2027 Summary of Benefits

Blue Medicare HMO℠

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare HMO plans for **January 1, 2027 – December 31, 2027**.

Plan:
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 **BlueCrossNC.com/Members/Medicare/Forms-Library** and click on Evidence of Coverage.
- 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 an HMO-POS (Point of Service) plan, you can go outside the network for your dental benefits. For dental services obtained out-of-network, benefits vary by plan. Not applicable to all plans.
- 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 your 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 and HMO-POS 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 **800-MEDICARE** (800-633-4227), TTY: 877-486-2048, 7 days a week, 24 hours a day. Or visit **Medicare.gov**.
- For more details, call **800-665-8037** (TTY: 711), current members call **888-310-4110** (TTY: 711), 7 days a week, 8 a.m. – 8 p.m., visit **BlueCrossNC.com/Shop-Plans/Medicare,** or contact your Blue Cross NC Authorized Independent Agent.

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MedicareRx Prescription Drug Coverage

Summary of Benefits

Plan offerings and premiums by county

Blue Medicare Enhanced℠ (HMO-POS) H3449-024-001 — Monthly premium: $41

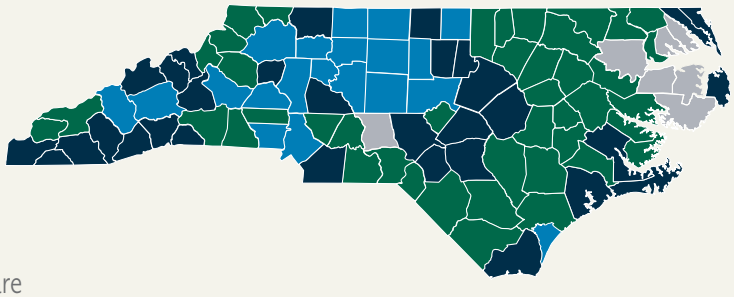
Alamance	Chatham	Gaston	Mecklenburg	Randolph	Wilkes
Buncombe	Davidson	Guilford	New Hanover	Rockingham	Yadkin
Burke	Davie	Haywood	Person	Stokes	
Catawba	Forsyth	Iredell			

Blue Medicare Enhanced℠ (HMO-POS) H3449-024-002 — Monthly premium: $50

Alexander	Clay	Harnett	Madison	Orange	Union
Brunswick	Craven	Henderson	McDowell	Polk	Wake
Camden	Cumberland	Hoke	Mitchell	Rowan	Yancey
Carteret	Currituck	Jackson	Moore	Surry	
Caswell	Dare	Johnston	Onslow	Transylvania	
Cherokee	Durham	Macon			

Blue Medicare Enhanced℠ (HMO-POS) H3449-024-003 — Monthly premium: $57

Alleghany	Caldwell	Gates	Lee	Pender	Stanly
Anson	Chowan	Graham	Lenoir	Pitt	Swain
Ashe	Cleveland	Granville	Lincoln	Richmond	Vance
Avery	Columbus	Greene	Martin	Robeson	Warren
Beaufort	Duplin	Halifax	Nash	Rutherford	Watauga
Bladen	Edgecombe	Hertford	Northampton	Sampson	Wayne
Cabarrus	Franklin	Jones	Pamlico	Scotland	Wilson



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 Enhanced℠ (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: $41 002: $50 003: $57
Deductible:	This plan has a Medicare Part B deductible for Chemotherapy and Other Part B drugs.	001: $265 002, 003: $270
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	$4,900
Benefits	**What You Should Know**	
Inpatient Hospital Care:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–6:	$399 copay
	Days 7–90:	$0 copay
	Days 91 and beyond:	$0 copay
Outpatient Services:*	Outpatient Hospital: **Per stay.**	$0-$410 copay
	Ambulatory Surgical Center:	$0-$200 copay
Doctor Visit:	Primary:	$0 copay
	Specialist:	$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.	$130 copay
Urgently Needed Services:		$50 copay

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

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Blue Medicare Enhanced℠ (HMO-POS)

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

Benefits	What You Should Know		PCP office	Any other setting
Diagnostic Services/ Labs/ Imaging:*	Diagnostic Tests and Procedures:		$0 copay	$25 copay
	Lab Services:		$0 copay	$25 copay
	Diagnostic Radiological Services:	MRI, CT, and Other Nuclear Medicine:	$0 copay	Lesser of 20% of cost or $150 copay
		PET:	$0 copay	$300 copay
		All Other Services:	$0 copay	$75 copay
	Therapeutic Radiological Services:		$0 copay	Lesser of 20% of cost or $60 copay
	X-rays:		$0 copay	$30 copay
Hearing Services:	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.		$20 copay
	Routine Hearing Exam:	One per year.		$0 copay***
	Hearing Aids:	One per ear, per year.		$499–$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.		$30 copay
	Comprehensive and Preventive Dental:	**$1,500** combined yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions, and dentures.**		$0 copay***

*May require prior authorization.
**Certain limits apply. For services obtained out-of-network, you will be responsible for 20% of preventive services and 40% of comprehensive services plus any additional costs up to the provider billed amount. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please see Evidence of Coverage for more information.
***Must use designated providers.
Note: This chart shows your portion of the costs.

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Blue Medicare Enhanced℠ (HMO-POS)

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Benefits		What You Should Know	
Vision Services:	Routine Eye Exam:	One per calendar year.	$0 copay
	Vision Allowance:	001, 002: $300 yearly allowance. 003: $250 yearly allowance.	$0 copay
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	$30 copay
	Glaucoma Screening and Diabetic Eye Exam:	For people who are at high risk of glaucoma or have diabetes.	$0 copay
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost
Mental Health Services:	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	$399 copay
		Days 6–90:	$0 copay
	Outpatient: (Mental health and substance use.)	Individual and group sessions.	$30 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20:	$10 copay
		Days 21–100:	$221 copay
Outpatient Rehabilitation Services:	Physical and Speech Language Therapy:		$25 copay
	Occupational Therapy:		$25 copay
	Cardiac Rehab Services:		$25 copay
	Pulmonary Rehab Services:		$20 copay

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

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Blue Medicare Enhanced℠ (HMO-POS)

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H3449-024-002
H3449-024-003

Benefits	What You Should Know	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	$250 copay
Medicare Part B Drugs:	Part B Insulins: 30-day supply.**	$35 copay
	Chemotherapy and Other Part B Drugs:***	0–20% of cost

Part D Drug Benefit Stages

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

Yearly Deductible Stage:†	Tiers 1, 2, and 6: $0 Tiers 3, 4, and 5: $700 This is the set amount that you pay before your plan begins to pay its share of the cost. Your deductible does not apply to covered insulin products and most adult Part D vaccines.
Initial Coverage Stage:	**Begins after you pay your yearly deductible.** You generally stay in this stage until your out-of-pocket drug costs reach **$2,400**. The amount you pay in this stage is shown in the chart on the next page.‡
Catastrophic Coverage Stage:	**Begins when your out-of-pocket drug costs reach $2,400.** During this stage, you pay nothing for your covered Part D drugs. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

*May require prior authorization.
**Part B deductible does not apply to Part B Insulins.
***May require prior authorization. Based on Inflation Reduction Act mandates.
†Deductible rules vary by medicine. Some medicines outside the standard deductible tiers may still have costs applied toward your deductible.
‡Your out-of-pocket drug costs include payments made in the Yearly Deductible Stage and the Initial Coverage Stage.
Note: This chart shows your portion of the costs.

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Blue Medicare Enhanced℠ (HMO-POS)

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Tiers	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
Tier 1 – Preferred Generic Drugs:	$0 copay	$0 copay	$0 copay	$15 copay	$45 copay
Tier 2 – Generic Drugs:	$4 copay	$12 copay	$0 copay	$20 copay	$60 copay
Tier 3 – Preferred Brand Drugs:	21% of cost	21% of cost	21% of cost	21% of cost	21% of cost
Tier 4 – Non-Preferred Drugs:	25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 5 – Specialty Tier Drugs:**	25% of cost	N/A	N/A	25% of cost	N/A
Tier 6 – Select Care Drugs:*** (up to 100-day supply)	$0 copay	$0 copay	$0 copay	$3 copay	$9 copay
Insulins:†	$35 copay	$105 copay	$105 copay	$35 copay	$105 copay

*Long-term care pharmacy benefit is covered the same as Standard Retail Pharmacies for 31 days instead of 30 days.
**Tier 5 drugs limited to 30-day supply.
***Tier 6 drugs include select generic medications used to treat high blood pressure, diabetes, high cholesterol, and osteoporosis; up to a 100-day supply.
†Cost-sharing for covered Part D insulins will be the lesser of $35, 25% coinsurance, or the applicable cost sharing amount for a one-month supply.
Note: Two-month (60-day) supplies may also be available. Standard Mail Order costs may differ.
Note: This chart shows your portion of the costs.

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Other Covered Benefits

Benefits	What You Should Know		
Medicare-Covered Podiatry Services:	Foot care.		$30 copay
Medical Equipment and Supplies:	Durable Medical Equipment and Supplies:*		20% of cost
	Diabetic Shoes or Inserts:		20% of cost
	Diabetes Supplies and Monitors:*	Preferred Brands	$0 copay
		Non-Preferred Brands	20% of cost
Fitness:	Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).		$0 copay
Over-the-Counter Products Allowance:	**001: $40** per quarter **002: $30** per quarter **003: $20** per quarter	Must use participating retail locations or designated catalog; no rollover.	$0 copay
Meals Benefit:	Two meals per day for seven 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.
Note: This chart shows your portion of the costs.