

BlueMedicare PPO<sup>SM</sup>

# 2016 Summary of Benefits

(Contract H3404, Plan 001)

---

January 1, 2016 - December 31, 2016

MedicareRx  
Prescription Drug Coverage X

Y0079\_ 7235 CMS Accepted 08312015  
U5047i, 8/15

PAGE 1 of 18

Visit us at [bcbsnc.com/medicare](http://bcbsnc.com/medicare)



BlueCross BlueShield  
of North Carolina

Smart choices for Medicare

# Section I - Introduction to Summary of benefits

---

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Medicare PPO Enhanced (PPO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Medicare PPO Enhanced (PPO)** covers and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

## Sections in this booklet

- Things to Know About **Blue Medicare PPO Enhanced (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-800-665-8037 (TTY / TDD 1-800-922-3140)**.

## Things to know about Blue Medicare PPO Enhanced (PPO)

### Hours of operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

### Blue Medicare PPO Enhanced (PPO) phone numbers and website

- If you are a member of this plan, call toll-free **1-877-494-7647 (TTY / TDD 1-888-451-9957)**.
- If you are not a member of this plan, call toll-free **1-800-665-8037 (TTY / TDD 1-800-922-3140)**.
- Our website: <http://www.bcbsnc.com/medicare>

*(continued on the next page)*

# Section I - Introduction to **Summary of benefits** (continued)

---

## **Who can join?**

To join **Blue Medicare PPO Enhanced (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in North Carolina: Alamance, Alexander, Anson, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Cabarrus, Caldwell, Carteret, Caswell, Catawba, Chatham, Chowan, Cleveland, Columbus, Cumberland, Davidson, Duplin, Edgecombe, Forsyth, Gaston, Gates, Guilford, Harnett, Haywood, Henderson, Hertford, Hoke, Iredell, Jones, Lee, Madison, Martin, McDowell, Mecklenburg, Mitchell, Nash, Onslow, Orange, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Sampson, Scotland, Stokes, Surry, Transylvania, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, and Yancey.

## **Which doctors, hospitals, and pharmacies can I use?**

**Blue Medicare PPO Enhanced (PPO)** has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider directory at our website (<http://www.bcbsnc.com/medicare>). You can see our plan's pharmacy directory at our website (<https://www.myprime.com/MyRx/MyPrime/MedicareD/pharmacy/BCBSNC>). Or, call us and we will send you a copy of the provider and pharmacy directories.

## **What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plans than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is covered by Original Medicare*.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [www.bcbsnc.com/content/medicare/formulary-home.htm](http://www.bcbsnc.com/content/medicare/formulary-home.htm).
- Or, call us and we will send you a copy of the formulary.

## **How will I determine my drug costs?**

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

## Section II – Summary of Benefits

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</b>	
<b>How much is the monthly premium?</b>	\$71.50 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	This plan does not have a deductible.
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$4,500 for services you receive from in-network providers.</li> <li>▪ \$7,800 for services you receive from any provider.</li> </ul> <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
	Blue Cross and Blue Shield of North Carolina is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

<b>Benefit</b>	<b>Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)</b>
----------------	---

**COVERED MEDICAL AND HOSPITAL BENEFITS**

**NOTE:**  
 ▪ SERVICES WITH A <sup>1</sup> MAY REQUIRE PRIOR AUTHORIZATION.

**OUTPATIENT CARE AND SERVICES**

<b>Acupuncture</b>	Not covered
<b>Ambulance<sup>1</sup></b>	<ul style="list-style-type: none"> <li>▪ In-network: \$250 copay</li> <li>▪ Out-of-network: \$250 copay</li> </ul> Covers medically necessary ambulance services
<b>Chiropractic Care</b>	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): <ul style="list-style-type: none"> <li>▪ In-network: \$20 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Dental Services</b>	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): <ul style="list-style-type: none"> <li>▪ In-network: \$50 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Diabetes Supplies and Services</b>	Diabetes monitoring supplies: <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Diabetes self-management training: <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul>

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>OUTPATIENT CARE AND SERVICES</b>	
<b>Diabetes Supplies and Services</b> (continued)	Therapeutic shoes or inserts: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Covers supplies such as: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
<b>Diagnostic Tests, Lab and Radiology Services, and X-Rays<sup>1</sup></b> (Costs for these services may vary based on place of service.)	Diagnostic radiology services (such as MRIs, CT scans): <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Diagnostic tests and procedures: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Lab services: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Outpatient x-rays: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Therapeutic radiology services (such as radiation treatment for cancer): <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> If the doctor provides you services in addition to the Outpatient Diagnostics Procedures, Therapeutic Radiology, Tests, Lab Services, a separate doctor visit copay may apply.
<b>Doctor's Office Visits</b>	Primary care physician visit: <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Specialist visit: <ul style="list-style-type: none"> <li>▪ In-network: \$50 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>OUTPATIENT CARE AND SERVICES</b>	
<b>Durable Medical Equipment</b> (wheelchairs, oxygen, etc.) <sup>1</sup>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Emergency Care</b>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> <p>Emergency services are covered worldwide.</p>
<b>Foot Care</b> (podiatry services)	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$50 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Hearing Services</b>	<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$50 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>In general, supplemental routine hearing exams and hearing aids not covered.</p>
<b>Home Health Care<sup>1</sup></b>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Part-time or intermittent skilled nursing and home health aide services</li> <li>▪ Physical therapy, occupational therapy, and speech therapy</li> <li>▪ Medical and social services</li> <li>▪ Medical equipment and supplies</li> </ul>
<b>Mental Health Care<sup>1</sup></b>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p>

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>OUTPATIENT CARE AND SERVICES</b>	
<b>Mental Health Care<sup>1</sup></b> (continued)	<p>In-network:</p> <ul style="list-style-type: none"> <li>▪ \$260 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> </ul> <p>Out-of-network:</p> <ul style="list-style-type: none"> <li>▪ 20% of the cost per day for days 1 through 190</li> </ul> <p>Outpatient group therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Outpatient individual therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>A benefit period starts anew for each Medicare-approved admission.</p>
<b>Outpatient Rehabilitation</b>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Occupational therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Physical therapy and speech and language therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Outpatient Substance Abuse<sup>1</sup></b>	<p>Group therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Individual therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>OUTPATIENT CARE AND SERVICES</b>	
<b>Outpatient Surgery<sup>1</sup></b>	Ambulatory surgical center: <ul style="list-style-type: none"> <li>▪ In-network: \$190 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Outpatient hospital: <ul style="list-style-type: none"> <li>▪ In-network: \$190 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Over-the-Counter Items</b>	Not Covered
<b>Prosthetic Devices</b> <i>(braces, artificial limbs, etc.)<sup>1</sup></i>	Prosthetic devices: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Related medical supplies: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Renal Dialysis</b>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<b>Transportation</b>	Not covered
<b>Urgently Needed Services</b>	\$65 copay
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): <ul style="list-style-type: none"> <li>▪ In-network: \$0-40 copay, depending on the service</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Routine eye exam (for up to 1): <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> Our plan pays up to \$100 for routine eye exams from any provider.

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>OUTPATIENT CARE AND SERVICES</b>	
<b>Vision Services</b> (continued)	Eyeglasses or contact lenses after cataract surgery: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> One routine eye exam every 12 months
<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> Our plan covers many preventive services, including: <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible Sigmoidoscopy)</li> <li>▪ Depression screening</li> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>▪ "Welcome to Medicare" preventive visit (one-time)</li> <li>▪ Yearly "Wellness" visit</li> </ul> Any additional preventive services approved by Medicare during the contract year will be covered.
<b>Hospice</b>	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.  Hospice is covered outside of our plan. Please contact us for more details.

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)
<b>INPATIENT CARE</b>	
<b>Inpatient Hospital Care<sup>1</sup></b>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>In-network:</p> <ul style="list-style-type: none"> <li>▪ \$295 copay per day for days 1 through 6</li> <li>▪ You pay nothing per day for days 7 through 90</li> <li>▪ You pay nothing per day for days 91 and beyond</li> </ul> <p>Out-of-network:</p> <ul style="list-style-type: none"> <li>▪ 20% of the cost per day for days 1 and beyond</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>A benefit period starts anew for each Medicare-approved admission.</p>
<b>Inpatient Mental Health Care</b>	<p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p>
<b>Skilled Nursing Facility (SNF)<sup>1</sup></b>	<p>Our plan covers up to 100 days in a SNF.</p> <p>In-network:</p> <ul style="list-style-type: none"> <li>▪ You pay nothing per day for days 1 through 20</li> <li>▪ \$75 copay per day for days 21 through 49</li> <li>▪ \$100 copay per day for days 50 through 100</li> </ul> <p>Out-of-network:</p> <ul style="list-style-type: none"> <li>▪ 20% of the cost per stay</li> </ul> <p>A benefit period starts anew for each Medicare-approved admission.</p>

## Section II – Summary of Benefits *(continued)*

Benefit	Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)																															
<b>PRESCRIPTION DRUG BENEFITS</b>																																
<b>How much do I pay?</b>	<p>For Part B drugs such as chemotherapy drugs:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Other Part B drugs:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>																															
<b>Initial Coverage</b>	<p>You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p><b>Preferred Retail Cost-Sharing</b></p> <table border="1" data-bbox="610 1108 1612 1913"> <thead> <tr> <th data-bbox="610 1108 878 1234">Tier</th> <th data-bbox="878 1108 1125 1234">One-month supply</th> <th data-bbox="1125 1108 1372 1234">Two-month supply</th> <th data-bbox="1372 1108 1612 1234">Three-month supply</th> </tr> </thead> <tbody> <tr> <td data-bbox="610 1234 878 1346">Tier 1 (Preferred Generic)</td> <td data-bbox="878 1234 1125 1346">\$3 copay</td> <td data-bbox="1125 1234 1372 1346">\$6 copay</td> <td data-bbox="1372 1234 1612 1346">\$9 copay</td> </tr> <tr> <td data-bbox="610 1346 878 1457">Tier 2 (Generic)</td> <td data-bbox="878 1346 1125 1457">\$6 copay</td> <td data-bbox="1125 1346 1372 1457">\$12 copay</td> <td data-bbox="1372 1346 1612 1457">\$18 copay</td> </tr> <tr> <td data-bbox="610 1457 878 1568">Tier 3 (Preferred Brand)</td> <td data-bbox="878 1457 1125 1568">\$40 copay</td> <td data-bbox="1125 1457 1372 1568">\$80 copay</td> <td data-bbox="1372 1457 1612 1568">\$120 copay</td> </tr> <tr> <td data-bbox="610 1568 878 1680">Tier 4 (Non- Preferred Brand)</td> <td data-bbox="878 1568 1125 1680">\$80 copay</td> <td data-bbox="1125 1568 1372 1680">\$160 copay</td> <td data-bbox="1372 1568 1612 1680">\$240 copay</td> </tr> <tr> <td data-bbox="610 1680 878 1791">Tier 5 (Specialty Tier)</td> <td data-bbox="878 1680 1125 1791">33% of the cost</td> <td data-bbox="1125 1680 1372 1791">33% of the cost</td> <td data-bbox="1372 1680 1612 1791">33% of the cost</td> </tr> <tr> <td data-bbox="610 1791 878 1913">Tier 6 (Select Care Drugs)</td> <td data-bbox="878 1791 1125 1913">\$0</td> <td data-bbox="1125 1791 1372 1913">\$0</td> <td data-bbox="1372 1791 1612 1913">\$0</td> </tr> </tbody> </table>				Tier	One-month supply	Two-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay	Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay	Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay	Tier 4 (Non- Preferred Brand)	\$80 copay	\$160 copay	\$240 copay	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost	Tier 6 (Select Care Drugs)	\$0	\$0	\$0
Tier	One-month supply	Two-month supply	Three-month supply																													
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay																													
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay																													
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay																													
Tier 4 (Non- Preferred Brand)	\$80 copay	\$160 copay	\$240 copay																													
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost																													
Tier 6 (Select Care Drugs)	\$0	\$0	\$0																													

**Blue Medicare PPO  
Enhanced (PPO)  
(H3404, Plan 001)**

**Benefit**

**PRESCRIPTION DRUG  
BENEFITS**

**Initial Coverage**  
(continued)

**Standard Retail Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
Tier 4 (Non- Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$5 copay	\$10 copay	\$15 copay

**Preferred Mail Order Cost-Sharing**

<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
Tier 1 (Preferred Generic)	\$3 copay	\$6 copay	\$9 copay
Tier 2 (Generic)	\$6 copay	\$12 copay	\$18 copay
Tier 3 (Preferred Brand)	\$40 copay	\$80 copay	\$120 copay
Tier 4 (Non- Preferred Brand)	\$80 copay	\$160 copay	\$240 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Section II – Summary of Benefits *(continued)*

<b>Benefit</b>	<b>Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)</b>			
<b>PRESCRIPTION DRUG BENEFITS</b>				
<b>Initial Coverage</b> (continued)	<b>Standard Mail Order Cost-Sharing</b>			
	<b>Tier</b>	<b>One-month supply</b>	<b>Two-month supply</b>	<b>Three-month supply</b>
	Tier 1 (Preferred Generic)	\$8 copay	\$16 copay	\$24 copay
	Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
	Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$135 copay
	Tier 4 (Non- Preferred Brand)	\$95 copay	\$190 copay	\$285 copay
	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost
	Tier 6 (Select Care Drugs)	\$5 copay	\$10 copay	\$15 copay
<p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>				

<b>Benefit</b>	<b>Blue Medicare PPO Enhanced (PPO) (H3404, Plan 001)</b>
----------------	---

<b>PRESCRIPTION DRUG BENEFITS</b>
---------------------------------------

<b>Coverage Gap</b>	<p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>
---------------------	---

<b>Catastrophic Coverage</b>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copay for all other drugs</li> </ul>
------------------------------	---



## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-665-8037. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-665-8037. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-665-8037。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-665-8037。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-665-8037. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-665-8037. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-665-8037, sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-665-8037. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-665-8037 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

## Multi-language Interpreter Services *(continued)*

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-665-8037. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-665-008-7308. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-665-8037 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-665-8037. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-665-8037. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-665-8037. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-665-8037. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため、無料の通訳サービスがあります。通訳をご用命になるには、1-800-665-8037にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

Blue Cross and Blue Shield of North Carolina (BCBSNC) is an PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.