



2023 Summary of Benefits

Blue Medicare HMOSM

MedicareRx
Prescription Drug Coverage X

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare HMO plans for **January 1, 2023 – December 31, 2023**.

Plans:

Medical Only (HMO-POS): H3449-012

Essential (HMO): H3449-027-001, H3449-027-002

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

Choice (HMO): H3449-026

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

- 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](https://www.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.
- With a HMO-POS (Point of Service) plan, you can go outside the network for your dental benefits. For dental services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.
- 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 information about Original Medicare or to request the *Medicare & You* handbook from Medicare, call 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, 7 days a week, 24 hours a day. Or visit [Medicare.gov](https://www.Medicare.gov).
- For more details, call **1-800-665-8037** (TTY: 711), current members call **1-888-310-4110** (TTY: 711), visit [Medicare.BlueCrossNC.com](https://www.Medicare.BlueCrossNC.com) or contact your Blue Cross NC Authorized Independent Agent.

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U5047, 8/22

Summary of Benefits

Plan Offering and Premium by County

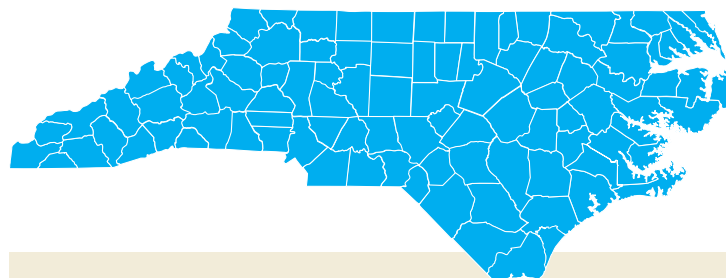
Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.

Blue Medicare Medical Only SM (HMO-POS)

H3449-012

Monthly Premium: \$0

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



Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.

Please note: To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

Summary of Benefits

Blue Medicare Medical OnlySM (HMO-POS)		H3449-012
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	\$0
Part B Premium Reduction:	Monthly reduction.	\$50 monthly
Deductible:	This plan has no medical deductible.	\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$3,900
Benefits	What You Should Know	
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$295 copay
	Days 6–90:	\$0 copay
	Days 91 and beyond:	\$0 copay
Outpatient Services:*	Outpatient Hospital: Per stay.	\$275 copay
	Ambulatory Surgical Center:	\$225 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.	\$110 copay
Urgently Needed Services:		\$60 copay

*May require prior authorization.

Summary of Benefits

Blue Medicare Medical OnlySM (HMO-POS)		H3449-012
Benefits	What You Should Know	
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:**	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures. \$0 copay***
Vision Services:	Routine Eye Exam:	One visit per calendar year. \$25 copay
	Routine Prescription Eyewear:	\$300 yearly allowance. \$0 copay
	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. Combined yearly allowance. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.

***Must use designated providers.

Summary of Benefits

Blue Medicare Medical Only SM (HMO-POS)		H3449-012	
Benefits	What You Should Know		
Mental Health Services:	Inpatient: * (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$295 copay
		Days 6–90:	\$0 copay
	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	\$25 copay
Skilled Nursing Facility: *	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20:	\$0 copay
		Days 21–60:	\$196 copay
		Days 61–100:	\$0 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:		\$25 copay
	Occupational Therapy:		\$40 copay
	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Services:		\$20 copay
Ambulance Services: *	Covers medically necessary ground and air ambulance services.		\$250 copay
Transportation:	24 one-way rides to health-related locations.		\$0 copay
Medicare Part B Drugs: *	20% of cost		

*May require prior authorization.

Summary of Benefits

Blue Medicare Medical OnlySM (HMO-POS)

H3449-012

Other Covered Benefits

Benefit
What You Should Know

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: *	Preferred Brands
Non-Preferred Brands**		20% of cost
Healthy Aging and Exercise Program:	Must use participating facilities.	\$0 copay***
Over-the-Counter Products Allowance:	Must use participating retail locations. Funds do not roll over quarter-to-quarter.	\$100 quarterly
Meals Benefit:	Two meals per day for 14 days post-discharge.	\$0 copay
Support for Caregivers:	Support and resources for non-professional caregivers.	\$0 copay
In-Home Assistance:	60 hours per year.	\$0 copay
Personal Emergency Response System:	Wearable device with fast access to emergency services.	\$0 copay

* May require prior authorization.

** With a medical exception.

*** This program includes the Standard network; Premium network may have monthly costs.

Summary of Benefits

Plan Offering and Premium by County

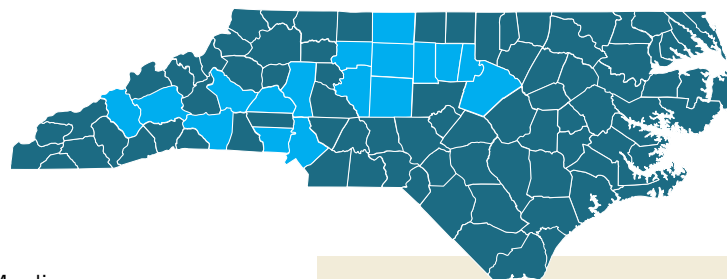
Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.

Blue Medicare EssentialSM (HMO)	H3449-027-001	Monthly Premium: \$0
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Alamance	Catawba	Forsyth	Haywood	Orange	Rutherford
Buncombe	Davidson	Gaston	Iredell	Randolph	Wake
Burke	Durham	Guilford	Mecklenburg	Rockingham	

Blue Medicare EssentialSM (HMO)	H3449-027-002	Monthly Premium: \$0
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Alexander	Chatham	Gates	Lenoir	Pasquotank	Swain
Alleghany	Cherokee	Graham	Lincoln	Pender	Transylvania
Anson	Chowan	Granville	Macon	Perquimans	Tyrrell
Ashe	Clay	Greene	Madison	Person	Union
Avery	Cleveland	Halifax	Martin	Pitt	Vance
Beaufort	Columbus	Harnett	McDowell	Polk	Warren
Bertie	Craven	Henderson	Mitchell	Richmond	Washington
Bladen	Cumberland	Hertford	Montgomery	Robeson	Watauga
Brunswick	Currituck	Hoke	Moore	Rowan	Wayne
Cabarrus	Dare	Hyde	Nash	Sampson	Wilkes
Caldwell	Davie	Jackson	New Hanover	Scotland	Wilson
Camden	Duplin	Johnston	Northampton	Stanly	Yadkin
Carteret	Edgecombe	Jones	Onslow	Stokes	Yancey
Caswell	Franklin	Lee	Pamlico	Surry	



Counties where Blue Medicare Essential (HMO) is available:

001 **002**

Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.

Please note: To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

Summary of Benefits

Blue Medicare 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:	Monthly reduction.	\$50 monthly
Annual Deductible:	This plan has no medical deductible.	\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$7,500

Benefits

What You Should Know

Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$335 copay
	Days 6–90:	\$0 copay
	Days 91 and beyond:	\$0 copay

Outpatient Services:*	Outpatient Hospital: Per stay.	001:	\$295 copay
		002:	\$345 copay
	Ambulatory Surgical Center:		\$275 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
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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.	\$95 copay
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Urgently Needed Services:		\$60 copay
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*May require prior authorization.

Summary of Benefits

Blue Medicare EssentialSM (HMO)

H3449-027-001
H3449-027-002

Benefits

What You Should Know

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:

\$100 yearly allowance.

\$0 copay

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. Must use designated providers.

Summary of Benefits

Blue Medicare Essential™ (HMO)		H3449-027-001 H3449-027-002
Benefits		What You Should Know
Mental Health Services:	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5: \$300 copay
	Outpatient: (Mental health* and substance use.)	Days 6–90: \$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20: \$0 copay
		Days 21–60: \$196 copay
		Days 61–100: \$0 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:	\$25 copay
	Occupational Therapy:	\$40 copay
	Cardiac Rehab Services:	\$0 copay
	Pulmonary Rehab Services:	\$20 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

Blue Medicare EssentialSM (HMO)

H3449-027-001
H3449-027-002

Part D, Prescription Drug Benefit Stages

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

Tiers 4 and 5: \$375

Annual Deductible:

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

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your costs on covered drugs reach **\$4,660**.¹ The amount you pay in this stage is shown in the chart on the next page.

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,660.

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 **\$7,400**.² 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. With the Insulin Savings Program, the amount you pay for insulin is the same as the Initial Coverage stage.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$7,400.

During this stage, you pay the greater of **\$4.15** or **5%** of the cost for generic drugs, and the greater of **\$10.35** or **5%** of the cost for brand-name drugs.

Footnotes:


1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.

2 Total year-to-date includes drug costs that only you have paid.

Summary of Benefits

Blue Medicare Essential™ (HMO)

H3449-027-001
H3449-027-002

 Prescription Drug Initial Coverage Limit (ICL)	Preferred Retail Pharmacies		Preferred Mail Order	Standard (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)	27% of cost	N/A	N/A	27% of cost	N/A
Select Care Drugs (Tier 6)	\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins (Tier 3, 4)	\$35 copay	\$105 copay	\$70 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.

Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.

Summary of Benefits

Blue Medicare EssentialSM (HMO)

H3449-027-001
H3449-027-002

Other Covered Benefits

Benefit	What You Should Know	
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:*	Preferred Brands
Non-Preferred Brands**		20% of cost
Healthy Aging and Exercise Program:	Must use participating facilities.	\$0 copay***
Meals Benefit:	Two meals per day for 14 days post-discharge.	\$0 copay
Support for Caregivers:	Support and resources for non-professional caregivers.	\$0 copay
Personal Emergency Response System:	Wearable device with fast access to emergency services.	\$0 copay

* May require prior authorization.

** With a medical exception.

*** This program includes the Standard network. Premium network may have monthly costs.

Summary of Benefits

Plan Offerings and Premiums by County

Blue Medicare Essential Plus (HMO-POS) is available in all 100 North Carolina counties.

Blue Medicare Essential PlusSM (HMO-POS) H3449-023-001 **Monthly Premium: \$0**

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

Blue Medicare Essential PlusSM (HMO-POS) H3449-023-002 **Monthly Premium: \$0**

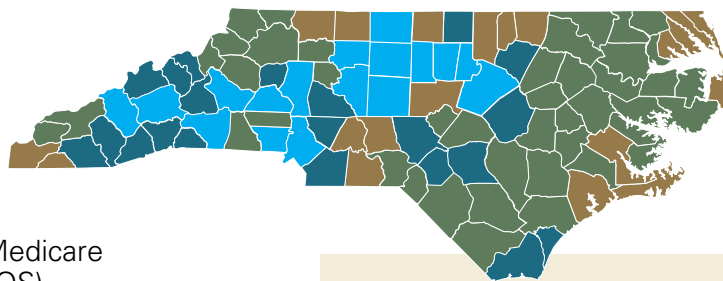
Alexander	Franklin	Johnston	Mitchell	Polk	Union
Brunswick	Henderson	Macon	Moore	Rowan	Yancey
Cabarrus	Hoke	Madison	New Hanover	Transylvania	
Cumberland	Jackson	McDowell	Person		

Blue Medicare Essential PlusSM (HMO-POS) H3449-023-004 **Monthly Premium: \$0**

Anson	Chatham	Currituck	Onslow	Stanly	Vance
Camden	Cherokee	Dare	Pasquotank	Stokes	Warren
Carteret	Clay	Granville	Perquimans	Surry	
Caswell	Craven	Montgomery			

Blue Medicare Essential PlusSM (HMO-POS) H3449-023-005 **Monthly Premium: \$0**

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-POS) is available:

- 001
- 002
- 004
- 005

Blue Medicare Essential Plus (HMO-POS) is available in all 100 North Carolina counties.

Please note: To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)

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**

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

Annual Maximum Out-of-Pocket: Does not include prescription drugs.

001:	\$3,950
002:	
004:	\$5,650
005:	

Benefits

What You Should Know

Inpatient Hospital Care:*
(Cost share applies per day. Benefit period applied per admission.)

Days 1–5:	\$335 copay
Days 6–90:	\$0 copay
Days 91 and beyond:	\$0 copay

Outpatient Services:*

Outpatient Hospital: Per stay.	\$295 copay
Ambulatory Surgical Center:	\$275 copay

Doctor Visit:

Primary:	\$0 copay
Specialist:	001: \$25 copay 002: \$25 copay 004: \$35 copay 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. **\$110 copay**

Urgently Needed Services: **\$60 copay**

*May require prior authorization.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)		H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
Benefits	What You Should Know	
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:	001: \$25 copay 002: \$25 copay 004: \$35 copay 005: \$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:*	001: \$25 copay 002: \$25 copay 004: \$35 copay 005: \$35 copay
	Comprehensive and Preventive Dental:	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.** \$0 copay***
Vision Services:	Routine Eye Exam:	One visit per calendar year. \$25 copay
	Routine Prescription Eyewear:	\$300 yearly allowance. \$0 copay
	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. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.

***Must use designated providers.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)

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

Benefits	What You Should Know			
Mental Health Services:	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$300 copay	
		Days 6–90:	\$0 copay	
	Outpatient: (Mental health* and substance use.)	Individual and group sessions.	001:	\$25 copay
			002:	
004:			\$35 copay	
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20:	\$0 copay	
		Days 21–60:	\$196 copay	
		Days 61–100:	\$0 copay	
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:		\$10 copay	
	Occupational Therapy:		\$40 copay	
	Cardiac Rehab Services:		\$0 copay	
	Pulmonary Rehab Services:		\$20 copay	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.		\$275 copay	
Transportation:	24 one-way rides to health-related locations.		\$0 copay	
Medicare Part B Drugs:*			20% of cost	

*May require prior authorization.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)

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

Part D, Prescription Drug Benefit Stages

	Tiers 1, 2, 3 and 6: \$0	Tiers 4 and 5: \$150
Annual Deductible:	This is the set amount that you pay before your plan begins to pay its share of the cost.	
Initial Coverage Limit (ICL):	<p>Begins after you pay your yearly deductible.</p> <p>You remain in this stage until your costs on covered drugs reach \$4,660.¹ The amount you pay in this stage is shown in the chart on the next page.</p>	
Coverage Gap:	<p>Begins when your total year-to-date costs on covered drugs exceed \$4,660.</p> <p>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 \$7,400.² 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. With the Insulin Savings Program, the amount you pay for insulin is the same as the Initial Coverage stage.</p>	
Catastrophic Coverage:	<p>Begins when your total year-to-date costs on covered drugs exceed \$7,400.</p> <p>During this stage, you pay the greater of \$4.15 or 5% of the cost for generic drugs, and the greater of \$10.35 or 5% of the cost for brand-name drugs.</p>	


Footnotes:

- 1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
- 2 Total year-to-date includes costs that only you have paid.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)

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

 Prescription Drug Initial Coverage Limit (ICL)	Preferred Retail Pharmacies		Preferred Mail Order	Standard (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)	30% of cost	N/A	N/A	30% of cost	N/A
Select Care Drugs (Tier 6)	\$0 copay	\$0 copay	\$0 copay	\$3 copay	\$3 copay
Insulins (Tier 3, 4)	\$35 copay	\$105 copay	\$70 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.

Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.

Summary of Benefits

Blue Medicare Essential PlusSM (HMO-POS)

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

Other Covered Benefits

Benefit

What You Should Know

Podiatry Services:	Foot care.	001:	\$25 copay
		002:	
		004:	\$35 copay
		005:	
Medical Equipment and Supplies:	Durable Medical Equipment and Supplies:*		20% of cost
	Diabetic Shoes or Inserts:		20% of cost
	Diabetes Supplies:*	Preferred Brands	
Non-Preferred Brands**			20% of cost
Healthy Aging and Exercise Program:	Must use participating facilities.		\$0 copay***
Over-the-Counter Products Allowance:	Must use participating retail locations.	001:	\$95 quarterly
		002:	
		004:	\$70 quarterly
		005:	
Meals Benefit:	Two meals per day for 14 days post-discharge.		\$0 copay
Support for Caregivers:	Support and resources for non-professional caregivers.		\$0 copay
In-Home Assistance:	60 hours per year.		\$0 copay
Personal Emergency Response System:	Wearable device with fast access to emergency services.		\$0 copay

* May require prior authorization.

** With a medical exception.

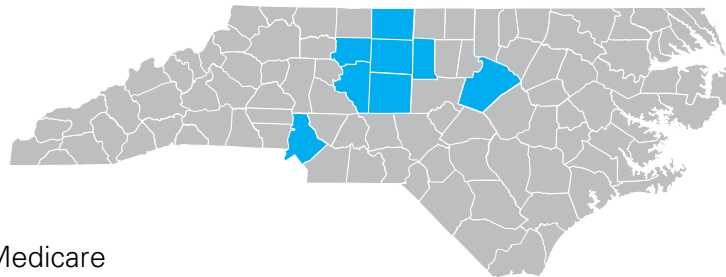
*** This program includes the Standard network. Premium network may have monthly costs.

Summary of Benefits

Plan Offering and Premium by County

BlueMedicare ChoiceSM (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 have both Medicare Part A and 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:	This plan has no medical deductible.	\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$3,200
Benefits	What You Should Know	
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$295 copay
	Days 6–90:	\$0 copay
	Days 91 and beyond:	\$0 copay
Outpatient Services:*	Outpatient Hospital: Per stay.	\$295 copay
	Ambulatory Surgical Center:	\$275 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.	\$125 copay
Urgently Needed Services:		\$60 copay

*May require prior authorization.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)		H3449-026	
Benefits		What You Should Know	
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:	\$200 yearly allowance.	\$0 copay
	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. Must use designated providers.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)		H3449-026
Benefits	What You Should Know	
Mental Health Services:	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5: \$295 copay
		Days 6–90: \$0 copay
	Outpatient: (Mental health* and substance use.)	Individual and group sessions. \$20 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20: \$0 copay
		Days 21–60: \$196 copay
		Days 61–100: \$0 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:	\$10 copay
	Occupational Therapy:	\$40 copay
	Cardiac Rehab Services:	\$0 copay
	Pulmonary Rehab Services:	\$20 copay
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Medicare Part B Drugs:*		20% of cost

*May require prior authorization.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)

H3449-026

Part D, Prescription Drug Benefit Stages

Annual Deductible: **All Tiers: \$0**

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

Initial Coverage Limit (ICL): **Begins after you pay your yearly deductible.**
 You remain in this stage until your costs on covered drugs reach **\$4,660**.¹ The amount you pay in this stage is shown in the chart on the next page.

Coverage Gap: **Begins when your total year-to-date costs on covered drugs exceed \$4,660.**
 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 **\$7,400**.² 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. With the Insulin Savings Program, the amount you pay for insulin is the same as the Initial Coverage stage.

Catastrophic Coverage: **Begins when your total year-to-date costs on covered drugs exceed \$7,400.**
 During this stage, you pay the greater of **\$4.15** or **5%** of the cost for generic drugs, and the greater of **\$10.35** or **5%** of the cost for brand-name drugs.


Footnotes:

- 1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.
- 2 Total year-to-date includes drug costs that only you have paid.

Summary of Benefits

Blue Medicare Choice SM (HMO)

H3449-026

 Prescription Drug Initial Coverage Limit (ICL)	Preferred Retail Pharmacies		Preferred Mail Order	Standard (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
Insulins (Tier 3, 4)	\$35 copay	\$105 copay	\$70 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.

Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.

Summary of Benefits

Blue Medicare ChoiceSM (HMO)

H3449-026

Other Covered Benefits

Benefit
What You Should Know
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:*

Preferred Brands

\$0 copay

Non-Preferred Brands**

20% of cost

Healthy Aging and Exercise Program:

Must use participating facilities.

\$0 copay***
Over-the-Counter Products Allowance:

Must use participating retail locations.

\$70 quarterly
Meals Benefit:

Two meals per day for 14 days post-discharge.

\$0 copay
Support for Caregivers:

Support and resources for non-professional caregivers.

\$0 copay
Personal Emergency Response System:

Wearable device with fast access to emergency services.

\$0 copay

* May require prior authorization.

** With a medical exception.

*** This program includes the Standard network. Premium network may have monthly costs.

Summary of Benefits

Plan Offerings and Premiums by County

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

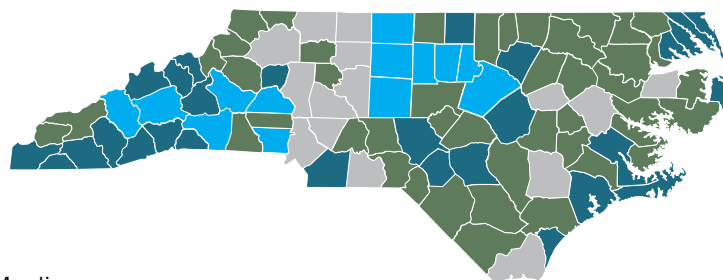
Alamance	Catawba	Guilford	Randolph	Wake
Buncombe	Durham	Haywood	Rockingham	
Burke	Gaston	Orange	Rutherford	

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

Alexander	Craven	Henderson	Madison	Onslow	Transylvania
Camden	Cumberland	Hoke	McDowell	Pasquotank	Union
Carteret	Currituck	Jackson	Mitchell	Perquimans	Yancey
Cherokee	Dare	Johnston	Moore	Person	
Clay	Franklin	Macon	New Hanover	Polk	

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

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



Counties where Blue Medicare Enhanced (HMO-POS) is available:

001 **002** **003**

Please note: To join Blue Medicare HMO plans, you must have both Medicare Part A and Medicare Part B and live in our service area.

Summary of Benefits

Blue Medicare EnhancedSM (HMO-POS)		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.	\$3,700
Benefits	What You Should Know	
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$335 copay
	Days 6–90:	\$0 copay
	Days 91 and beyond:	\$0 copay
Outpatient Services:*	Outpatient Hospital: Per stay.	\$295 copay
	Ambulatory Surgical Center:	\$200 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.	\$110 copay
Urgently Needed Services:		\$60 copay

*May require prior authorization.

Summary of Benefits

Blue Medicare EnhancedSM (HMO-POS)		H3449-024-001 H3449-024-002 H3449-024-003
Benefits	What You Should Know	
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:	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures. ** \$0 copay***
Vision Services:	Routine Eye Exam:	One visit per calendar year. \$25 copay
	Routine Prescription Eyewear:	\$300 yearly allowance. \$0 copay
	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. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.

***Must use designated providers.

Summary of Benefits

Blue Medicare Enhanced SM (HMO-POS)		H3449-024-001 H3449-024-002 H3449-024-003
Benefits	What You Should Know	
Mental Health Services:	Inpatient: [*] (Cost share applies per day. Benefit period applied per admission.)	Days 1–5: \$300 copay
		Days 6–90: \$0 copay
	Outpatient: (Mental health [*] and substance use.)	Individual and group sessions. \$25 copay
Skilled Nursing Facility: [*]	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20: \$0 copay
		Days 21–60: \$196 copay
		Days 61–100: \$0 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:	\$10 copay
	Occupational Therapy:	\$40 copay
	Cardiac Rehab Services:	\$0 copay
	Pulmonary Rehab Services:	\$20 copay
Ambulance Services: [*]	Covers medically necessary ground and air ambulance services.	\$250 copay
Transportation:	24 one-way rides to health-related locations.	\$0 copay
Medicare Part B Drugs: [*]		20% of cost

^{*}May require prior authorization.

Summary of Benefits

Blue Medicare EnhancedSM (HMO-POS)

H3449-024-001

H3449-024-002

H3449-024-003

Part D, Prescription Drug Benefit Stages

Annual Deductible:

All Tiers: \$0

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

Initial Coverage Limit (ICL):

Begins after you pay your yearly deductible.

You remain in this stage until your costs on covered drugs reach **\$4,660**.¹ The amount you pay in this stage is shown in the chart on the next page.

Coverage Gap:

Begins when your total year-to-date costs on covered drugs exceed \$4,660.

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 **\$7,400**.² 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. With the Insulin Savings Program, the amount you pay for insulin is the same as the Initial Coverage stage.

Catastrophic Coverage:

Begins when your total year-to-date costs on covered drugs exceed \$7,400.

During this stage, you pay the greater of **\$4.15** or **5%** of the cost for generic drugs, and the greater of **\$10.35** or **5%** of the cost for brand-name drugs.

Footnotes:

1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.

2 Total year-to-date includes drug costs that only you have paid.


Summary of Benefits

BlueMedicare EnhancedSM (HMO-POS)

H3449-024-001

H3449-024-002

H3449-024-003

 Prescription Drug Initial Coverage Limit (ICL)	Preferred Retail Pharmacies		Preferred Mail Order	Standard (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
Insulins (Tier 3, 4)	\$35 copay	\$105 copay	\$70 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days.

Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ.

Summary of Benefits

Blue Medicare EnhancedSM (HMO-POS)

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

Other Covered Benefits

Benefit

What You Should Know

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:^{*}

Preferred Brands

\$0 copay

Non-Preferred Brands^{**}

20% of cost

Healthy Aging and Exercise Program:

Must use participating facilities.

\$0 copay^{***}

Over-the-Counter Products Allowance:

Must use participating retail locations.

\$95 quarterly

Meals Benefit:

2 meals per day for 14 days post-discharge.

\$0 copay

Support for Caregivers:

Support and resources for non-professional caregivers.

\$0 copay

In-Home Assistance:

60 hours per year.

\$0 copay

Personal Emergency Response System:

Wearable device with fast access to emergency services.

\$0 copay

* May require prior authorization.

** With a medical exception.

*** This program includes the Standard network. Premium network may have monthly costs.

Summary of Benefits

BlueMedicare HMO™

Prescription Drug – Frequently Asked Questions

Which drugs are covered?

For commonly used drugs, see the Common Drugs page of the Blue Medicare Advantage HMO enrollment kit. For a comprehensive list of covered drugs, visit [Medicare.BlueCrossNC.com/Medicare/Prescription-Drug-Coverage](https://www.Medicare.BlueCrossNC.com/Medicare/Prescription-Drug-Coverage).

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. **The network includes Harris Teeter, Sam’s Club, Walgreens, Walmart and more, plus many independent pharmacies.** You may choose Standard (Non-Preferred) Pharmacies to fill prescriptions, but your costs may be higher.

Our **Preferred Mail Order Pharmacy Network** includes:

- AllianceRx Walgreens Pharmacy
- Express Scripts® Pharmacy
- Postal Prescription Services (PPS)®

Tiers 1, 2 and 6 have a \$0 copayment for a 90-day supply at a Preferred Mail Order Pharmacy. And with Tiers 3 and 4, you pay no more than two times the 30-day copay at a Preferred Mail Order Pharmacy.

How do I find a Preferred Pharmacy?

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

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Can I choose a standalone Medicare prescription drug plan (PDP) instead of what comes with my Medicare Advantage plan?

No. Medicare does not allow a standalone prescription drug plan with a Medicare Advantage plan. For prescription benefits, you have two choices:

- Original Medicare plus a PDP plan, or a
- Medicare Advantage plan that includes prescription coverage.

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



Or contact your Blue Cross NC Authorized Independent Agent.