2022 Summary of Benefits

BlueMedicare HMO℠

MedicareRx 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, 2022 – December 31, 2022.**

Plans:
Medical Only (HMO): H3449-012
Essential (HMO): H3449-027-001, H3449-027-002
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:

- The benefits information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. Visit *Medicare.BlueCrossNC.com/medicare/forms-library* and click on the Evidence of Coverage tab.
- 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 and Blue Shield of North Carolina is an HMO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
- For more details, call **1-800-665-8037** (TTY: 711) or current members call **1-888-310-4110** (TTY: 711). You can also visit ***Medicare.BlueCrossNC.com*** or contact your Blue Cross NC Authorized Agent.

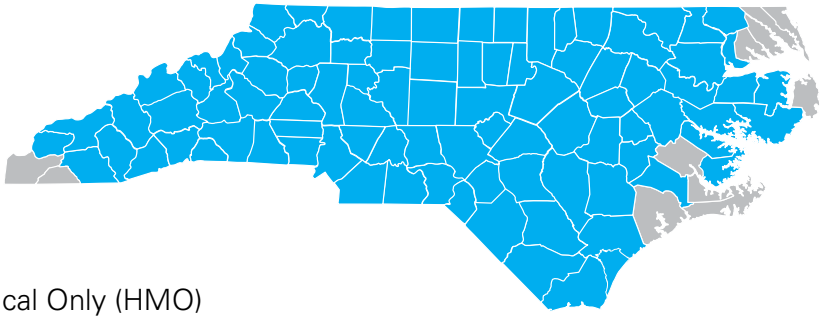
Y0079_10404_M CMS Accepted 08202021
U5047, 8/21

Summary of Benefits

Plan Offering and Premium by County:

Blue Medicare Medical Only℠ (HMO) H3449-012 **Monthly Premium: $0**

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



Counties where
Blue Medicare Medical Only (HMO)
is available:

012

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

BlueMedicare Medical Only℠ (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.	$3,900
Benefits		
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$295 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	**Ambulatory Surgical Center:**	$225 copay
	Outpatient Hospital:	$275 copay
Doctor Visit:	**Primary:**	$0 copay
	Specialist:*	$25 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

BlueMedicare Medical Only℠ (HMO)

Benefits			H3449-012
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.	$25 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:	**Medicare-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$25 copay
	Comprehensive and Preventive Dental:**	Yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.	$2,000
Vision Services:	**Routine Eye Exam:**	One visit per calendar year.	$25 copay
	Routine Prescription Eyewear:	Yearly allowance.	$300
	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.
**Certain limits apply.

Summary of Benefits

BlueMedicare Medical Only℠ (HMO)

Benefits			H3449-012
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$295 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:	$188 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.	$25 copay
Medical Equipment and Supplies:		**Durable Medical Equipment and Supplies:***	20% of cost
		Diabetic Shoes or Inserts:	20% of cost
		Diabetes Supplies:*	$0 copay
Over-the-Counter Products Allowance:			$100 quarterly
Healthy Aging and Exercise Program:		Participating facilities.	$0 copay

*May require prior authorization.

Summary of Benefits

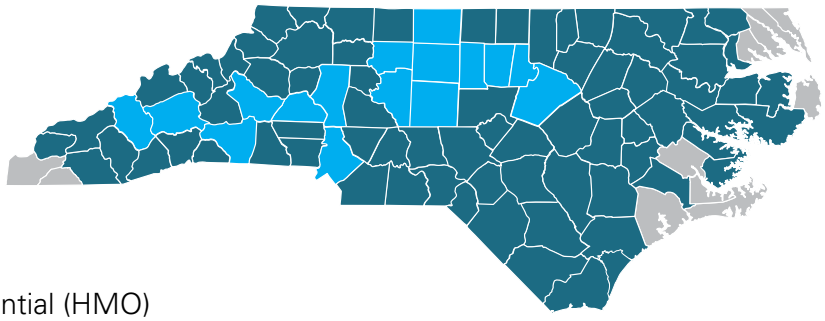
Plan Offering and Premium by County:

Blue Medicare Essential℠ (HMO) H3449-027-001 — Monthly Premium: $0

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

Blue Medicare Essential℠ (HMO) H3449-027-002 — Monthly Premium: $0

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



Counties where
Blue Medicare Essential (HMO)
is available:

001 002

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

BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

Monthly Premium:	You must also continue to pay your Medicare Part B premium.		$0
Part B Premium Reduction:			$50 monthly
Annual Deductible:	This plan has no medical deductible.		$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.		$5,900
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: Per stay.	001:	$295 copay
		002:	$345 copay
Doctor Visit:	**Primary:**	001:	$5 copay
		002:	$10 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

BlueMedicare Essential℠ (HMO) **Benefits**			H3449-027-001 H3449-027-002
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:	**Medicare-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:	Oral exams, cleanings, X-rays and screenings.**	$0 copay
Vision Services:	**Routine Eye Exam:**	One visit per calendar year.	$25 copay
	Routine Prescription Eyewear:	Yearly allowance.	$100
	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.
**Certain limits apply.

Summary of Benefits

BlueMedicare Essential℠ (HMO)

Benefits			H3449-027-001 H3449-027-002
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:	$188 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

*May require prior authorization.

Summary of Benefits Prescription Drug Coverage

Blue Medicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

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. **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 **$4,430**. (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 $4,430.** 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 **$7,050**. 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 $7,050.** During this stage, you pay the greater of **$3.95** or **5%** of the cost for generic drugs, and the greater of **$9.85** or **5%** of the cost for brand-name drugs.

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Essential℠ (HMO)

H3449-027-001
H3449-027-002

	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
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)	$90 copay	$270 copay	$180 copay	$100 copay	$300 copay
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

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
Insulin Savings Program:	30 day supply.	$35 copay
Over-the-Counter Products Allowance:	001:	$25 quarterly
	002:	N/A
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.
Notes: Two-month (60-day) supplies may also be available. Non-preferred mail order costs may differ.

Summary of Benefits

Plan Offerings and Premiums by County:

Blue Medicare Essential Plus℠ (HMO) H3449-023-001 — Monthly Premium: $0

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

Blue Medicare Essential Plus℠ (HMO) H3449-023-002 — Monthly Premium: $0

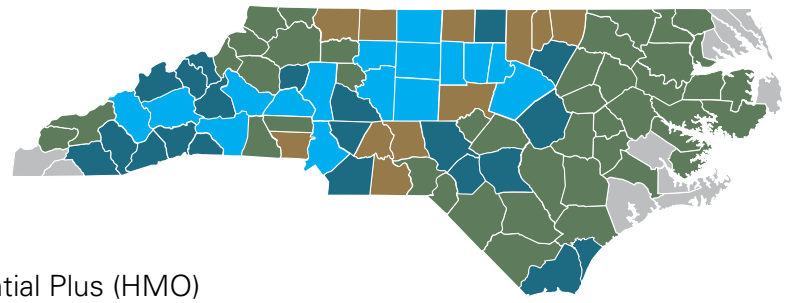
Alexander	Franklin	Johnston	Mitchell	Polk	Yancey
Brunswick	Henderson	Macon	Moore	Rowan	
Cabarrus	Hoke	Madison	New Hanover	Transylvania	
Cumberland	Jackson	McDowell	Person	Union	

Blue Medicare Essential Plus℠ (HMO) H3449-023-004 — Monthly Premium: $10

Anson	Chatham	Granville	Stanly	Surry	Warren
Caswell	Gaston	Montgomery	Stokes	Vance	

Blue Medicare Essential Plus℠ (HMO) H3449-023-005 — Monthly Premium: $26

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



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

001 002 004 005

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

BlueMedicare Essential Plus℠ (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.	001: 002: $0 004: $10 005: $26
Deductible:	These plans have no medical deductible.	$0
Annual Maximum Out-of-Pocket:	Does not include prescription drugs.	001: $4,200 002: $4,900 004: 005: $5,900
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: Per stay.	$295 copay
Doctor Visit:	**Primary:**	$0 copay
	Specialist:*	001: $25 copay 002: 004: 005: $35 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

BlueMedicare Essential Plus℠ (HMO) Benefits				H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
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.	001: 002: 004: 005:	$25 copay $35 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:	**Medicare-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	001: 002: 004: 005:	$25 copay $35 copay
	Comprehensive and Preventive Dental:**	Yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.		$2,000
Vision Services:	**Routine Eye Exam:**	One visit per calendar year.		$25 copay
	Routine Prescription 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.
**Certain limits apply.

Summary of Benefits

BlueMedicare Essential Plus℠ (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:	$188 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

*May require prior authorization.

Summary of Benefits Prescription Drug Coverage

BlueMedicare Essential Plus℠ (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 **$4,430**. (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 $4,430.** 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 **$7,050**. 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 $7,050.** During this stage, you pay the greater of **$3.95** or **5%** of the cost for generic drugs, and the greater of **$9.85** or **5%** of the cost for brand-name drugs.

Summary of Benefits Prescription Drug Coverage

BlueMedicare Essential Plus℠ (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)	$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)	$90 copay	$270 copay	$180 copay	$100 copay	$300 copay
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

Podiatry Services:	Foot care.	001:	$25 copay
		002: 004: 005:	$35 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****		20% of cost
	Diabetic Shoes or Inserts:		20% of cost
	Diabetes Supplies:**		$0 copay
Insulin Savings Program:	30 day supply.		$35 copay
Over-the-Counter Products Allowance:		001:	$95 quarterly
		002: 004: 005:	$70 quarterly
Healthy Aging and Exercise Program:	Participating facilities.		$0 copay

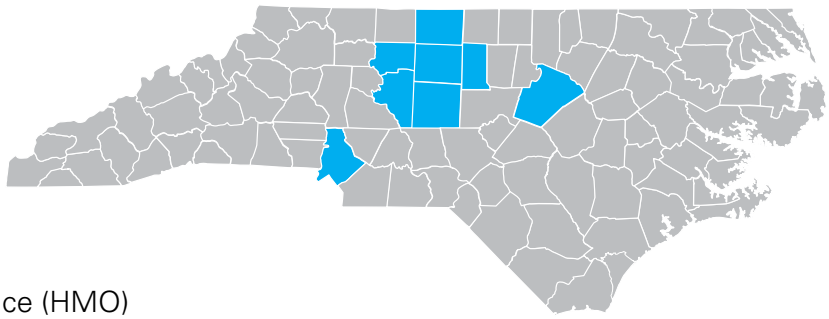
*Long-term care pharmacy benefit is covered the same as retail non-preferred for 31 days instead of 30 days.
**May require prior authorization.
Notes: Two-month (60-day) supplies may also be available. Non-preferred mail order costs may differ.

Summary of Benefits

Plan Offering and Premium by County:

BlueMedicare Choice℠ (HMO) H3449-026 **Monthly Premium: $0**

Alamance	Forsyth	Mecklenburg	Rockingham
Davidson	Guilford	Randolph	Wake



Counties where
Blue Medicare Choice (HMO)
is available:

026

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

BlueMedicare Choice℠ (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.	$3,400
Benefits		
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$295 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	**Ambulatory Surgical Center:**	$275 copay
	Outpatient Hospital: Per stay.	$295 copay
Doctor Visit:	**Primary:**	$0 copay
	Specialist:*	$20 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

BlueMedicare Choice℠ (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.	$20 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:	**Medicare-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	$20 copay
	Preventive Dental:	Oral exams, cleanings, X-rays and screenings.**	$0 copay
Vision Services:	**Routine Eye Exam:**	One visit per calendar year.	$25 copay
	Routine Prescription 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.
**Certain limits apply.

Summary of Benefits

BlueMedicare Choice℠ (HMO)

Benefits			H3449-026
Mental Health Services:	**Inpatient:*** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–6:**	$295 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:	$188 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

*May require prior authorization.

Summary of Benefits Prescription Drug Coverage

BlueMedicare Choice℠ (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 **$4,430**. (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 $4,430.** 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 **$7,050**. 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 $7,050.** During this stage, you pay the greater of **$3.95** or **5%** of the cost for generic drugs, and the greater of **$9.85** or **5%** of the cost for brand-name drugs.

Summary of Benefits — Prescription Drug Coverage

BlueMedicare Choice℠ (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)	$90 copay	$270 copay	$180 copay	$100 copay	$300 copay
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

Podiatry Services:	Foot care.	$20 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****	20% of cost
	Diabetic Shoes or Inserts:	20% of cost
	Diabetes Supplies:**	$0 copay
Insulin Savings Program:	30 day supply.	$35 copay
Over-the-Counter Products Allowance:		$70 quarterly
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.
Notes: Two-month (60-day) supplies may also be available. Non-preferred mail order costs may differ.

Summary of Benefits

Plan Offerings and Premiums by County:

Blue Medicare Enhanced℠ (HMO) H3449-024-001 — Monthly Premium: $19

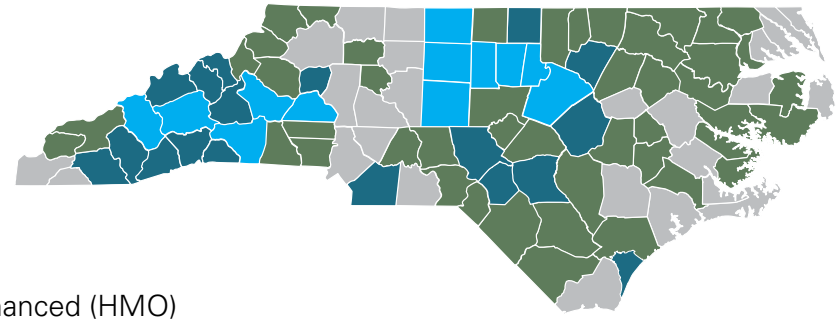
Alamance	Burke	Durham	Haywood	Randolph	Rutherford
Buncombe	Catawba	Guilford	Orange	Rockingham	Wake

Blue Medicare Enhanced℠ (HMO) H3449-024-002 — Monthly Premium: $34

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

Blue Medicare Enhanced℠ (HMO) H3449-024-003 — Monthly Premium: $49

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



Counties where
Blue Medicare Enhanced (HMO)
is available:

001 002 003

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

BlueMedicare Enhanced℠ (HMO)

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

Monthly Premium:	You must also continue to pay your Medicare Part B premium.	001:	$19
		002:	$34
		003:	$49
Deductible:	These plans have no medical deductible.		$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	001:	$3,900
		002:	$4,500
		003:	$4,900

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:**		$200 copay
	Outpatient Hospital: Per stay.		$295 copay
Doctor Visit:	**Primary:**		$0 copay
	Specialist:*	001:	$25 copay
		002: 003:	$30 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

BlueMedicare Enhanced℠ (HMO)

Benefits				H3449-024-001 H3449-024-002 H3449-024-003
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.	001:	$25 copay
			002: 003:	$30 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:	**Medicare-Covered Dental Services:***	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	001:	$25 copay
			002: 003:	$30 copay
	Comprehensive and Preventive Dental:**	Yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.		$2,000
Vision Services:	**Routine Eye Exam:**	One visit per calendar year.		$25 copay
	Routine Prescription 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.
**Certain limits apply.

Summary of Benefits

BlueMedicare Enhanced℠ (HMO)

Benefits			H3449-024-001 H3449-024-002 H3449-024-003
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:	$188 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

*May require prior authorization.

Summary of Benefits Prescription Drug Coverage

BlueMedicare Enhanced℠ (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 **$4,430**. (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 $4,430.** 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 **$7,050**. 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 $7,050.** During this stage, you pay the greater of **$3.95** or **5%** of the cost for generic drugs, and the greater of **$9.85** or **5%** of the cost for brand-name drugs.

Summary of Benefits Prescription Drug Coverage

BlueMedicare Enhanced℠ (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)	$90 copay	$270 copay	$180 copay	$100 copay	$300 copay
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

Podiatry Services:	Foot care.	001:	$25 copay
		002: 003:	$30 copay
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****		20% of cost
	Diabetic Shoes or Inserts:		20% of cost
	Diabetes Supplies:**		$0 copay
Insulin Savings Program:	30 day supply.		$35 copay
Over-the-Counter Products Allowance:			$95 quarterly
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.
Notes: Two-month (60-day) supplies may also be available. Non-preferred mail order costs may differ.

Summary of Benefits Prescription Drug Coverage

Which drugs are covered?

See the Prescription Drug Coverage section of the Blue Medicare Advantage HMO book.

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 Mail Order Pharmacy Network includes AllianceRx Walgreens Prime, Express Scripts and Kroger Postal Prescription Services.
- Tiers 1, 2 and 6 have a $0 copayment for a 90-day supply at a Preferred Mail Order Pharmacy. And for Tiers 3 and 4 (after any deductible is met if applicable), you pay no more than two times the 30-day copay for a 90-day supply at a Preferred Mail Order Pharmacy.

How do I find a preferred pharmacy?

- To find a pharmacy, go to ***Medicare.BlueCrossNC.com***. Click on "Find a 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*

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

Phone: **1-800-665-8037** (TTY: 711) or current members call **1-888-310-4110** (TTY: 711)

Hours: 7 days a week, 8 a.m. – 8 p.m. **Visit:** ***Medicare.BlueCrossNC.com***

Or contact your Blue Cross NC **Authorized Agent.**