

Blue Medicare HMOSM

2018 HMO Summary of Benefits

Contracts H3449-012, H3449-023-001, H3449-023-002, H3449-005

January 1, 2018 – December 31, 2018

Medicare_{Rx}
Prescription Drug Coverage _{Rx}

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**BlueCross BlueShield
of North Carolina**

Medicare plans to fit your needs

HMO Summary of Benefits

This is a summary of drug and health services covered under Blue Medicare HMO Plans

January 1, 2018 – December 31, 2018.

Blue Cross and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. The benefits information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage.”

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

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

Our service area includes the following counties in North Carolina:

Medical Only H3449-012

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

Essential H3449-023-001

Alamance, Buncombe, Catawba, Guilford, Haywood, Henderson, Madison, McDowell, Mitchell, Orange, Polk, Randolph, Rockingham, Transylvania and Yancey

Essential H3449-023-002

Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Cabarrus, Caldwell, Caswell, Chatham, Chowan, Cleveland, Columbus, Cumberland, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Gates, Granville, Greene, Halifax, Harnett, Hertford, Hoke, Hyde, Iredell, Johnston, Jones, Lee, Lincoln, Martin, Mecklenburg, Montgomery, Nash, New Hanover, Northampton, Pamlico, Pender, Person, Pitt, Richmond, Robeson, Rowan, Sampson, Scotland, Stanly, Stokes, Surry, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson and Yadkin

Enhanced H3449-005

Alexander, Alleghany, Ashe, Avery, Beaufort, Bertie, Bladen, Buncombe, Caldwell, Catawba, Chatham, Chowan, Cleveland, Columbus, Cumberland, Durham, Edgecombe, Franklin, Gaston, Gates, Granville, Greene, Guilford, Halifax, Haywood, Henderson, Hertford, Hyde, Johnston, Jones, Lee, Madison, Martin, Nash, New Hanover, Northampton, Orange, Pender, Person, Polk, Robeson, Rockingham, Sampson, Scotland, Vance, Warren, Watauga, Wayne and Yancey

HMO Summary of Benefits

Benefit	What You Should Know
Monthly Premium:	You must continue to pay your Medicare Part B premium.
Deductible:	These plans have no medical deductible.
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.
Inpatient Hospital Care:* Cost share applies per admission/per stay.	Days 1–6: Days 7–90: Days 91 & beyond:
Outpatient Services:*	Ambulatory Surgical Center: Outpatient Hospital:
Doctor Visit:	Primary: Specialist:
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care:	If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. Emergency services are covered worldwide.
Urgently Needed Services:	
Diagnostic Services/Labs/Imaging:*	Diagnostic Tests, Labs, Radiology Services and X-rays.

Note: This chart shows your portion of the costs. *May require prior authorization.

HMO Summary of Benefits

Medical Only	Essential		Enhanced
H3449-012	H3449-023-001	H3449-023-002	H3449-005
\$0	\$56.80	\$76.00	\$110.40
\$0	\$0	\$0	\$0
\$5,500	\$6,700	\$6,700	\$5,500
\$300 copay \$0 copay \$0 copay	\$300 copay \$0 copay \$0 copay	\$300 copay \$0 copay \$0 copay	\$300 copay \$0 copay \$0 copay
\$200 copay \$300 copay	\$200 copay \$300 copay	\$200 copay \$300 copay	\$175 copay \$275 copay
\$25 copay \$50 copay	\$10 copay \$50 copay	\$10 copay \$50 copay	\$5 copay \$40 copay
\$0 copay	\$0 copay	\$0 copay	\$0 copay
\$80 copay	\$80 copay	\$80 copay	\$80 copay
\$65 copay	\$65 copay	\$65 copay	\$65 copay
20% of cost	20% of cost	20% of cost	20% of cost

Note: This chart shows your portion of the costs.

HMO Summary of Benefits

Benefit		What You Should Know
Hearing Services:		Exams to diagnose and treat hearing and balance issues.
Dental Services:*		Limited dental services. This does not include services in connection with care, treatment, filling, removal or replacement of teeth.
Vision Services:	Routine Eye Exam:	Once every 12 months. Plan pays up to \$100 for routine eye exams.
	Medicare-Covered Glaucoma Test:	For people who are at high risk of glaucoma.
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of injuries and illnesses of the eye.
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.
Mental Health Services:*	Inpatient: (Cost share applies per admission/ per stay.)	Days 1–6: Days 7–90: Days 91–190:
	Outpatient:	Group/individual/substance abuse.

Note: This chart shows your portion of the costs. *May require prior authorization.

HMO Summary of Benefits

Medical Only	Essential		Enhanced
H3449-012	H3449-023-001	H3449-023-002	H3449-005
\$50 copay	\$50 copay	\$50 copay	\$40 copay
\$50 copay	\$50 copay	\$50 copay	\$40 copay
\$25 copay	\$25 copay	\$25 copay	\$25 copay
\$0 copay	\$0 copay	\$0 copay	\$0 copay
\$25 copay	\$25 copay	\$25 copay	\$25 copay
20% of cost	20% of cost	20% of cost	20% of cost
\$270 copay \$0 copay \$0 copay	\$270 copay \$0 copay \$0 copay	\$270 copay \$0 copay \$0 copay	\$270 copay \$0 copay \$0 copay
\$40 copay	\$40 copay	\$40 copay	\$40 copay

Note: This chart shows your portion of the costs.

HMO Summary of Benefits

Benefit	What You Should Know
Skilled Nursing Facility:* Cost share applies per admission/ per stay.	Days 1–20: Days 21–60: Days 61–100:
Outpatient Rehabilitation Services*:	Occupational, Physical & Speech Language Therapy: Cardiac & Pulmonary Rehab Services:
Ambulance Services:*	Covers medically necessary ambulance services.
Transportation:	
Medicare Part B Drugs:*	
Podiatry Services (Foot Care):*	
Medical Equipment & Supplies:*	Durable Medical Equipment & Supplies: Prosthetics: Diabetic Shoes or Inserts: Diabetes Supplies:

Note: This chart shows your portion of the costs. *May require prior authorization.

HMO Summary of Benefits

Medical Only	Essential		Enhanced
H3449-012	H3449-023-001	H3449-023-002	H3449-005
\$0 copay \$167.50 copay \$0 copay	\$0 copay \$167.50 copay \$0 copay	\$0 copay \$167.50 copay \$0 copay	\$0 copay \$167.50 copay \$0 copay
\$40 copay 20% of cost	\$40 copay 20% of cost	\$40 copay 20% of cost	\$40 copay 20% of cost
\$250 copay	\$275 copay	\$275 copay	\$250 copay
Not Covered	Not Covered	Not Covered	Not Covered
20% of cost	20% of cost	20% of cost	20% of cost
\$50 copay	\$50 copay	\$50 copay	\$40 copay
20% of cost 20% of cost 20% of cost \$0 copay	20% of cost 20% of cost 20% of cost \$0 copay	20% of cost 20% of cost 20% of cost \$0 copay	20% of cost 20% of cost 20% of cost \$0 copay

Note: This chart shows your portion of the costs.

HMO Summary of Benefits

Essential

H3449-023-001 & H3449-023-002

Deductible:	Tiers 1, 2 & 6: Tiers 3, 4 & 5:	\$0 \$355
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Essential H3449-023-001 & H3449-023-002

Benefit	Preferred Retail or Mail-Order Pharmacies			Non-preferred Retail or Mail-Order Pharmacies		
	1-month 30-day supply	2-months 60-day supply	3-months 90-day supply	1-month 30-day supply	2-months 60-day supply	3-months 90-day supply
Tier 1 - Preferred Generic:	\$3 copay	\$6 copay	\$9 copay	\$15 copay	\$30 copay	\$45 copay
Tier 2 - Generic:	\$10 copay	\$20 copay	\$30 copay	\$20 copay	\$40 copay	\$60 copay
Tier 3 - Preferred Brand-name:	\$37 copay	\$74 copay	\$111 copay	\$47 copay	\$94 copay	\$141 copay
Tier 4 - Non-preferred Brand-name:	45% of cost	45% of cost	45% of cost	50% of cost	50% of cost	50% of cost
Tier 5 - Specialty:	25% of cost	Tier 5 is limited to a one-month (30-day) supply		25% of cost	Tier 5 is limited to a one-month (30-day) supply	
Tier 6 - Select Care:	\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay	\$3 copay

Note:

- This chart shows your portion of the costs. Benefits shown are available at preferred pharmacies.
- Our preferred pharmacy and preferred mail-order pharmacy networks include: **EPIC, Walgreens, Walmart** and other local pharmacy networks. To find a pharmacy near you, go to www.bcbsnc.com/medicare. Click on "Find a Doctor, Drug or Pharmacy" (top right corner).
- The Preferred Pharmacy Network is a select network of national and local independent pharmacies designed to help save you money on your prescriptions. You may choose non-preferred pharmacies to fill prescriptions, but your costs may be higher. Our pharmacy network may change at any time. You will receive notice when necessary.
- Cost sharing may vary depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

HMO Summary of Benefits

What You Should Know		Enhanced H3449-005
Deductible:	This plan has no drug deductible.	\$0

Drugs	Enhanced H3449-005					
	Preferred Retail or Mail-Order Pharmacies			Non-preferred Retail or Mail-Order Pharmacies		
	1-month 30-day supply	2-months 60-day supply	3-months 90-day supply	1-month 30-day supply	2-months 60-day supply	3-months 90-day supply
Tier 1 - Preferred Generic:	\$3 copay	\$6 copay	\$9 copay	\$15 copay	\$30 copay	\$45 copay
Tier 2 - Generic:	\$6 copay	\$12 copay	\$18 copay	\$20 copay	\$40 copay	\$60 copay
Tier 3 - Preferred Brand-name:	\$37 copay	\$74 copay	\$111 copay	\$47 copay	\$94 copay	\$141 copay
Tier 4 - Non-preferred Brand-name:	45% of cost	45% of cost	45% of cost	50% of cost	50% of cost	50% of cost
Tier 5 - Specialty:	33% of cost	Tier 5 is limited to a one-month (30-day) supply		33% of cost	Tier 5 is limited to a one-month (30-day) supply	
Tier 6 - Select Care:	\$0 copay	\$0 copay	\$0 copay	\$1 copay	\$1 copay	\$1 copay

Note:

- This chart shows your portion of the costs. Benefits shown are available at preferred pharmacies.
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- Cost sharing may vary depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.

HMO Summary of Benefits

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. If you have questions or need to request a copy of the handbook, see the contact information below.

This Blue Medicare HMO Enrollment Kit is available in other formats such as Braille and large print.

If you have questions about Blue Medicare HMO from Blue Cross and Blue Shield of North Carolina (Blue Cross NC), contact an Authorized Agent near you, or call the number below to speak with us directly.

Note:

- Limitations, copayments, and restrictions may apply.
- Benefits, premiums and/or copayments and/or coinsurance may change on January 1 of each year.
- The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.
- This information is not a complete description of benefits. Contact the plan for more details.
- All other marks and trade names are the property of their respective owners.

Medicare & You handbook information:

Contact Medicare



Phone: 1-800-MEDICARE
(1-800-633-4227)

Hours: 7 days a wk., 24 hrs. a day

Online: www.medicare.gov



TTY/TTD: 1-877-486-2048

How to Find a Drug or Pharmacy:

Go to www.bcbsnc.com/medicare



Click on “Find a Doctor, **Drug** or **Pharmacy**” (top right corner)

For more information about Blue Medicare HMO plans:

Members Contact Blue Cross NC Customer Service



Phone: 1-888-310-4110

TTY: 1-888-451-9957

Hours: 7 days a wk., 8 a.m. – 8 p.m.



Non-members Contact the Blue Cross NC Direct Sales Team

Phone: 1-800-665-8037

TTY: 1-800-922-3140

Hours: 7 days a wk., 8 a.m. – 8 p.m.



OR Contact a Blue Cross NC **Authorized Agent** near you.

Blue Medicare HMO™
Blue Medicare PPO™

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service

Call: 1-800-665-8037, 1-800-922-3140 (TTY)

Hours: Daily, 8 a.m. to 8 p.m.

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

Blue Cross NC, P.O. Box 2291, Durham, NC 27702

**Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office**

Call: 919-765-1663, 1-888-291-1783 (TTY)

Fax: 919-287-5613

E-mail: civilrightscordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

**Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201**

Call: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available online at:

<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Contact:

Customer Service

Call: 1-800-665-8037, 1-800-922-3140 (TTY)

Hours: Daily, 8 a.m. to 8 p.m.

Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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Blue Medicare HMO™
Blue Medicare PPO™
Blue Medicare Rx™ (PDP)

Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Services number on the back of your member ID card.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número que figura al dorso de su tarjeta de identificación.

注意：如果您講廣東話或普通話，您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服部電話號碼。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng trên mặt sau thẻ thành viên ID của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객 서비스 전화번호로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Téléphonnez le Service clients au numéro qui figure au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء الموضح على ظهر بطاقة هوية العضو الخاصة بك.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xovtoo ntawm Lub Chaw Pab Cuam Tswv Cuab uas nyob sab tom qab koj daim npav tswv cuab ID.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на оборотной стороне вашей карточки участника.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Serbisyo sa Kostumer sa likod ng Id kard ng miyembro.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. તમારા સભ્યપદ ઓળખપત્રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગ્રાહક સેવાઓના નંબર પર કોલ કરો.

ចំណាំ: ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមហៅទៅកាន់សេវាកម្មជំនួយប្រើលេខទូរស័ព្ទនៅខាងខ្នងកាតសមាជិករបស់លោកអ្នក។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Nummer des Kundenservice an, die auf der Rückseite Ihrer Mitglieds-ID-Karte angegeben ist.

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवाएं नंबर पर कॉल करें।

ឡើងខ្ទុប: ភ្ញាក់ងារលើកិច្ចសន្យាសមាសភាព, មិកាណបំណិកាណខ្ពុយភ្លើងចំណងឃាសាឃតិកែងងារងារ. កែងងារងារខ្ពុយបំណិកាណល្អាតាតាមប្រើលេខងារងារបំណិកាណខ្ពុយងារងារ.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。メンバーIDカードの裏面のカスタマーサービス番号にお電話ください。

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