2025 Summary of Benefits

Blue Medicare PPO Enhanced℠ (PPO)

This is a summary of health services and prescription drug coverage that is covered under Blue Medicare PPO for **January 1, 2025 – December 31, 2025.**

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

- 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 the Evidence of Coverage tab.
- Blue Medicare PPO has a network of doctors, hospitals, pharmacies and other providers. You'll get your health care at lower prices by using in-network providers.
- Out-of-network/non-contracted providers are under no obligation to treat Blue Cross NC members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.
- Cost sharing may vary depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
- Plans may offer supplemental benefits in addition to Part C and Part D benefits.
- Blue Cross and Blue Shield of North Carolina is a PPO 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**.
- For more details, call **1-800-665-8037** (TTY: 711), current members call **1-888-310-4110** (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

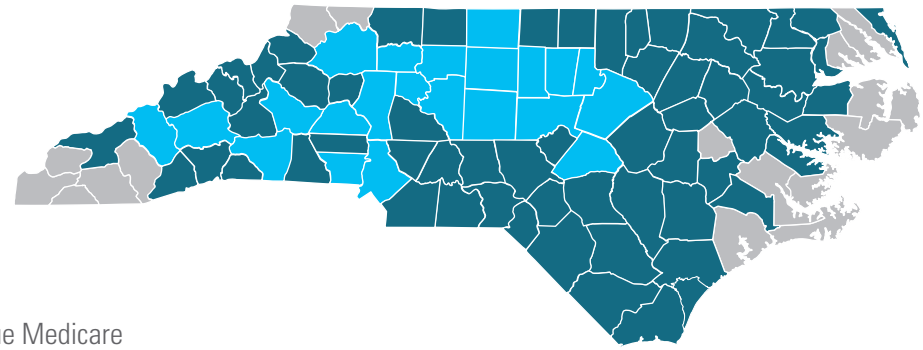
Plan Offering and Premium By County

Blue Medicare PPO Enhanced℠ (PPO) H3404-003-001 **Monthly Premium: $25**

Alamance	Chatham	Forsyth	Haywood	Randolph	Wilkes
Buncombe	Davidson	Gaston	Iredell	Rockingham	Yadkin
Burke	Davie	Guilford	Mecklenburg	Rutherford	
Catawba	Durham	Harnett	Orange	Wake	

Blue Medicare PPO Enhanced℠ (PPO) H3404-003-002 **Monthly Premium: $45**

Alexander	Chowan	Halifax	Martin	Pitt	Swain
Anson	Cleveland	Henderson	McDowell	Polk	Transylvania
Avery	Columbus	Hertford	Mitchell	Richmond	Union
Beaufort	Cumberland	Hoke	Montgomery	Robeson	Vance
Bertie	Currituck	Johnston	Moore	Rowan	Warren
Bladen	Duplin	Jones	Nash	Sampson	Washington
Brunswick	Edgecombe	Lee	New Hanover	Scotland	Watauga
Cabarrus	Franklin	Lenoir	Northampton	Stanly	Wayne
Caldwell	Gates	Lincoln	Pender	Stokes	Wilson
Caswell	Granville	Madison	Person	Surry	Yancey



Counties where Blue Medicare PPO Enhanced is available:

001 002

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

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Blue Medicare PPO Enhanced℠ (PPO)			H3404-003-001 H3404-003-002
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	001:	$25
		002:	$45
Deductible:	These plans have no medical deductible.	001:	$0
		002:	$0

Benefits	What You Should Know		In-Network	Out-of-Network*
Annual Out-of-Pocket Maximum:			$5,900	$5,900
Inpatient Hospital Care:** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–5:**		$335 copay	40% of cost
	Days 6–90:		$0 copay	40% of cost
	Days 91 and beyond:		$0 copay	40% of cost
Outpatient Services:**	**Outpatient Hospital:** Per stay.		$335 copay	40% of cost
	Ambulatory Surgical Center:		$300 copay	40% of cost
Doctor Visit:	**Primary:**		$0 copay	40% of cost
	Specialist:	001:	$20 copay	40% of cost
		002:	$30 copay	40% of cost
Preventive Care:	Any additional preventive services approved by Medicare during the contract year will be covered.		$0 copay	$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.		$120 copay	$120 copay
Urgently Needed Services:			$55 copay	$55 copay

*Out-of-network/non-contracted providers are under no obligation to treat Plan 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.
**May require prior authorization.
Note: This chart shows your portion of the costs.

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Blue Medicare PPO Enhanced℠ (PPO)

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Benefits		What You Should Know	PCP Office	Any Other Setting	Out-of-Network*
Diagnostic Services/ Labs/ Imaging:**	Diagnostic Tests and Procedures:		$0 copay	$25 copay	40% of cost
	Lab Services:		$0 copay	$5 copay	40% of cost
	Diagnostic Radiological Services:	MRI, CT and Other Nuclear Medicine:	$0 copay	Lesser of 20% of cost or $150 copay	40% of cost
		PET:	$0 copay	$300 copay	40% of cost
		All Other Services:	$0 copay	$75 copay	40% of cost
	Therapeutic Radiological Services:		$0 copay	Lesser of 20% of cost or $60 copay	40% of cost
	X-rays:		$0 copay	$15 copay	40% of cost

Benefits		What You Should Know		In-Network	Out-of-Network
Hearing Services:	Medicare-Covered Hearing Exam:	Exam to diagnose and treat hearing and balance issues.	001:	$20 copay	40% of cost
			002:	$30 copay	40% of cost
	Routine Hearing Exam:	One per year. Must use designated providers.		$0 copay	Not covered
	Hearing Aids:	One per ear, per year. Must use designated providers.		$699–$999 copay	Not covered
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:	$20 copay	40% of cost
			002:	$30 copay	40% of cost
	Comprehensive and Preventive Dental:	$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.***		$0 copay	20% of cost

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Benefits		What You Should Know		In-Network	Out-of-Network*
Vision Services:	**Routine Eye Exam:**	One per calendar year.		$0 copay	40% of cost
	Vision Allowance:	$300 yearly allowance.		$0 copay	Not covered
	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	001:	$20 copay	40% of cost
			002:	$30 copay	40% of cost
	Glaucoma Screening:	For people who are at high risk of glaucoma.		$0 copay	$0 copay
	Diabetic Eye Exam:	For people who have diabetes.		$0 copay	40% of cost
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.		20% of cost	40% of cost
Mental Health Services:	**Inpatient:**** (Cost share applies per day. Benefit period applied per admission.)	**Days 1–5:**		$300 copay	40% of cost
		Days 6–90:		$0 copay	40% of cost
	Outpatient: (Mental health** and substance use.)	Individual and group sessions.	001:	$20 copay	40% of cost
			002:	$30 copay	40% of cost
Skilled Nursing Facility:**	(Cost share applies per day. Benefit period applied per admission.)	**Days 1–20:**		$0 copay	40% of cost
		Days 21–60:		$214 copay	40% of cost
		Days 61–100:		$0 copay	40% of cost
Outpatient Rehabilitation Services:	**Physical and Speech Language Therapy:**			$10 copay	40% of cost
	Occupational Therapy:			$10 copay	40% of cost
	Cardiac Rehab Services:			$0 copay	40% of cost
	Pulmonary Rehab Services:			$15 copay	40% of cost

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

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Benefits	What You Should Know	In-Network	Out-of-Network*
Ambulance Services:**	Covers medically necessary ground and air ambulance services.	$250 copay	$250 copay
Transportation:	24 one-way rides to health-related locations. Must use designated providers.	$0 copay	Not covered
Medicare Part B Drugs:	**Part B Insulins:** 30-day supply.	$35 copay	40% of cost
	Chemotherapy and Other Part B Drugs:***	0–20% of cost	40% of cost

Part D, Prescription Drug Benefit Stages

H3404-003-001
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Yearly Deductible Stage:	**All Tiers:** $0 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 **$2,000**. 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 $2,000.** 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.

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**May require prior authorization.
***May require prior authorization. Based on Inflation Reduction Act mandates.
† 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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	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)	$45 copay	$135 copay	$90 copay	$47 copay	$141 copay
Non-Preferred Drugs: (Tier 4)	$99 copay	$297 copay	$198 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:	$35 copay	$105 copay	$90 copay	$35 copay	$105 copay
Insulins: Tier 4:	$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.
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		In-Network	Out-of-Network*
Podiatry Services:	Foot care.	001:	$20 copay	40% of cost
		002:	$30 copay	40% of cost
Medical Equipment and Supplies:	**Durable Medical Equipment and Supplies:****		20% of cost	40% of cost
	Diabetic Shoes or Inserts:		20% of cost	40% of cost
	Diabetes Supplies:**	Preferred Brands	$0 copay	40% of cost
		Non-Preferred Brands***	20% of cost	40% of cost
Fitness:	$112/month to spend with designated vendor on gym memberships, classes and select equipment; no rollover.		$0 copay	Not covered
PPO Travel Program:	Extended network in the U.S.		Included	40% of cost
Over-the-Counter Products Allowance:	001: $100 per quarter	Must use participating retail locations or designated catalog; no rollover.	$0 copay	Not covered
	002: $75 per quarter		$0 copay	Not covered
Meals Benefit:	Two meals per day for 14 days post-discharge.		$0 copay	Not covered
Support for Caregivers:	Support and resources for non-professional caregivers.		$0 copay	Not covered
In-Home Assistance:	60 hours per year.		$0 copay	Not covered
Personal Emergency Response System:	Wearable device with fast access to emergency services.		$0 copay	Not covered
Home Safety Devices:†	Two devices per year.		$0 copay	Not covered

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**May require prior authorization. ***With a medical exception.
†Devices must be ordered from approved product list using designated provider.
Note: This chart shows your portion of the costs.