



2021 Summary of Benefits

BlueMedicare HMOSM

Medicare^{Rx}
Prescription Drug Coverage

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

Plans:

Medical Only (HMO): H3449-012

Essential (HMO): H3449-025

Essential Plus (HMO): H3449-023-001, H3449-023-002, H3449-023-004, H3449-023-005

Choice (HMO): H3449-026

Enhanced (HMO): H3449-024-001, H3449-024-002, H3449-024-003

Notes:

- Blue Medicare HMO has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for their services.
- Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of North Carolina (Blue Cross NC) members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.
- Cost sharing may vary depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
- Plans may offer supplemental benefits in addition to Part C and Part D benefits.
- Blue Cross NC is an HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.
- The benefits information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. For more details, contact Blue Cross NC at **1-888-247-4142** (TTY: 711), access online at [BlueCrossNC.com/Medicare](https://www.BlueCrossNC.com/Medicare) or call your Blue Cross NC Authorized Agent.

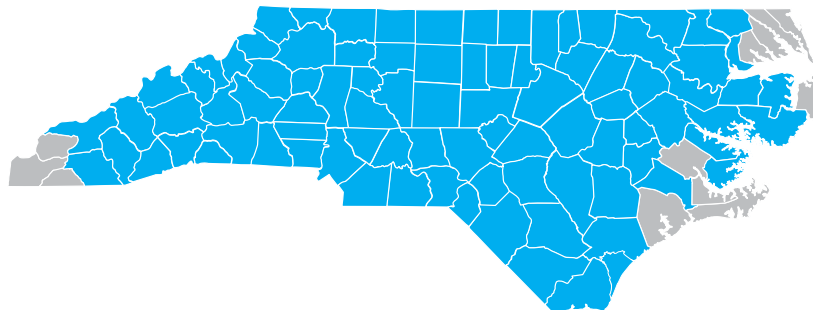
Summary of Benefits

Plan Offering and Premium By County:

Blue Medicare Medical Only SM (HMO) H3449-012

Monthly Premium: \$0

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



 Counties where Blue Medicare Only (HMO) is available.

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

Summary of Benefits

Blue Medicare Medical OnlySM (HMO)

H3449-012

Monthly Premium:

You must also continue to pay your Medicare Part B premium.

\$0

Deductible:

This plan has no medical deductible.

\$0

Annual Maximum Out-of-Pocket Amount:

Does not include prescription drugs.

\$4,400

Benefits

Inpatient Hospital Care:*

(Cost share applies per day. Benefit period applied per admission.)

Days 1–6:

\$335 copay

Days 7–90:

\$0 copay

Days 91 and beyond:

\$0 copay

Outpatient Services:*

Ambulatory Surgical Center:

\$225 copay

Outpatient Hospital:

\$325 copay

Doctor Visit:

Primary:

\$20 copay

Specialist:

\$40 copay

Preventive Care:

Any additional preventive services approved by Medicare during the contract year will be covered.

\$0 copay

Emergency Care:

If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide.

\$90 copay

Urgently Needed Services:

\$65 copay

* May require prior authorization.

Blue Medicare Medical OnlySM (HMO)

Summary of Benefits

Summary of Benefits

Blue Medicare Medical OnlySM (HMO)

Benefits

H3449-012

Diagnostic Services/ Labs/Imaging:

Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.

\$0–\$300
copay

Medicare-Covered Hearing Exam:

Exams to diagnose and treat hearing and balance issues.

\$40 copay

Hearing Services:

Routine Hearing Exam:

One per year. Must use designated providers.

\$0 copay

Hearing Aids:

One per ear, per year. Must use designated providers.

\$699–\$999
copay

Dental Services:

Medical-Covered Dental Services:*

Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.

\$40 copay

Preventive Dental:

Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).

\$300

Routine Eye Exam:

Once every 12 months.

\$25 copay

Routine Eyewear:

Yearly allowance.

\$100

Vision Services:

Medicare-Covered Eye Exam:

For the diagnosis and treatment of illnesses and injuries of the eye.

\$25 copay

Medicare-Covered Glaucoma Test:

For people who are at high risk of glaucoma.

\$0 copay

Eyewear After Cataract Surgery:

One pair of eyeglasses or one pair of contact lenses.

20% of cost

* May require prior authorization.

Summary of Benefits

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

* May require prior authorization.

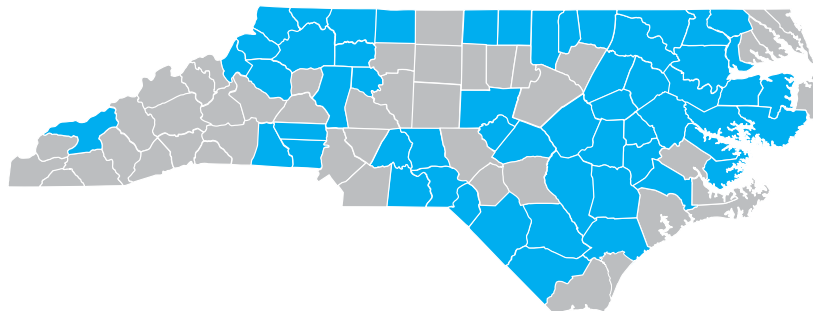
Summary of Benefits

Plan Offering and Premium By County:

BlueMedicare EssentialSM (HMO) H3449-025

Monthly Premium: \$0

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



 Counties where Blue Medicare Essential (HMO) is available.

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

Summary of Benefits

Blue Medicare EssentialSM (HMO)

H3449-025

Monthly Premium:

You must also continue to pay your Medicare Part B premium.

\$0

Annual Deductible:

This plan has no medical deductible.

\$0

Annual Maximum Out-of-Pocket Amount:

Does not include prescription drugs.

\$6,700

Benefits

Inpatient Hospital Care:*

(Cost share applies per day. Benefit period applied per admission.)

Days 1–6:

\$335 copay

Days 7–90:

\$0 copay

Days 91 and beyond:

\$0 copay

Outpatient Services:*

Ambulatory Surgical Center:

\$275 copay

Outpatient Hospital:

\$335 copay

Doctor Visit:

Primary:

\$10 copay

Specialist:

\$50 copay

Preventive Care:

Any additional preventive services approved by Medicare during the contract year will be covered.

\$0 copay

Emergency Care:

If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide.

\$90 copay

Urgently Needed Services:

\$65 copay

* May require prior authorization.

Blue Medicare EssentialSM (HMO)

Summary of Benefits

Summary of Benefits

Blue Medicare EssentialSM (HMO)

Benefits

H3449-025

Diagnostic Services/ Labs/Imaging:

Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.

\$0–\$300
copay

Medicare-Covered Hearing Exam:

Exams to diagnose and treat hearing and balance issues.

\$50 copay

Hearing Services:

Routine Hearing Exam:

One per year. Must use designated providers.

\$0 copay

Hearing Aids:

One per ear, per year. Must use designated providers.

\$699–\$999
copay

Dental Services:

Medical-Covered Dental Services:*

Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.

\$50 copay

Preventive Dental:

Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).

\$250

Routine Eye Exam:

Once every 12 months.

\$25 copay

Routine Eyewear:

Yearly allowance.

\$100

Vision Services:

Medicare-Covered Eye Exam:

For the diagnosis and treatment of illnesses and injuries of the eye.

\$25 copay

Medicare-Covered Glaucoma Test:

For people who are at high risk of glaucoma.

\$0 copay

Eyewear After Cataract Surgery:

One pair of eyeglasses or one pair of contact lenses.

20% of cost

* May require prior authorization.

Summary of Benefits

Blue Medicare EssentialSM (HMO)

Benefits

H3449-025

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

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



Blue Medicare EssentialSM (HMO)

H3449-025

Part D, Prescription Drug Benefit Stages

Annual Deductible:

This is the set amount that you pay before your plan begins to pay its share of the cost.

Tiers 1, 2, 3 and 6: \$0

Tiers 4 and 5: \$375

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your total year-to-date costs on covered drugs reach **\$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,130.

In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **\$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **\$0** copayment at preferred pharmacies or a **\$3** copayment at non-preferred pharmacies.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$6,550.

During this stage, you pay the greater of **\$3.70** or **5%** of the cost for generic drugs, and the greater of **\$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, [see pages 17–20](#).

Summary of Benefits Prescription Drug Coverage

Blue Medicare EssentialSM (HMO)

H3449-025

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

Other Covered Benefits		H3449-025
Podiatry Services:	Foot care	\$50 copay
Medical Equipment and Supplies:	Durable Medical Equipment and Supplies: **	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	\$0 copay
Healthy Aging and Exercise Program:	Participating facilities	\$0 copay

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

** May require prior authorization.

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

Summary of Benefits

Plan Offerings and Premiums By County:

BlueMedicare Essential PlusSM (HMO) H3449-023-001

Monthly Premium: \$0

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

BlueMedicare Essential PlusSM (HMO) H3449-023-002

Monthly Premium: \$0

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

BlueMedicare Essential PlusSM (HMO) H3449-023-004

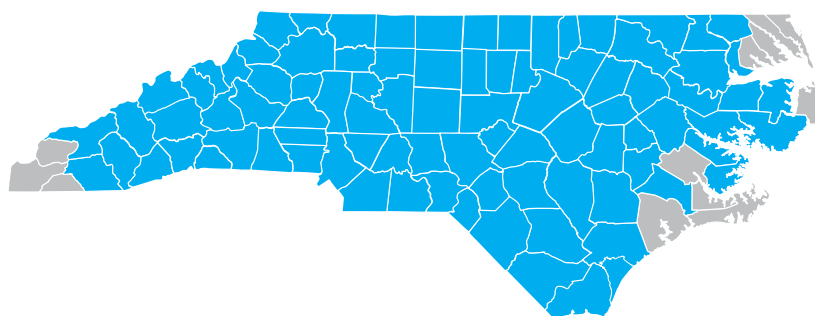
Monthly Premium: \$19


Anson	Chatham	Johnston	Stanly	Surry	Warren
Caswell	Granville	Montgomery	Stokes	Vance	

BlueMedicare Essential PlusSM (HMO) H3449-023-005

Monthly Premium: \$39

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



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

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

Summary of Benefits

Blue Medicare Essential Plus SM (HMO)		H3449-023-001	H3449-023-002	H3449-023-004	H3449-023-005
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	\$0	\$0	\$19	\$39
Deductible:	These plans have no medical deductible.	\$0	\$0	\$0	\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$4,200	\$5,400	\$6,700	\$6,700
Benefits					
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–6:	\$335 copay			
	Days 7–90:	\$0 copay			
	Days 91 and beyond:	\$0 copay			
Outpatient Services:*	Ambulatory Surgical Center:	\$275 copay			
	Outpatient Hospital:	\$335 copay			
Doctor Visit:	Primary:	\$0 copay			
	Specialist:	\$45 copay			
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay			
Emergency Care:	If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide.	\$90 copay			
Urgently Needed Services:		\$65 copay			

* May require prior authorization.

Summary of Benefits

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

* May require prior authorization.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO)

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

Benefits

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

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

* May require prior authorization.

Summary of Benefits Prescription Drug Coverage

Blue Medicare Essential PlusSM (HMO)

H3449-023-001

H3449-023-002

H3449-023-004

H3449-023-005

Part D, Prescription Drug Benefit Stages

Annual Deductible:

This is the set amount that you pay before your plan begins to pay its share of the cost.

Tiers 1, 2, 3 and 6: \$0

Tiers 4 and 5: \$195

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your total year-to-date costs on covered drugs reach **\$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,130.

In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **\$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **\$0** copayment at preferred pharmacies or a **\$3** copayment at non-preferred pharmacies.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$6,550.

During this stage, you pay the greater of **\$3.70** or **5%** of the cost for generic drugs, and the greater of **\$9.20** or **5%** of the cost for brand-name drugs.

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

Summary of Benefits Prescription Drug Coverage

BlueMedicare Essential PlusSM (HMO)

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

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

Other Covered Benefits

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

Podiatry Services: Foot care \$45 copay

Medical Equipment and Supplies: **Durable Medical Equipment and Supplies: **** 20% of cost

Diabetic Shoes or Inserts: 20% of cost

Diabetes Supplies:** \$0 copay

Healthy Aging and Exercise Program: Participating facilities \$0 copay

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

** May require prior authorization.

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

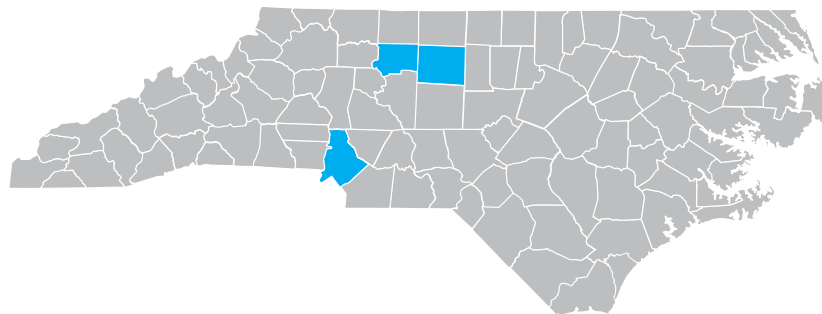
Summary of Benefits

Plan Offering and Premium By County:

BlueMedicare ChoiceSM (HMO) H3449-026:

Monthly Premium: \$0

Forsyth
Guilford
Mecklenburg



 Counties where Blue Medicare Choice (HMO) is available.

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

Summary of Benefits

Blue Medicare ChoiceSM (HMO)

H3449-026

Monthly Premium: You must also continue to pay your Medicare Part B premium. \$0

Deductible: These plans have no medical deductible. \$0

Annual Maximum Out-of-Pocket Amount: Does not include prescription drugs. \$3,900

Benefits

Inpatient Hospital Care:*

(Cost share applies per day. Benefit period applied per admission.)

Days 1–6: \$335 copay

Days 7–90: \$0 copay

Days 91 and beyond: \$0 copay

Outpatient Services:*

Ambulatory Surgical Center: \$275 copay

Outpatient Hospital: \$335 copay

Doctor Visit:

Primary: Tier 1: \$0 copay
Others: \$35 copay

Specialist: \$40 copay

Preventive Care:

Any additional preventive services approved by Medicare during the contract year will be covered. \$0 copay

Emergency Care:

If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide. \$90 copay

Urgently Needed Services:

\$65 copay

* May require prior authorization.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)

Benefits

H3449-026

Diagnostic Services/ Labs/Imaging:

Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.

\$0–\$300
copay

Hearing Services:

Medicare-Covered Hearing Exam:

Exams to diagnose and treat hearing and balance issues.

\$40 copay

Routine Hearing Exam:

One per year. Must use designated providers.

\$0 copay

Hearing Aids:

One per ear, per year. Must use designated providers.

\$699–\$999
copay

Dental Services:

Medical-Covered Dental Services:*

Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.

\$40 copay

Preventive Dental:

Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).

\$325

Vision Services:

Routine Eye Exam:

Once every 12 months.

\$25 copay

Routine Eyewear:

Yearly allowance.

\$200

Medicare-Covered Eye Exam:

For the diagnosis and treatment of illnesses and injuries of the eye.

\$25 copay

Medicare-Covered Glaucoma Test:

For people who are at high risk of glaucoma.

\$0 copay

Eyewear After Cataract Surgery:

One pair of eyeglasses or one pair of contact lenses.

20% of cost

* May require prior authorization.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)

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

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

* May require prior authorization.



Blue Medicare Choice SM (HMO)

H3449-026

Part D, Prescription Drug Benefit Stages

Annual Deductible:

This is the set amount that you pay before your plan begins to pay its share of the cost.

All Tiers: \$0

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your total year-to-date costs on covered drugs reach **\$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,130.

In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **\$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **\$0** copayment at preferred pharmacies or a **\$3** copayment at non-preferred pharmacies.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$6,550.

During this stage, you pay the greater of **\$3.70** or **5%** of the cost for generic drugs, and the greater of **\$9.20** or **5%** of the cost for brand-name drugs.

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

Summary of Benefits Prescription Drug Coverage

Blue Medicare ChoiceSM (HMO)

H3449-026

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

Other Covered Benefits		H3449-026
Podiatry Services:	Foot care	\$40 copay
Medical Equipment and Supplies:	Durable Medical Equipment and Supplies: **	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies: **	\$0 copay
Healthy Aging and Exercise Program:	Participating facilities	\$0 copay

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

** May require prior authorization.

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

Blue Medicare ChoiceSM (HMO)

Summary of Benefits

Summary of Benefits

Plan Offerings and Premiums By County:

BlueMedicare EnhancedSM (HMO) H3449-024-001:

Monthly Premium: \$39

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

BlueMedicare EnhancedSM (HMO) H3449-024-002:

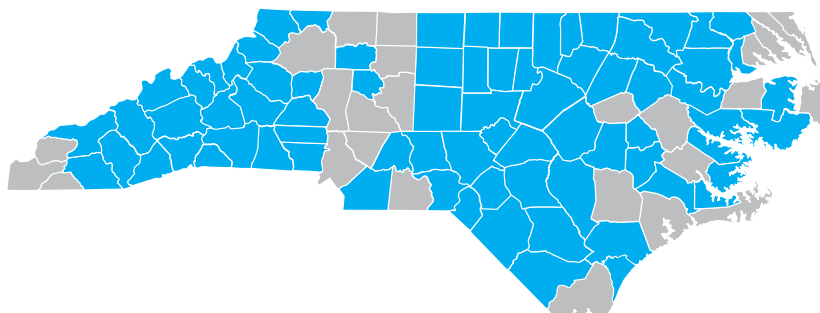
Monthly Premium: \$49

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

BlueMedicare EnhancedSM (HMO) H3449-024-003:

Monthly Premium: \$75

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



 Counties where Blue Medicare Enhanced (HMO) is available.

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

Summary of Benefits

Blue Medicare Enhanced SM (HMO)		H34449-024-001	H34449-024-002	H34449-024-003
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	\$39	\$49	\$75
Deductible:	These plans have no medical deductible.	\$0	\$0	\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$3,900	\$4,900	\$5,500
Benefits				
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–6:	\$335 copay		
	Days 7–90:	\$0 copay		
	Days 91 and beyond:	\$0 copay		
Outpatient Services:*	Ambulatory Surgical Center:	\$200 copay		
	Outpatient Hospital:	\$300 copay		
Doctor Visit:	Primary:	\$0 copay		
	Specialist:	\$40 copay		
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay		
Emergency Care:	If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Emergency services are covered worldwide.	\$90 copay		
Urgently Needed Services:		\$65 copay		

* May require prior authorization.

Summary of Benefits

Blue Medicare EnhancedSM (HMO)

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

Benefits

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

* May require prior authorization.

Summary of Benefits

Blue Medicare EnhancedSM (HMO)

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

Benefits

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

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

* May require prior authorization.

Summary of Benefits



Prescription Drug Coverage

BlueMedicare EnhancedSM (HMO)

H3449-024-001

H3449-024-002

H3449-024-003

Part D, Prescription Drug Benefit Stages

Annual Deductible:

This is the set amount that you pay before your plan begins to pay its share of the cost.

All Tiers: \$0

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your total year-to-date costs on covered drugs reach **\$4,130**. (Total year-to-date drug costs include the total drug costs paid by you and any Part D plan from the beginning of the calendar year.)

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,130.

In this stage, you'll pay **25%** of the cost for generic drugs and **25%** of the cost for brand-name drugs, excluding dispensing and administration fees, until your total year-to-date costs reach **\$6,550**. Tier 6 drugs are fully covered in the Coverage Gap; there's a **\$0** copayment at preferred pharmacies or a **\$1** copayment at non-preferred pharmacies.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$6,550.

During this stage, you pay the greater of **\$3.70** or **5%** of the cost for generic drugs, and the greater of **\$9.20** or **5%** of the cost for brand-name drugs.

To find more information on prescription drug coverage, [see pages 17–20](#).

Summary of Benefits Prescription Drug Coverage

Blue Medicare EnhancedSM (HMO)

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

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

Other Covered Benefits

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

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

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

** May require prior authorization.

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

Blue Medicare EnhancedSM (HMO)

Summary of Benefits

Summary of Benefits Prescription Drug Coverage

Which drugs are covered?

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

Which pharmacies can I use?

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

How do I find a preferred pharmacy?

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

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



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



TTY: 1-877-486-2048



Hours: 7 days a week, 24 hours a day



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

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



Phone: 1-800-665-8037



TTY: 711



Hours: 7 days a week, 8 a.m. – 8 p.m.



Visit: [BlueCrossNC.com/Medicare](https://www.BlueCrossNC.com/Medicare)

Or contact your Blue Cross NC Authorized Agent.