



# BlueCross BlueShield of North Carolina

***Blue Medicare Essential<sup>SM</sup> (HMO) (H3449-027-002) offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC)***

## Annual Notice of Change for 2027

You're enrolled as a member of Blue Medicare Essential.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Blue Medicare Essential.
- To change to a **different plan**, visit [Medicare.gov](https://www.medicare.gov) or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at <https://www.bluecrossnc.com/members/medicare> or call Customer Service at 1-888-310-4110 (TTY users call 711) to get a copy by mail.

### More Resources

- Call Customer Service at 1-888-310-4110 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m. daily. This call is free.
- This document is available in languages other than English, in braille, in large print or other alternate formats. Please call Customer Service for additional information.

### About Blue Medicare Essential

- Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
- When this material says "we," "us," or "our," it means Blue Cross and Blue Shield of North Carolina (Blue Cross NC). When it says "plan" or "our plan," it means Blue Medicare Essential.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Blue Medicare Essential.** Starting January 1, 2027, you'll get your medical and drug coverage through Blue Medicare Essential. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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## Summary of Important Costs for 2027

|                                                                                                                                                                                                                                                                          | 2026<br>(this year)                                                                                                                                                             | 2027<br>(next year)                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher than this amount. Go to Section 1.1 for details.                                                                                                                                                            | \$0                                                                                                                                                                             | \$0                                                                                                                                                                             |
| <b>Deductible</b>                                                                                                                                                                                                                                                        | \$0                                                                                                                                                                             | \$140, for Chemotherapy/Radiation Drugs and Other Medicare Part B drugs - except for insulin furnished through an item of durable medical equipment.                            |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)                                                                                                         | \$9,250                                                                                                                                                                         | \$9,850                                                                                                                                                                         |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                        | \$10 per visit                                                                                                                                                                  | \$10 per visit                                                                                                                                                                  |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                          | \$45 per visit                                                                                                                                                                  | \$50 per visit                                                                                                                                                                  |
| <b>Inpatient hospital stays</b><br>Includes various inpatient hospital stays such as acute care, rehabilitation, and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | You pay a \$407 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital.<br><br>You pay \$0 for additional days at a network hospital. | You pay a \$407 copayment per day for the first 6 days for each Medicare-covered admission to a network hospital.<br><br>You pay \$0 for additional days at a network hospital. |

|                                                                                                                                                  | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <b>Part D drug coverage deductible</b><br>\$615 (Tiers 3, 4 and 5 only) except for covered insulin products and most adult Part D vaccines<br><br><b>Copayment/Coinsurance during the Initial Coverage Stage:</b><br><br><b>Drug Tier 1:</b> \$0 per prescription for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy<br><br><b>Drug Tier 1:</b> \$15 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy<br><br><b>Drug Tier 2:</b> \$4 per prescription for a 30-day supply at a preferred retail pharmacy<br><br><b>Drug Tier 2:</b> \$0 per prescription for a 30-day supply at a preferred mail order pharmacy<br><br><b>Drug Tier 2:</b> \$20 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy<br><br><b>Drug Tier 3:</b> 25% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy<br><br><b>Drug Tier 3:</b> 25% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy | <b>Part D drug coverage deductible</b><br>\$700 (Tiers 3, 4 and 5 only) except for covered insulin products and most adult Part D vaccines<br><br><b>Copayment/Coinsurance during the Initial Coverage Stage:</b><br><br><b>Drug Tier 1:</b> \$0 per prescription for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy<br><br><b>Drug Tier 1:</b> \$15 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy<br><br><b>Drug Tier 2:</b> \$4 per prescription for a 30-day supply at a preferred retail pharmacy<br><br><b>Drug Tier 2:</b> \$0 per prescription for a 30-day supply at a preferred mail order pharmacy<br><br><b>Drug Tier 2:</b> \$20 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy<br><br><b>Drug Tier 3:</b> 21% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy<br><br><b>Drug Tier 3:</b> 21% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy |

|  | <b>2026</b><br><b>(this year)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>2027</b><br><b>(next year)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4:</b> 25% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 4:</b> 25% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5:</b> 25% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 5:</b> 25% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>Drug Tier 6:</b> \$0 per prescription for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 6:</b> \$3 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>Catastrophic Coverage Stage:</b></p> <p>During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that</p> | <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 4:</b> 26% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 4:</b> 26% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>You pay no more than \$35 per month supply of each covered insulin product on this tier.</b></p> <p><b>Drug Tier 5:</b> 25% of the total cost for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 5:</b> 25% of the total cost for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>Drug Tier 6:</b> \$0 per prescription for a 30-day supply at a preferred retail pharmacy or preferred mail order pharmacy</p> <p><b>Drug Tier 6:</b> \$3 per prescription for a 30-day supply at a standard retail pharmacy, standard mail order pharmacy, or out-of-network pharmacy</p> <p><b>Catastrophic Coverage Stage:</b></p> <p>During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that</p> |

|  | <b>2026<br/>(this year)</b>             | <b>2027<br/>(next year)</b>             |
|--|-----------------------------------------|-----------------------------------------|
|  | are covered under our enhanced benefit. | are covered under our enhanced benefit. |

## SECTION 1 Changes to Benefits & Costs for Next Year

### Section 1.1 Changes to the Monthly Plan Premium

|                                                                                                                                  | 2026<br>(this year) | 2027<br>(next year) |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| <b>Monthly plan premium</b><br>(You must also continue to pay your Medicare Part B premium).                                     | \$0                 | \$0                 |
| <b>Part B premium reduction</b><br>This amount will be deducted from your Part B premium. This means you'll pay less for Part B. | \$62.50 per month   | \$51 per month      |

### Factors that could change your Part D Premium Amount

- **Late Enrollment Penalty** - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- **Higher Income Surcharge** - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services (and other health services not covered by Medicare) for the rest of the calendar year.

|                                                                                                                                                                                                                                                                           | 2026<br>(this year) | 2027<br>(next year)                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amount</b><br>Your costs for covered medical services (such as copayments and deductibles) <b>count</b> toward your maximum out-of-pocket amount. Your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. | \$9,250             | \$9,850<br><br><b>Once you've paid \$9,850 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.</b> |

### Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory*

<https://www.bluecrossnc.com/members/medicare/find-care> to see if your providers (primary care providers, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at <https://www.bluecrossnc.com/members/medicare>.
- Call Customer Service at 1-888-310-4110 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-888-310-4110 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

### Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory*

<https://www.bluecrossnc.com/members/medicare/forms-library> to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at <https://www.bluecrossnc.com/members/medicare>.
- Call Customer Service at 1-888-310-4110 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-888-310-4110 (TTY users call 711) for help.

### Section 1.5 Changes to Benefits & Costs for Medical Services

|                                              | 2026<br>(this year)                                                                                                                      | 2027<br>(next year)                                                                                                                        |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture for Chronic Low Back Pain</b> | You pay a \$45 copay for this benefit.                                                                                                   | You pay a \$50 copay for this benefit.                                                                                                     |
| <b>Cardiac Rehabilitation Services</b>       | <b>Cardiac Rehab</b><br>You pay a \$0 copay for this benefit.<br><b>Intensive Cardiac Rehab</b><br>You pay a \$0 copay for this benefit. | <b>Cardiac Rehab</b><br>You pay a \$30 copay for this benefit.<br><b>Intensive Cardiac Rehab</b><br>You pay a \$30 copay for this benefit. |
| <b>Dental Services</b>                       | <b>Medicare-covered Dental Services</b><br>You pay a \$45 copay for this benefit.                                                        | <b>Medicare-covered Dental Services</b><br>You pay a \$50 copay for this benefit.                                                          |

|                                                                           | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           | <b>Non-Medicare-covered Dental Services</b><br><b>Preventive Dental</b><br>You pay a \$0 copay for this benefit.<br><b>Comprehensive Dental</b><br>You pay a \$0 copay for this benefit.                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Non-Medicare-covered Dental Services</b><br><b>Preventive Dental</b><br>Not covered.<br><b>Comprehensive Dental</b><br>Not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Diabetes Self-Management Training, Diabetic Services, and Supplies</b> | <p>The plan covers Ascensia (Contour) branded blood glucose meters. All other branded blood glucose meters are subject to a medical exception.</p> <p>The plan covers Ascensia (Contour) branded blood glucose test strips. A medical exception is required for all other branded test strips. All brands of test strips are subject to a quantity limit of 204 test strips per 30 days.</p> <p>The plan covers Dexcom and Freestyle branded continuous glucose monitors (CGMs). A medical exception is required for all other branded CGMs. CGM products are subject to quantity limits per product labeling.</p> | <p>The plan covers Ascensia (Contour) and Roche (Accu-Chek) branded blood glucose meters. Blood glucose meters are subject to prior authorization.</p> <p>The plan covers Ascensia (Contour) and Roche (Accu-Chek) branded blood glucose test strips. A prior authorization is required for all other branded test strips. All brands of test strips are subject to a quantity limit of 200 test strips per 30 days.</p> <p>The plan covers Dexcom and Freestyle branded continuous glucose monitors (CGMs). A prior authorization is required for all other branded CGMs. CGM products are subject to quantity limits per product labeling.</p> |
| <b>Durable Medical Equipment (DME) and related supplies</b>               | Prior authorization is required if the equipment's purchase price is greater than \$1,200.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Prior authorization is required if the equipment's purchase price is greater than \$1,000.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Meal Benefit</b>                                                       | <b>Mom's Meals</b><br>After your inpatient stay in either the hospital or a nursing facility and you have been discharged home, you are eligible to receive 2 meals per day for 14 days at no extra cost to you.                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Mom's Meals</b><br>After your inpatient stay in either the hospital or a nursing facility and you have been discharged home, you are eligible to receive 2 meals per day for 7 days at no extra cost to you.                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Medicare Part B Drugs</b>                                              | You pay 0 - 20% coinsurance of the total cost for chemotherapy/radiation and other Part B drugs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$140 deductible applies to chemotherapy/radiation and other Part B drugs – except insulin furnished through an item of durable medical equipment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                                                            | 2026<br>(this year)                                                                                                                                                                                                                                                  | 2027<br>(next year)                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            |                                                                                                                                                                                                                                                                      | Once your deductible has been satisfied, you pay 0 - 20% coinsurance of the total cost.                                                                                                                                                                               |
| <b>Mental Health Services</b>                                              | <b>Mental Health Specialty Services (Individual and Group Sessions)</b><br>You pay a \$40 copay for this benefit.<br><br><b>Psychiatric Services (Individual and Group Sessions)</b><br>You pay a \$40 copay for this benefit.                                       | <b>Mental Health Specialty Services (Individual and Group Sessions)</b><br>You pay a \$50 copay for this benefit.<br><br><b>Psychiatric Services (Individual and Group Sessions)</b><br>You pay a \$50 copay for this benefit.                                        |
| <b>Outpatient Diagnostic Services</b>                                      | <b>Diagnostic Procedures/Tests other than PCP</b><br>You pay a \$25 copay for this benefit.<br><br><b>Lab Services other than PCP</b><br>You pay a \$5 copay for this benefit.<br><br><b>X-Ray Services other than PCP</b><br>You pay a \$15 copay for this benefit. | <b>Diagnostic Procedures/Tests other than PCP</b><br>You pay a \$75 copay for this benefit.<br><br><b>Lab Services other than PCP</b><br>You pay a \$25 copay for this benefit.<br><br><b>X-Ray Services other than PCP</b><br>You pay a \$30 copay for this benefit. |
| <b>Outpatient Hospital Services</b>                                        | <b>Outpatient Hospital Services</b><br>You pay up to a \$335 copay for this benefit.<br><br><b>Observation Services</b><br>You pay a \$335 copay for this benefit.                                                                                                   | <b>Outpatient Hospital Services</b><br>You pay up to a \$475 copay for this benefit.<br><br><b>Observation Services</b><br>You pay a \$475 copay for this benefit.                                                                                                    |
| <b>Outpatient Rehabilitation Services</b>                                  | <b>Occupational Therapy Services</b><br>You pay a \$25 copay for this benefit.<br><br><b>Physical/Speech Therapy Services</b><br>You pay a \$25 copay for this benefit.                                                                                              | <b>Occupational Therapy Services</b><br>You pay a \$35 copay for this benefit.<br><br><b>Physical/Speech Therapy Services</b><br>You pay a \$35 copay for this benefit.                                                                                               |
| <b>Outpatient Substance Abuse Services (Individual and Group Sessions)</b> | You pay a \$40 copay for this benefit.                                                                                                                                                                                                                               | You pay a \$50 copay for this benefit.                                                                                                                                                                                                                                |
| <b>Part D and Part B Drug Transition Benefit Period</b>                    | The transition benefit period for a temporary supply of a Part D or Part B drug is 90 days.                                                                                                                                                                          | The transition benefit period for a temporary supply of a Part D or Part B drug is 108 days.<br><br>See your Evidence of Coverage for more information about a temporary supply.                                                                                      |
| <b>Pharmacy Network</b>                                                    | Amazon Pharmacy is the preferred mail-order pharmacy.                                                                                                                                                                                                                | Senior Life Pharmacy is the preferred mail-order pharmacy.                                                                                                                                                                                                            |

|                                       | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                              | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                       | Walgreens Mail Service, Express Scripts Pharmacy (ESI), and Postal Prescription Services (PPS) are available as standard (non-preferred) mail-order pharmacies.                                                                                                                                                                                                                                  | Amazon Pharmacy and Walgreens Mail Service are available as preferred retail pharmacies.<br><br>Express Scripts Pharmacy (ESI) and Postal Prescription Services (PPS) are no longer in the pharmacy network.<br><br>This is not a complete list of pharmacy network changes. The pharmacy network may change at any time. Review the 2027 Pharmacy Directory at <a href="https://BlueCrossNC.com/Members/Medicare/Forms-Library">BlueCrossNC.com/Members/Medicare/Forms-Library</a> to see which pharmacies are in our network. Drug costs may vary based on the pharmacy you use. See your Evidence of Coverage for more information about your pharmacy choices. |
| <b>Physician Services</b>             | <p><b>Physician Specialist Services</b><br/>You pay a \$45 copay for this benefit.</p> <p><b>Other Health Care Professional</b><br/>You pay a \$10 - \$45 copay for this benefit.</p> <p><b>Additional Telehealth</b><br/>You pay a \$0 - \$45 copay for this benefit.</p>                                                                                                                       | <p><b>Physician Specialist Services</b><br/>You pay a \$50 copay for this benefit.</p> <p><b>Other Health Care Professional</b><br/>You pay a \$10 - \$50 copay for this benefit.</p> <p><b>Additional Telehealth</b><br/>You pay a \$0 - \$50 copay for this benefit.</p>                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization</b>            | <p><b>The following benefits require Prior Authorization in 2026:</b></p> <ul style="list-style-type: none"> <li>- Opioid Treatment Program Services</li> <li>- Outpatient Substance Abuse (Individual Sessions)</li> </ul> <p><b>The following benefit does not require Prior Authorization in 2026:</b></p> <ul style="list-style-type: none"> <li>- Preferred Blood Glucose Meters</li> </ul> | <p><b>The following benefits do not require Prior Authorization in 2027:</b></p> <ul style="list-style-type: none"> <li>- Opioid Treatment Program Services</li> <li>- Outpatient Substance Abuse (Individual Sessions)</li> </ul> <p><b>The following benefit will require Prior Authorization in 2027:</b></p> <ul style="list-style-type: none"> <li>- Preferred Blood Glucose Meters</li> </ul>                                                                                                                                                                                                                                                                |
| <b>Skilled Nursing Facility (SNF)</b> | <p>You pay a \$0 copay per day for days 1-20.</p> <p>You pay a \$218 copay per day for days 21-100.</p>                                                                                                                                                                                                                                                                                          | <p>You pay a \$0 copay per day for days 1-20.</p> <p>You pay a \$221 copay per day for days 21-100.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|              | 2026<br>(this year)                                                                                                                                                                                                                                           | 2027<br>(next year)                                                                                                                                           |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Vision Care* | <b>Non-Medicare-covered</b><br><b>Contact Lens Exam</b><br>You pay a \$25 copay for this benefit.<br><b>Routine Eye Exam</b><br>You pay a \$0 copay for this benefit.<br><b>Vision Allowance</b><br>You receive a \$100 vision allowance (including eyewear). | <b>Non-Medicare-covered</b><br><b>Contact Lens Exam</b><br>Not covered.<br><b>Routine Eye Exam</b><br>Not covered.<br><b>Vision Allowance</b><br>Not covered. |

\*Administered through Blue FlexCard. Keep your existing Blue FlexCard.

## Section 1.6 Changes to Part D Drug Coverage

### Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is posted online at <https://www.bluecrossnc.com/members/medicare/forms-library>.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Service at 1-888-310-4110 (TTY users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2026, call Customer Service at 1-888-310-4110 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tiers 3, 4 and 5 drugs until you've reached the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,400.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

### Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                          | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | <p><b>\$615 (Tiers 3, 4 and 5 only)</b></p> <p>During this stage, you pay \$0 cost sharing for a 30-day supply at a preferred retail or preferred mail order pharmacy, and \$15 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 1</b>;</p> <p>you pay \$4 cost sharing for a 30-day supply at a preferred retail pharmacy, \$0 cost sharing for a 30-day supply at a preferred mail order pharmacy, and \$20 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 2</b>;</p> <p>you pay \$0 cost sharing for a 30-day supply at a preferred retail or preferred mail order pharmacy, and \$3 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 6</b>;</p> <p>and the full cost of drugs on Tiers 3, 4 and 5 until you've reached the yearly deductible.</p> | <p><b>\$700 (Tiers 3, 4 and 5 only)</b></p> <p>During this stage, you pay \$0 cost sharing for a 30-day supply at a preferred retail or preferred mail order pharmacy, and \$15 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 1</b>;</p> <p>you pay \$4 cost sharing for a 30-day supply at a preferred retail pharmacy, \$0 cost sharing for a 30-day supply at a preferred mail order pharmacy, and \$20 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 2</b>;</p> <p>you pay \$0 cost sharing for a 30-day supply at a preferred retail or preferred mail order pharmacy, and \$3 cost sharing for a 30-day supply at a standard retail or standard mail order pharmacy, for drugs on <b>Tier 6</b>;</p> <p>and the full cost of drugs on Tiers 3, 4 and 5 until you've reached the yearly deductible.</p> |

### Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your Evidence of Coverage.

Once you've paid \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                         | 2026<br>(this year)                                                                                                                                                                                                                                                                               | 2027<br>(next year)                                                                                                                                                                                                                                                                               |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1 (Preferred Generic Drugs)</b> | <b>Standard cost sharing:</b><br>You pay \$15 per prescription.<br><b>Preferred cost sharing:</b><br>You pay \$0 per prescription.                                                                                                                                                                | <b>Standard cost sharing:</b><br>You pay \$15 per prescription.<br><b>Preferred cost sharing:</b><br>You pay \$0 per prescription.                                                                                                                                                                |
| <b>Tier 2 (Generic Drugs)</b>           | <b>Standard cost sharing:</b><br>You pay \$20 per prescription.<br><b>Preferred cost sharing:</b><br>You pay \$4 per prescription.                                                                                                                                                                | <b>Standard cost sharing:</b><br>You pay \$20 per prescription.<br><b>Preferred cost sharing:</b><br>You pay \$4 per prescription.                                                                                                                                                                |
| <b>Tier 3 (Preferred Brand Drugs)</b>   | <b>Standard cost sharing:</b><br>You pay 25% of the total cost.<br>Your cost for a one-month mail order prescription is 25% of the total cost.<br><b>Preferred cost sharing:</b><br>You pay 25% of the total cost.<br>Your cost for a one-month mail order prescription is 25% of the total cost. | <b>Standard cost sharing:</b><br>You pay 21% of the total cost.<br>Your cost for a one-month mail order prescription is 21% of the total cost.<br><b>Preferred cost sharing:</b><br>You pay 21% of the total cost.<br>Your cost for a one-month mail order prescription is 21% of the total cost. |

|                                     | 2026<br>(this year)                                                                                                                                                                                                                                                                                              | 2027<br>(next year)                                                                                                                                                                                                                                                                                              |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 4 (Non-Preferred Drugs)</b> | <p><b>Standard cost sharing:</b><br/>You pay 25% of the total cost.<br/>Your cost for a one-month mail order prescription is 25% of the total cost.</p> <p><b>Preferred cost sharing:</b><br/>You pay 25% of the total cost.<br/>Your cost for a one-month mail order prescription is 25% of the total cost.</p> | <p><b>Standard cost sharing:</b><br/>You pay 26% of the total cost.<br/>Your cost for a one-month mail order prescription is 26% of the total cost.</p> <p><b>Preferred cost sharing:</b><br/>You pay 26% of the total cost.<br/>Your cost for a one-month mail order prescription is 26% of the total cost.</p> |
| <b>Tier 5 (Specialty Drugs)</b>     | <p><b>Standard cost sharing:</b><br/>You pay 25% of the total cost.</p> <p><b>Preferred cost sharing:</b><br/>You pay 25% of the total cost.<br/>Tier 5 is limited to a 30-day supply per fill.</p>                                                                                                              | <p><b>Standard cost sharing:</b><br/>You pay 25% of the total cost.</p> <p><b>Preferred cost sharing:</b><br/>You pay 25% of the total cost.<br/>Tier 5 is limited to a 30-day supply per fill.</p>                                                                                                              |
| <b>Tier 6 (Select Care Drugs)</b>   | <p><b>Standard cost sharing:</b><br/>You pay \$3 per prescription.</p> <p><b>Preferred cost sharing:</b><br/>You pay \$0 per prescription.</p>                                                                                                                                                                   | <p><b>Standard cost sharing:</b><br/>You pay \$3 per prescription.</p> <p><b>Preferred cost sharing:</b><br/>You pay \$0 per prescription.</p>                                                                                                                                                                   |

## SECTION 2 Administrative Changes

|                               | 2026<br>(this year)                                                     | 2027<br>(next year)                                                                                                                                                                                             |
|-------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Appeals and Grievances</b> | You can submit your appeal or complaint by phone, mail, fax, and email. | You can submit your appeal or complaint by phone, mail, fax, email and the member portal at <a href="https://www.bluecrossnc.com/members/member-portal">https://www.bluecrossnc.com/members/member-portal</a> . |

|                                           | 2026<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2027<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Blue FlexCard</b>                      | <p>In 2026, the following benefits and rewards are administered through Blue FlexCard:</p> <ul style="list-style-type: none"> <li>• Earned 2025 Rewards</li> <li>• 2026 Rewards</li> <li>• Vision Allowance</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>In 2027, the following benefits and rewards are administered through Blue FlexCard:</p> <ul style="list-style-type: none"> <li>• Earned 2026 Rewards</li> <li>• 2027 Rewards</li> </ul> <p><b>Be sure to keep your card.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Medicare Part D Drug Claim Form</b>    | <p>Completed forms should be mailed to:<br/>Blue Medicare HMO<br/>PO Box 2251<br/>Durham, NC 27702-2251</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>Completed forms should be mailed to:<br/>OptumRx<br/>PO Box 650287<br/>Dallas, TX 75265-0287</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Medicare Prescription Payment Plan</b> | <p>If you have an open balance for your 2025 Medicare Prescription Payment Plan claims, you will receive invoices that show those outstanding balances. As a reminder, you are required to promptly pay your Medicare Prescription Payment Plan invoices to remain in the program.</p> <p>You are not able to use a credit card to make Medicare Prescription Payment Plan payments.</p> <p>M3P Election Forms should be mailed to:<br/>SimplicityRx<br/>Mailstop: 1001<br/>MPPP Election Dept.<br/>13900 N. Harvey Ave<br/>Edmond, OK 73013</p> <p>Final payments for 2025 Medicare Prescription Payment Plan invoices are due by February 1, 2026.</p> | <p>If you have an open balance from your 2026 Medicare Prescription Payment Plan claims and are participating in the Medicare Prescription Payment Plan for 2027, you will receive two separate invoices. As a reminder, you are required to promptly pay your Medicare Prescription Payment Plan invoices to remain in the program.</p> <p>You will be able to use a credit card to make your 2027 Medicare Prescription Payment Plan payments through the Medicare Prescription Payment Plan portal connected to the Blue Cross NC member portal.</p> <p>M3P Election Forms should be mailed to:<br/>Blue Cross NC<br/>Attn: M3P Election Processes<br/>PO Box 650287<br/>Dallas, TX 75265-0287</p> <p>Final payments for 2026 Medicare Prescription Payment Plan invoices are due by February 1, 2027.</p> |
| <b>Member ID Card</b>                     | <p>The Rx BIN on your member ID card is <b>015905</b>. Your pharmacy uses this number to process claims.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>The Rx BIN on your member ID card will change to <b>029230</b>.</p> <p>You will receive a new member ID card for 2027.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                                 | 2026<br>(this year)                                                                                                                                        | 2027<br>(next year)                                                                                                                                                                              |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                 |                                                                                                                                                            | Please use your new card beginning January 1, 2027, and show it to your pharmacy when filling prescriptions.                                                                                     |
| <b>Member Submitted Medical Claims</b>          | Members can submit medical claims for reimbursement by email at <a href="mailto:MemberClaimsSubmission@bcbsnc.com">MemberClaimsSubmission@bcbsnc.com</a> . | Members cannot submit medical claims for reimbursement via email.                                                                                                                                |
| <b>Prescription Drug Benefit Administration</b> | Your Medicare Part D prescription drug benefits are administered through Prime Therapeutics.                                                               | Beginning January 1, 2027, your Medicare Part D prescription drug benefits will be administered through Optum Rx.<br><br>Please review your 2027 plan materials for changes that may impact you. |

### SECTION 3 How to Change Plans

**To stay in Blue Medicare Essential, you don't need to do anything.** Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Blue Medicare Essential.

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Blue Medicare Essential. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with Medicare separate drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from Blue Medicare Essential.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Customer Service at 1-888-310-4110 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [Medicare.gov](https://www.medicare.gov), check the Medicare & You 2027 handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Blue Cross NC offers other Medicare health plans and Medicare prescription drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

### Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

### Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## SECTION 4 Get Help Paying for Prescription Drugs

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You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** *North Carolina* has a program called *NC HIV Medication Assistance Program (NC HMAP)* that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](https://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the *North Carolina HIV Medication Assistance Program (NC HMAP)*. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call NC HMAP at 1-877-466-2232 (toll free in NC) or 1-

919-733-9161 (out-of-state) or visit their website at <https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html>. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-888-310-4110 (TTY users call 711) or visit [Medicare.gov](https://www.medicare.gov).

## SECTION 5 Questions?

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### Get Help from Blue Medicare Essential

- **Call Customer Service at 1-888-310-4110. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m. daily. Calls to these numbers are free.

- **Read your 2027 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Blue Medicare Essential. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at <https://www.bluecrossnc.com/members/medicare/forms-library> or call Customer Service at 1-888-310-4110 (TTY users call 711) to ask us to mail you a copy.

- **Visit <https://www.bluecrossnc.com/members/medicare/forms-library>**

Our website has the most up-to-date information about our provider network (Provider Directory/Pharmacy Directory) and our List of Covered Drugs (formulary/Drug List).

### Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In North Carolina, the SHIP is called Seniors' Health Insurance Information Program (SHIIP).

Call SHIIP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call SHIIP at 1-855-408-1212. Learn more about SHIIP by visiting <http://www.ncdoi.com/SHIIP>.

### Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with [Medicare.gov](https://www.medicare.gov)**

You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [Medicare.gov](https://www.medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2027***

The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**Review other plan materials available as of October 15, 2026.**

View online or request a printed copy by calling us. **1-888-310-4110 (TTY 711)** 8 a.m. to 8 p.m. daily

Requests for a printed copy of these documents can be made as a One-Time or a Permanent request. Your preference will remain in effect until you either disenroll from the plan or submit a request to discontinue future mailings.

**Evidence of Coverage (EOC)**

Your EOC provides you with details about your plan benefits.

To view your EOC, visit <https://www.bluecrossnc.com/members/medicare/forms-library> and select the **Evidence of Coverage** for your plan. You can also request a printed or electronic copy by scanning the QR code on the enclosed insert.

**Formulary**

Your Formulary is a list of drugs covered by your plan.

To view your formulary, visit <https://www.bluecrossnc.com/members/medicare/forms-library> and select your plan under **Formulary (List of Covered Drugs)**. You can also request a printed or electronic copy by scanning the QR code on the enclosed insert.

**Provider Directory or Pharmacy Directory**

To search for providers online, visit <https://www.bluecrossnc.com/members/medicare/find-care>.

You may also view our **Notice of Privacy Practices** online at <https://www.bluecrossnc.com/policies-best-practices/notice-privacy-practices>.

**The Women's Health and Cancer Rights Act (WHCRA) of 1998**

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Customer Service for more information. Hours of operation are 8 a.m. to 8 p.m. daily.