Medicare Advantage plans offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS) and administered by its parent company, Blue Cross and Blue Shield of North Carolina (BCBSNC)

**BlueMedicare HMO™**

**BlueMedicare PPO™**

- Plans with low monthly premiums
- No referrals required to see specialists
- Low copayments and costs
- Health care benefits and Medicare prescription drug coverage in one plan
Blue Medicare HMO and Blue Medicare PPO plans, offered by PARTNERS, can help simplify management of your health benefits, provide you with more coverage than Original Medicare and help limit your out-of-pocket costs.

**Through a contract with the federal government, PARTNERS will:**

- **Manage your Original Medicare benefits**
- **Provide you with enhanced medical coverage beyond Original Medicare**
- **Include Medicare prescription drug coverage with most plans**

Medicare pays PARTNERS a fixed monthly amount to provide your Medicare health care coverage. Since Medicare prescription drug (Part D) coverage is built right into most plans, there is no need to buy one plan for enhanced medical benefits and another plan for your Medicare prescription drug benefits.

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**Choices to meet your needs and your budget**

**Blue Medicare HMO**

Health coverage within a large network of doctors and specialists

- **Plans with low monthly premiums**
- **No referrals required to see specialists**
- **Available with or without Medicare prescription drug (Part D) coverage**

**Blue Medicare PPO**

Freedom to see providers in- or out-of-network

- **No referrals required to see specialists**
- **Includes Medicare prescription drug (Part D) coverage**
- **All medically necessary benefits are covered whether in- or out-of-network**
Why you should choose a Blue Medicare HMO or Blue Medicare PPO plan

With other types of plans, your health care plan and your Original Medicare benefits are separate. Blue Medicare HMO and Blue Medicare PPO plans offered by PARTNERS are different.

Here’s how it works
PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. PARTNERS will manage your Original Medicare benefits and, with most plans, can provide you with medical benefits and Medicare prescription drug coverage – all in one plan.

Medicare makes a monthly payment to PARTNERS for each member. The plan uses this payment to pay claims for services to members provided through contracted primary care providers, specialists, hospitals and pharmacies.
Member benefits

Both Blue Medicare HMO and Blue Medicare PPO plans offer more coverage than Original Medicare, including:

- **Plans with low monthly premiums**
- **No referrals required to see specialists**
- Low copayments for doctor office visits
- Medicare prescription drug (Part D) coverage
- Coverage for:
  + Inpatient / outpatient services
  + Skilled nursing facility care
  + Home health care
  + Worldwide emergency medical care
  + Ambulance and urgent care
  + Preventive care and more!

Benefit highlights

For a complete outline of coverage, please refer to each plan’s Summary of Benefits.

<table>
<thead>
<tr>
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<th>Enhanced plan</th>
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<tbody>
<tr>
<td>Additional monthly premium*</td>
<td>$59</td>
</tr>
<tr>
<td>Provider choice</td>
<td>• In-network benefits</td>
</tr>
<tr>
<td></td>
<td>• No referrals required</td>
</tr>
<tr>
<td>Primary care provider office visits</td>
<td>$15 for in-network visits only</td>
</tr>
<tr>
<td>Inpatient hospital stay</td>
<td>$350 / stay</td>
</tr>
<tr>
<td>Medicare prescription drug coverage**</td>
<td>Enhanced drug benefits</td>
</tr>
<tr>
<td>Diagnostic tests, lab work and X-rays</td>
<td>10%</td>
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### Comparison of Benefits: Blue Medicare HMO vs. Blue Medicare PPO

<table>
<thead>
<tr>
<th>Medical-only plan</th>
<th>Standard plan</th>
<th>Enhanced Plus plan</th>
<th>Enhanced plan</th>
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<tbody>
<tr>
<td>$0</td>
<td>$22</td>
<td>$101.60</td>
<td>$67.40</td>
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- **Medical-only plan**
  - Must visit a participating provider to see specialists

- **Standard plan**
  - $0
  - $22

- **Enhanced Plus plan**
  - $101.60

- **Enhanced plan**
  - $67.40

- **In- and out-of-network benefits**
  - Choose any in-network or out-of-network provider and pay the same costs

- **Inpatient hospital stay**
  - $350 / stay

- **Medicare prescription drug coverage**
  - **None**
  - **Standard drug benefits**
  - Enhanced drug benefits

- **Primary care provider office visits**
  - $15 for in-network visits only
  - $10 for in-network visits only
  - $15 for in-network visits only
  - $15 for in-network and out-of-network visits
  - $30 for in-network visits; 20% for out-of-network visits

- **Diagnostic tests, lab work and X-rays**
  - 10%
  - $0
  - 30%

*You must continue to pay the Medicare Part B premium in addition to your plan premium.*

**Formulary applies.*
Enrolling in a plan

Eligibility requirements
To be eligible for a Blue Medicare HMO or Blue Medicare PPO plan, you must be:

- Entitled to Medicare Part A and enrolled in Medicare Part B
- Live in a CMS-approved area (see map and chart below)

Due to Federal regulations, you may not be eligible to join a Blue Medicare HMO or Blue Medicare PPO plan if you are medically determined to have End Stage Renal Disease (ESRD) unless you meet exception qualifications. Please call for more information.

CMS-approved area
Blue Medicare HMO and Blue Medicare PPO plans are available in select counties across North Carolina. Refer to the map and county chart below to determine if you live in a county where the plans are offered.

Blue Medicare HMO and Blue Medicare PPO plans are available in the following counties (shown in dark blue above):

- Alamance
- Alexander
- Alleghany
- Ashe
- Avery
- Cabarrus
- Caldwell
- Caswell
- Catawba
- Chatham
- Cumberland
- Davidson
- Davie
- Durham
- Forsyth
- Gaston
- Guilford
- Halifax
- Hoke
- Iredell
- Johnston
- Mecklenburg
- Nash
- Northampton
- Orange
- Person
- Randolph
- Richmond
- Rockingham
- Rowan
- Stanly
- Stokes
- Surry
- Wake
- Watauga
- Wilkes
- Yadkin
Steps to enrolling in a plan

1 Choose a plan
After reviewing the enclosed material, decide in which plan you want to enroll. (You will indicate your plan choice on the enrollment form by checking the appropriate box beside the plan you select.)

2 Select a primary care provider (PCP)
If there is not a Provider Directory in your enrollment kit, please visit www.bcbsnc.com/medicare to review the plan’s participating providers. If you need assistance finding a provider, you may speak to a sales representative by calling 1-800-665-8037, 7 days a week, 8 a.m. – 8 p.m. For the hearing and speech impaired (TTY/TDD), please call 1-888-451-9957.

3 Complete the enrollment form
Fill out the enrollment form. You must complete one enrollment form per person. Do not forget to sign and date the form. Do not forget to check the appropriate box beside the plan you want.

4 Include payment for the first month’s premium
If applicable, attach a check or money order for the first month’s premium. If you prefer, your monthly premiums may be drafted automatically from your bank account. To register for a bank draft, complete the Authorization Agreement for Automatic Bank Draft Payments form. When you mail your enrollment materials (see instructions below), include the form and a voided check for the bank account that will be drafted. To have your payments deducted from your Social Security check, please check the appropriate box on the enrollment form for this payment method.

5 Mail your enrollment materials
After completing your enrollment form, return the following materials in the postage-paid envelope provided:

- Enrollment form
- Premium payment OR Authorization Agreement for Automatic Bank Draft form with a voided check

6 Enrollment confirmation
You will receive acknowledgement of your enrollment request via mail.

NOTE: There are some limits set by the federal government on when and how often Medicare beneficiaries may enroll in or change Medicare Advantage and Medicare Prescription Drug Plans. For more information on these enrollment rules, call the BCBSNC Sales Department at 1-800-665-8037, 7 days a week, 8 a.m. – 8 p.m. For the hearing and speech impaired (TTY/TDD), call: 1-888-451-9957.
Visiting the doctor

**Blue Medicare HMO**
As a member of Blue Medicare HMO, you may only visit doctors within the network of contracted doctors in order to access your benefits. You must choose a primary care provider (PCP) from within that network to coordinate your care. For your PCP, you can select a family practice doctor, general practice doctor, internal medicine doctor, or nurse practitioner or physician assistant, where available. **You may visit a contracted doctor or specialist at any time without a referral.**
Your PCP can coordinate and provide you with ongoing health care. If you see a doctor outside the network – except in emergencies or urgent-care situations or for out-of-area renal dialysis – you will be responsible for the costs.

**Blue Medicare PPO**
As a member of Blue Medicare PPO, you have access to a network of contracted doctors. You must choose a PCP to coordinate your care. For your PCP, you can select a family practice doctor, general practice doctor, internal medicine doctor, or nurse practitioner or physician assistant, where available. You may visit a doctor outside of the network; however, you may be responsible for more of the cost. You may also visit a doctor or specialist at any time without a referral.
Medicare offers prescription drug (Part D) coverage to help you pay for the prescription drugs you need. With this coverage you can fill your prescriptions at participating pharmacies close to where you live or through mail order. Everyone with Medicare is eligible for Part D coverage, but it is not mandatory. Part D coverage is a voluntary program that you may choose to purchase annually. However, if you do not enroll when you first become eligible, you may have to pay more for prescription drug coverage if you decide to enroll later.

Prescription drug coverage is available with most Blue Medicare HMO and Blue Medicare PPO plans. That means you can have your medical benefits and prescription drug coverage with one plan, for one premium. (You must continue to pay your Medicare Part B premium.)

**Compare benefits**

Review the diagrams displayed on the next page to learn how standard and enhanced Medicare prescription drug (Part D) benefits work. To read the diagram, start at Phase 1 at the bottom. As the total amount you spend on prescription drugs increases during a calendar year, you will move through some or all of the phases of coverage. For example, while a person who purchases very few prescription drugs may not move beyond Phase 1 during the calendar year, a person who purchases several prescription drugs may reach Phase 3 or 4. Remember, always present your plan’s member ID card when filling your prescriptions.

*(continued on the next page)*
Understanding your Medicare prescription drug (Part D) benefits (continued)

**Standard benefits**

Medicare requires that all companies that provide Medicare Part D prescription drug coverage offer the Medicare standard plan. The **standard benefits** offered by PARTNERS meet Medicare’s requirements.

**Catastrophic coverage**

**Phase 4:** Once you have spent $4,050 in true out-of-pocket costs, you will pay very little for prescription drugs. For the rest of the year, you will pay just 5% (or $2.25 generic/$5.60 brand, whichever is greater) of the total cost of covered prescription drugs. Your plan will pay the rest.

**Coverage gap**

**Phase 3:** Once your total annual drug costs exceed $2,510, you will pay 100% of your prescription drug costs until your true out-of-pocket expenses reach $4,050. This period is referred to as the “coverage gap.”

**Initial coverage level**

**Phase 2:** Once your total annual drug costs exceed $275, you will pay 25% of the total cost of covered prescription drugs. Your plan will pay 75%.

**$275 deductible**

**Phase 1:** You pay the first $275 of your prescription drug costs for a given calendar year.

**NOTE:** For members who qualify for low-income assistance, benefits may vary.
## Enhanced benefits

The **enhanced benefits** offered by PARTNERS meet Medicare’s requirements for the standard plan *plus*… you pay no deductible to get your coverage started and you avoid the coverage gap when you purchase generic drugs.

### Catastrophic coverage

**Phase 4:** Once your total annual out-of-pocket drug costs exceed $4,050, **you pay very little for prescription drugs**. You generally pay just 5% (or $2.25 generic/$5.60 brand, whichever is greater), and your plan pays the rest.

### Coverage gap

**Phase 3:** Once your total annual drug costs exceed $2,510, you can avoid the “coverage gap” when you purchase generic drugs.

### Initial coverage level

**Phase 2:** You pay $10 for generic, $30 for brand and 25% coinsurance for certain specialty drugs.

### Phase 1: Your coverage starts right away.

<table>
<thead>
<tr>
<th>Brand-name drugs</th>
<th>Specialty drugs</th>
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<tbody>
<tr>
<td>You pay $30</td>
<td>You pay $30</td>
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<tr>
<td>You pay 25%</td>
<td>You pay 25%</td>
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<table>
<thead>
<tr>
<th>You pay $4,050 (True out-of-pocket costs)</th>
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</table>

<table>
<thead>
<tr>
<th>You pay $2,510 (Total drug costs)</th>
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</table>

<table>
<thead>
<tr>
<th>You pay $275 (Total drug costs)</th>
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Your plan for better health.
Covered prescription drugs
Both the enhanced and standard benefits are based on a formulary (a preferred list of prescription drugs) that was developed using guidelines from the Federal government. The formulary covers all the drugs eligible for coverage under Medicare Part D and includes many of the most popular prescription drugs used by Medicare beneficiaries – more than 3,700 drugs. The formulary includes generic, brand-name and specialty drugs. Both the standard and enhanced benefits cover: prescription drugs, vaccines (not all vaccines are covered), insulin, and certain medical supplies associated with injection of insulin (syringes, needles, alcohol swabs and gauze).

Prescription drugs that are not covered
Medicare Part D plans do not cover certain drugs, or classes of drugs, that are excluded by law, such as over-the-counter medications, prescription vitamins, benzodiazepines, barbiturates and erectile dysfunction drugs. In general, all drugs covered by Medicare prescription drug benefits must be:

- Available only by prescription
- Approved by the FDA
- Used for a medically accepted indication

How to find out if your prescriptions are covered by the formulary
1 Go to www.bcbsnc.com/medicare. Click on the Find a Drug link and then select the appropriate formulary.
2 Call 1-800-665-8037 7 days a week, 8 a.m. – 8 p.m. and speak to a sales representative to determine if a specific drug is covered. Hearing and speech impaired (TTY/TDD users) call 1-888-451-9957.

Filling your prescriptions
You can fill your prescriptions at a large network of participating pharmacies throughout North Carolina. Most of the major chain pharmacies are part of the network, and you can fill your prescriptions at any of their locations nationwide. You must use participating pharmacies to fill your prescriptions in order to receive coverage, except in the case of an emergency or in certain situations when traveling outside of the service area.

Finding a participating pharmacy
Our network includes a variety of pharmacies, including retail, home infusion, Indian/Tribal/Urban organizations and long-term-care pharmacies. To locate a pharmacy near you, you can:

(continued on the next page)
1  Go to www.bcbsnc.com/medicare. Click on the Find a Drug link.

2  Speak with a sales representative by calling 1-800-665-8037, 7 days a week, 8 a.m. – 8 p.m. Hearing and speech impaired (TDD/TTY), please call 1-888-451-9957. Representatives can help find a pharmacy near you.

Mail order
You can also fill your prescriptions through our mail order prescription program, which uses Medco, one of the largest network mail order pharmacies in the country. To enroll in the mail order program, you must complete a “Medco By Mail Order Form.” To request this form, please call 1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO, 7 days a week, 8 a.m. – 8 p.m. Hearing and speech impaired (TDD/TTY), please call 1-888-451-9957.

90-day supply
If your doctor writes you a prescription for a 90-day supply of covered prescription drugs, you can receive the full supply at one time at a network pharmacy or through mail order. Your cost for a 90-day supply will vary depending on your package and phase of coverage.

Policies and procedures

Coverage determination
A coverage determination may be needed to determine whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. (Also see the description of the exceptions process.) You must contact PARTNERS if you would like to request a coverage determination, including an exception. You cannot request an appeal if PARTNERS has not issued a coverage determination.

The following are examples of when you may ask for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by us
- If you have received a Part D prescription drug that you believe may be covered by us while you were a member, but we have declined coverage at the point of sale
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped and you believe you have extenuating circumstances that should exclude you from the reduction/non-coverage
- If there is a limit on the quantity (or dose) of the drug, and you disagree with the requirement or dosage limitation
- If you bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense

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**Requesting a coverage determination**

**Standard:** To ask for a standard decision, you or your appointed representative may call the Customer Service Department at 1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO, 7 days a week, 8 a.m. – 8 p.m. (Hearing and speech impaired TTY/TDD, call: 1-888-451-9957). You can also deliver a written request to Blue Medicare HMO/PPO Administrator, 5660 University Parkway, Winston-Salem, NC 27105, Monday-Friday from 8 a.m. – 5 p.m. You may fax your request to 1-888-446-8535.

**Fast:** To ask for a fast decision, you, your physician, or your appointed representative may call the Customer Service Department at 1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO, 7 days a week, 8 a.m. – 8 p.m. (Hearing and speech impaired TTY/TDD, call: 1-888-451-9957). You can also deliver a written request to Blue Medicare HMO/PPO Administrator, 5660 University Parkway, Winston-Salem, NC 27105, Monday-Friday from 8 a.m. – 5 p.m. You may fax your request to 1-888-446-8535. After regular business hours, you should consult with a contracting pharmacy regarding your need for an emergency or temporary supply of medication. You may also call our Customer Service Department and leave a message on the Part D After Hours Exception Request Voicemail. Be sure to ask for a “fast,” “expedited,” or “24-hour” review. NOTE: You cannot ask for a fast decision on a request for coverage of a drug already purchased.

**Receiving your coverage determination decision**

Generally, you will receive a decision no later than 72 hours after your request has been received, but it may be made sooner if your health condition requires. If your request involves a request for an exception (including a formulary exception or an exception from utilization management rules, such as dosage or quantity limits), a decision must be made no later than 72 hours after your doctor’s “supporting statement” (explaining why the drug you are asking for is medically necessary) has been received.

If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible. You will be notified verbally about the prescription drug you have requested. You will get this notification when a decision has been made under the timeframe explained above. If your request is not approved, you will receive an explanation in writing and be advised of your right to appeal the decision.

If you get a fast review, you will receive a decision within 24 hours after you or your

(continued on the next page)
doctor asks for a fast review – sooner if your health requires. If your request involves a request for an exception, you must receive a decision no later than 24 hours after we get your doctor’s “supporting statement.”

**Exceptions to coverage rules**
Exceptions are part of the coverage determination process. You, your authorized representative, or your prescribing physician may request an exception to seek coverage of a drug that:

- **Is not on the formulary**
- **Requires prior authorization**
- **Has quantity limitations**

**Example of an exception request**
If the Plan’s formulary does not include a drug that you or your prescribing physician feel is necessary, then you or your prescribing physician may request an exception so that you may obtain coverage of this drug. If the Plan does not grant the requested exception, then you or your prescribing physician may file an appeal.

**Making an exception request**
You or your prescribing physician may request an exception to the coverage rules for your Medicare prescription drug plan via:

- **Phone:** 1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO, (Hearing and speech impaired TTY/TDD: 1-888-451-9957), 7 days a week, 8 a.m. – 8 p.m. Physicians should call: 336-774-5400 or 1-888-296-9790
- **Mail:** Blue Medicare HMO/PPO Administrator, Attn: MAPD Exceptions Request, P.O. Box 17509, Winston-Salem, NC 27116-7509

A specific form is not required for you to make an exception request. The request must include your prescribing physician’s statement that he/she has determined that the preferred drug either would not be as effective for you and/or would have adverse effects for you.

**Receiving an exception request decision**
Your exception request will be reviewed and both you and your prescribing physician will be notified of the decision as soon as your health requires, but no later than 72 hours from the time physician’s “supporting statement” was received. Faster exception decisions are available if this 72-hour time frame could seriously harm your health or ability to function.

If the decision is not in your favor, the notice will be given by phone followed by a written notice within three business days. The notice will tell you how to pursue your appeal rights if you are dissatisfied with the decision.

**Appeals process**
An appeal is your opportunity to request a re-determination of an adverse coverage determination, which includes denied exception requests.

*(continued on the next page)*
Example of an appeal
If we deny your request for an exception to cover a non-formulary drug, then you may file an appeal of the denial. An appeal can only be filed after an exception has been requested and denied by the Plan.

Filing an appeal
If you receive a coverage determination denial, you or your appointed representative may file an appeal. A specific form is not required for you to file an appeal. An appeal must be filed within 60 calendar days of the date of the denial notice and must be in writing, unless you are filing an expedited or fast appeal. You may submit it via:

- **Mail:** Blue Medicare HMO/PPO Administrator, Attn: Appeals and Grievance Unit, P.O. Box 17509, Winston-Salem, NC 27116-7509
- **Fax:** 336-794-8836 1-888-375-8836
- **In person:** Blue Cross and Blue Shield of North Carolina, 5660 University Parkway, Winston-Salem, NC 27105

Receiving a decision on your appeal
A standard review of your appeal will be performed as soon as your health requires but no later than seven calendar days after your appeal is received. Requests for an expedited or fast appeal will be reviewed as soon as possible, but no later than 72 hours following the receipt of the request.

An individual who was not involved with your original coverage determination will make a decision on your appeal.

You will receive a written response to your appeal. The decision on an expedited appeal will be provided by phone followed by the written notice. If the decision is to deny the appeal, the notice will advise you of your right to submit your appeal to the Independent Review Entity (IRE) with instructions on how to do so. If timeframes are missed for claims adjudication or review of the appeal, the appeal will automatically be forwarded to the IRE for a decision. There may be additional levels of appeal available to you. You will be informed of your additional rights in the notice, or you may refer to your Evidence of Coverage for further details.

Grievance process
A grievance is a complaint that you may file if you are dissatisfied with Blue Medicare HMO or Blue Medicare PPO or with a contracted provider for reasons other than a decision on a coverage determination. Grievances also include complaints regarding the timeliness, appropriateness, access to, or setting of a covered prescription drug.

Example of a grievance
If you are dissatisfied with the service you received from a pharmacist or plan representative, then you may file a grievance.

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Filing a grievance

The grievance must be filed within 60 days after the event or incident that caused you to be dissatisfied. A specific form is not required for you to file a grievance. You or your appointed representative may file a grievance via:

- **Phone:** 1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO, (Hearing and speech impaired TTY/TDD: 1-888-451-9957), 7 days a week, 8 a.m. – 8 p.m.
- **Mail:** Blue Medicare HMO/PPO Administrator, Attn: Appeals and Grievance Unit, P.O. Box 17509, Winston-Salem, NC 27116-7509
- **Fax** 1-888-375-8836
- **In person:** Blue Cross and Blue Shield of North Carolina, 5660 University Parkway, Winston-Salem, NC 27105

Receiving a grievance decision

The resolution of a grievance will be made as quickly as your concern requires, but no more than 30 calendar days after our receipt of the grievance. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. If you request a written response to an oral grievance, one will be provided within 30 days after receipt of the grievance. A written response will be provided for all written grievances. Our decision on a grievance is final and is not subject to an appeal. You have the right to an expedited review of a grievance concerning our refusal to grant an expedited coverage determination or expedited appeal. This type of grievance will be responded to within 24 hours after our receipt of the grievance.

Quality improvement

If you have a concern relating to the quality of services that you received through your Medicare Advantage prescription drug benefits, then, in addition to the review, you can also request review by the following organizations:

- **The Carolinas Center for Medical Excellence (CCME) Quality Improvement Organization (QIO) in North Carolina**

CCME, formerly known as Medical Review of North Carolina Inc., is a nonprofit, medical care quality improvement organization. CCME has been designated by the Centers for Medicare & Medicaid Services as the Quality Improvement Organization (QIO) for North Carolina. The QIO conducts case reviews to ensure that Medicare beneficiaries receive the quality of medical care that they expect and are entitled to receive. CCME serves as an independent, impartial third party to review Medicare beneficiary complaints.

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Quality of care complaints filed with the QIO must be made in writing. You can write to CCME at The Carolinas Center for Medical Excellence, 100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598. Assistance is available, Monday – Friday, 8 a.m. – 5 p.m. by calling:

- QIO number for appeals: 1-800-682-2650
- QIO number for complaints: 1-800-722-0468
- TTY/TDD users, dial 711, North Carolina’s text telephone relay line
- Web inquiries: www.mrnc.org

**Seniors’ Health Insurance Information Program (SHIIP)**

SHIIP is a state consumer division of the North Carolina Department of Insurance. SHIIP assists senior citizens with Medicare, Medicare Part D, Medicare supplements, Medicare Advantage, Medicare fraud and abuse and long-term care insurance questions.

Assistance is available by calling 1-800-443-9354 (for the hearing impaired TTY/TDD: 1-800-735-2962), Monday-Friday, 8 a.m. – 5 p.m. You may also send an e-mail to ncshiip@ncdoi.net or visit SHIIP’s Web site at www.ncshiip.com.

**Notice of possible contract termination**

PARTNERS, a Blue Cross and Blue Shield of North Carolina (BCBSNC) company, has a contract with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Advantage HMO and PPO plans. CMS is the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed and either PARTNERS or CMS can decide to end it. Members will get a 90-day advance, written notice in this situation. It is also possible for our contract to end at some other time. If the contract is going to end, we will generally tell members 90 days in advance. Advance notice may be as little as 30 days or even fewer days if CMS ends our contract in the middle of the year. In this notice, we would provide a written description of alternatives available for obtaining Medicare services within the service area. We are also required to notify the general public of a contract termination via local newspapers.

If PARTNERS decides to stop offering Medicare Advantage plans or change our service area so that it no longer includes the area where you live, membership in PARTNERS Medicare Advantage plans will end for everyone in that service area, and members will have to change to a different plan. Members will continue to get services through PARTNERS until the contract ends.
Qualifying for financial assistance

If you have Medicare and Medicaid, you already qualify for low-income assistance. If you do not qualify for Medicaid, you may still qualify for some assistance. The amount of assistance will depend on your income and resources and will be applied to the cost of the Medicare prescription drug coverage portion of your Medicare Advantage plan.

You may be able to get extra help to pay for your prescription drug premiums and costs. To find out if you qualify for extra help, call:

- **1-800-MEDICARE (1-800-633-4227).** TTY/TDD users should call 1-877-486-2048, 24 hours a day / 7 days a week
- **Social Security Administration at** 1-800-772-1213, 7 a.m. – 7 p.m., Mon.-Fri. TTY/TDD users should call 1-800-325-0778
- **Your state Medicaid office**

If you do qualify for extra help for your Medicare prescription drug costs, the amount of your premium and costs at the pharmacy will be lower. Once you have enrolled in Blue Medicare HMO or Blue Medicare PPO, Medicare will tell the plan how much assistance you are receiving and you will be sent information on the amount you will pay.
Frequently asked questions

Q: What happens to my Medicare coverage when I join a Medicare Advantage plan?
A: Once you become a member of Blue Medicare HMO or Blue Medicare PPO, you transfer the administration of your Medicare benefits to the plan. This means you maintain your status as a Medicare beneficiary, plus you gain the enhanced coverage available through your Medicare Advantage health plan. You will receive a member ID card that you must present when using your benefits.

Q: Are annual physicals covered?
A: Yes. Routine health examinations are covered and encouraged for all members.

Q: What happens if I have a medical emergency?
A: If you have a medical emergency, go to the nearest medical facility or call 911. Emergency medical services are covered for you in or out of the service area. Please contact your primary care provider (PCP) within 48 hours so your PCP can coordinate your follow-up care. Emergency services require a copayment, but it will be waived if you are admitted to the hospital on an inpatient basis within 48 hours.

Q: If I am a military retiree, can I join a Medicare Advantage plan without losing my military benefits?
A: Once you join Blue Medicare HMO or Blue Medicare PPO, you can continue to use your military benefits at military facilities, and you can use your Medicare Advantage plan benefits outside of the military system.

Q: Can I buy a stand-alone Medicare prescription drug package?
A: Yes, but if you enroll in a Medicare Advantage plan and want Medicare prescription drug coverage, you must enroll in a Medicare Advantage Prescription Drug Plan – one that includes both medical and prescription drug benefits.

Q: If I choose the Blue Medicare HMO plan that does not include Medicare prescription drug coverage, can I buy separately from another source?
A: No. If you choose to enroll in our Medicare Advantage plan that does not include drug coverage, federal regulations prohibit you from purchasing a separate Medicare prescription drug plan from another company.
**Q:** Can I use my Medicare prescription drug coverage to order my drugs from Canada?

**A:** No. Only drugs purchased in the United States are eligible for Medicare prescription drug coverage.

**Q:** Can I continue to use my drug discount card?

**A:** Drug discount cards are not the same as Medicare prescription drug (Part D) coverage. All Medicare-approved drug discount cards expired when you enrolled in Medicare prescription drug coverage, or May 15, 2006, whichever came first.

There are other non-Medicare approved drug discount cards that may continue to exist. If you enroll in a Medicare Advantage plan that includes Medicare prescription drug coverage, you should contact the issuer of the card to see if you can keep your non-Medicare-approved drug discount card to use in addition to your coverage.
Notes:

For more information or to enroll,
call: 1-800-665-8037
TTY/TDD: 1-888-451-9957
7 days a week, 8 a.m. – 8 p.m.
1 Formulary applies.

2 You must use plan’s providers except in emergency or urgent care situations or for out-of-area renal dialysis.

3 Member responsibility on Blue Medicare PPO may be greater for services received out-of-network than services received in-network. Many out-of-network services are subject to coinsurance, which is based on the Medicare allowed amount and not on the potentially lower contract amount. With the exception of emergency or urgent care, it may cost more to get care from non-plan or non-preferred providers.

Benefits, premium and/or copayment/coinsurance may change on January 1, 2009. Please contact BCBSNC for details.

This brochure may be available in alternative formats upon request.

Blue Medicare HMO and Blue Medicare PPO plans are offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS), a subsidiary of Blue Cross and Blue Shield of North Carolina (BCBSNC). PARTNERS is a Medicare Advantage organization with a Medicare contract to provide HMO and PPO plans. Plans are administered by BCBSNC. BCBSNC and PARTNERS do not discriminate based on color, gender, religion, national origin, age, race, disability, handicap, sexual orientation, genetic information, source of payment or health status as defined by the Centers for Medicare & Medicaid Services (CMS). All qualified Medicare beneficiaries may apply. You must be entitled to Medicare Part A and enrolled in Medicare Part B and must reside in the CMS approved service area. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or another third party.

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