay the greater of **$3.70** or **5%** of the cost for generic drugs, and the greater of **$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, **see pages 17–20.**

Summary of Benefits — Prescription Drug Coverage

Blue Medicare Enhanced℠ (HMO)

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

	Preferred Pharmacies		Preferred Mail Order	Non-Preferred Pharmacies	
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Non-Preferred Drugs (Tier 4)	45% of cost	45% of cost	45% of cost	50% of cost	50% of cost
Specialty Tier Drugs (Tier 5)	33% of cost	N/A	N/A	33% of cost	N/A
Select Care Drugs (Tier 6)	$0 copay	$0 copay	$0 copay	$1 copay	$1 copay

Other Covered Benefits	H3449-024-001, H3449-024-002, H3449-024-003	
Podiatry Services:	Foot care	$40 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	$0 copay
Healthy Aging and Exercise Program:	Participating facilities	$0 copay

* Long-term care pharmacy benefit is covered the same as retail non-preferred for 31 days instead of 30 days.

** May require prior authorization.

Note: Two-month (60-day) supplies may also be available.

Summary of Benefits Prescription Drug Coverage

Which drugs are covered?

See the Prescription Drug Coverage section of this book, pages 17–20.

Which pharmacies can I use?

- Our Preferred Pharmacy Network is a select network of national and local independent pharmacies designed to help save you money on your prescriptions. You may choose non-preferred pharmacies to fill prescriptions, but your costs may be higher.
- **Our preferred pharmacy and preferred mail order pharmacy networks include EPIC, Walmart, Walgreens, AllianceRx Walgreens Prime and others.**
- Tiers 1 and 2 have a $0 copayment for a 90-day supply. And with Tier 3, you pay no more than 2 times the 30-day copay at a preferred mail order pharmacy.

How do I find a preferred pharmacy?

- To find a pharmacy near you, go to ***BlueCrossNC.com/Medicare*** (Click on "Find Doctor/Drug/Facility".)
- The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

For more information about Original Medicare, request the ***Medicare & You*** handbook from **Medicare:**

Phone: 1-800-MEDICARE (1-800-633-4227) **TTY:** 1-877-486-2048

Hours: 7 days a week, 24 hours a day **Visit:** *Medicare.gov*

Have Medicare questions? We've got answers. Contact **Blue Cross NC:**

Phone: **1-800-665-8037** **TTY:** 711

Hours: 7 days a week, 8 a.m. – 8 p.m. **Visit:** ***BlueCrossNC.com/Medicare***

Or contact your Blue Cross NC **Authorized Agent.**