



## 2021 Summary of Benefits

### Blue Medicare PPO<sup>SM</sup>

MedicareRx  
Prescription Drug Coverage X

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

Plans: Blue Medicare PPO Enhanced H3404-003-001 and H3404-003-002

#### Notes:

- Blue Medicare PPO has a network of doctors, hospitals, pharmacies and other providers. You'll get your health care at lower prices by using in-network providers.
- Out-of-network/non-contracted providers are under no obligation to treat 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 and Blue Shield of North Carolina (Blue Cross NC) is a PPO 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 **1-877-494-7647** (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 PPO Enhanced<sup>SM</sup> H3404-003-001:

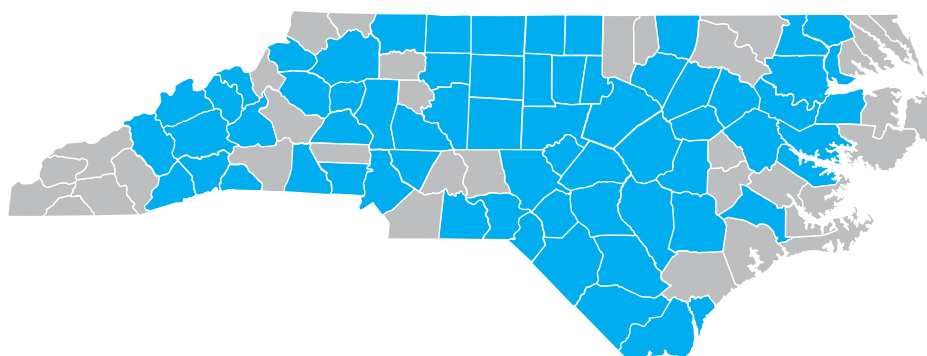
**Monthly Premium: \$59**

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

**Blue**Medicare PPO Enhanced<sup>SM</sup> H3404-003-002:

**Monthly Premium: \$69**

Alexander	Chatham	Gates	Madison	Polk	Warren
Anson	Chowan	Harnett	Martin	Richmond	Washington
Beaufort	Cleveland	Henderson	McDowell	Robeson	Watauga
Bertie	Columbus	Hertford	Mitchell	Rowan	Wayne
Bladen	Cumberland	Hoke	Moore	Sampson	Wilkes
Brunswick	Duplin	Iredell	Nash	Scotland	Wilson
Cabarrus	Edgecombe	Johnston	New Hanover	Stokes	Yancey
Caldwell	Franklin	Jones	Person	Surry	
Caswell	Gaston	Lee	Pitt	Transylvania	



 Counties where Blue Medicare PPO is available.

**Please note:** To join Blue Medicare PPO 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 PPO Enhanced<sup>SM</sup>

What You Should Know		H3404-003-001	H3404-003-002
<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	\$59	\$69
<b>Deductible:</b>	These plans have no medical deductible.	\$0	\$0

### PPO Enhanced H3404-003-001 and H3404-003-002

Benefit	What You Should Know	In-Network	Out-of-Network
<b>Annual Out-of-Pocket Maximum:</b>		\$5,900	\$11,300
<b>Inpatient Hospital Care:*</b> (Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–6:</b>	\$335 copay	40% of cost
	<b>Days 7–90:</b>	\$0 copay	40% of cost
	<b>Days 91 and beyond:</b>	\$0 copay	40% of cost
<b>Outpatient Services:*</b>	<b>Ambulatory Surgical Center:</b>	\$200 copay	40% of cost
	<b>Outpatient Hospital:</b>	\$300 copay	40% of cost
<b>Doctor Visit:</b>	<b>Primary:</b>	\$10 copay	40% of cost
	<b>Specialist:</b>	\$50 copay	40% of cost
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay	\$0 copay
<b>Emergency Care:</b>	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	\$90 copay
<b>Urgently Needed Services:</b>		\$65 copay	\$65 copay

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

# Summary of Benefits

## Blue Medicare PPO Enhanced<sup>SM</sup>

H3404-003-001  
H3404-003-002

Benefit		What You Should Know	In-Network	Out-of-Network
<b>Diagnostic Services/ Labs/Imaging:</b>		Diagnostic tests, labs, radiology services and X-rays. Copay varies with service.	\$0–\$300 copay	40% of cost
<b>Hearing Services:</b>	<b>Medicare-Covered Hearing Exam:</b>	Exam to diagnose and treat hearing and balance issues.	\$50 copay	40% of cost
	<b>Routine Hearing Exam:</b>	One per year. Must use designated providers.	\$0 copay	\$0 copay
	<b>Hearing Aids:</b>	One per ear, per year. Must use designated providers.	\$699–\$999	\$699–\$999
<b>Dental Services:</b>	<b>Medical-Covered Dental Services:</b>		\$50 copay	40% of cost
	<b>Preventive Dental:</b>	Yearly allowance for preventive services (oral exams, cleaning, fluoride treatment and X-rays).	\$325	
<b>Vision Services:</b>	<b>Routine Eye Exam:</b>	Once every 12 months.	\$25 copay	40% of cost
	<b>Routine Eyewear:</b>	Yearly allowance.	\$200	
	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	\$25 copay	40% of cost
	<b>Medicare-Covered Glaucoma Test:</b>	For people who are at high risk of glaucoma.	\$0 copay	\$0 copay
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost	40% of cost

Note: This chart shows your portion of the costs.

# Summary of Benefits

## Blue Medicare PPO Enhanced<sup>SM</sup>

H3404-003-001

H3404-003-002

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

To find other covered benefits, **see the bottom of page 29.**  
For prescription drug coverage information, **see pages 28–29.**

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

# Summary of Benefits Prescription Drug Coverage

**Blue** Medicare PPO Enhanced<sup>SM</sup>

H3404-003-001  
H3404-003-002

## 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 19–22.

# Summary of Benefits Prescription Drug Coverage

**Blue**Medicare PPO Enhanced<sup>SM</sup>

H3404-003-001  
H3404-003-002

	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
<b>Preferred Generic Drugs</b> (Tier 1)	\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
<b>Generic Drugs</b> (Tier 2)	\$6 copay	\$18 copay	\$0 copay	\$20 copay	\$60 copay
<b>Preferred Brand Drugs</b> (Tier 3)	\$37 copay	\$111 copay	\$74 copay	\$47 copay	\$141 copay
<b>Non-Preferred Drugs</b> (Tier 4)	45% of cost	45% of cost	45% of cost	50% of cost	50% of cost
<b>Specialty Tier Drugs</b> (Tier 5)	33% of cost	N/A	N/A	33% of cost	N/A
<b>Select Care Drugs</b> (Tier 6)	\$0 copay	\$0 copay	\$0 copay	\$1 copay	\$1 copay

Other Covered Benefits	H3404-003-001 H3404-003-002	In-Network	Out-of-Network
<b>Podiatry Services:</b>	Foot care	\$50 copay	40% of cost
<b>Medical Equipment and Supplies:</b>	<b>Durable Medical Equipment and Supplies: **</b>	20% of cost	40% of cost
	<b>Diabetic Shoes or Inserts:</b>	20% of cost	40% of cost
	<b>Diabetes Supplies:**</b>	\$0 copay	40% of cost
<b>Healthy Aging and Exercise Program:</b>	Must use participating facilities	\$0 copay	\$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 PPO Enhanced<sup>SM</sup>

Summary of Benefits

# Summary of Benefits Prescription Drug Coverage

## Which drugs are covered?

See the Prescription Drug Coverage section of this book, pages 19–22.

## 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.**