# 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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U5047c, 8/24

MedicareRx
Prescription Drug Coverage

# Summary of Benefits

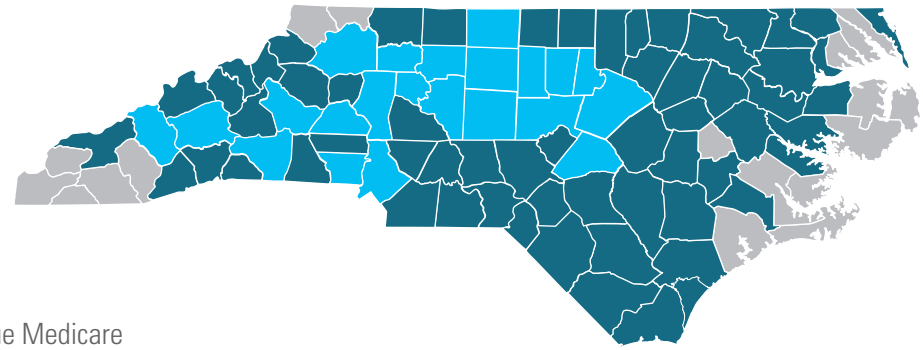
## Plan Offering and Premium By County

### 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.

# Summary of Benefits

| Blue Medicare PPO Enhanced℠ (PPO) | | | H3404-003-001<br>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.

# Summary of Benefits

## Blue Medicare PPO Enhanced℠ (PPO)

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H3404-003-002

| 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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# Summary of Benefits

## Blue Medicare PPO Enhanced℠ (PPO)

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H3404-003-002

| 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.

# Summary of Benefits

## Blue Medicare PPO Enhanced℠ (PPO)

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H3404-003-002

| 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
H3404-003-002

| | |
|---|---|
| **Yearly Deductible Stage:** | **All Tiers:** $0<br>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.

# Summary of Benefits

## Blue Medicare PPO Enhanced℠ (PPO)

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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.

# Summary of Benefits

## Blue Medicare PPO Enhanced℠ (PPO)

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H3404-003-002

### 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.