2026 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 plans for **January 1, 2026 – December 31, 2026**.

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 **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 **877-494-7647** (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, 8/25

MedicareRx
Prescription Drug Coverage

Summary of benefits

Plan offerings and premiums by county

Blue Medicare PPO Enhanced℠ (PPO)

H3404-003-001

Monthly premium: $35

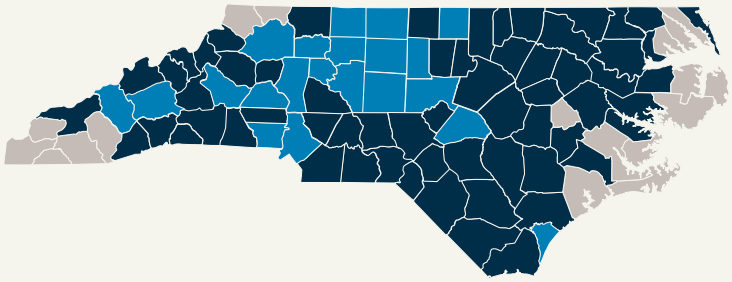
Alamance	Chatham	Gaston	Iredell	Person	Stokes
Buncombe	Davidson	Guilford	Mecklenburg	Randolph	Wilkes
Burke	Davie	Harnett	New Hanover	Rockingham	Yadkin
Catawba	Forsyth	Haywood			

Blue Medicare PPO Enhanced℠ (PPO)

H3404-003-002

Monthly premium: $53

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



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 H3404-003-002
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	001: $35 002: $53
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:			$6,300	$6,300
Inpatient Hospital Care:** (Cost share applies per day. Benefit period applied per admission.)	Days 1–6:		$350 copay	40% of cost
	Days 7–90:		$0 copay	40% of cost
	Days 91 and beyond:		$0 copay	40% of cost
Outpatient Services:**	Outpatient Hospital: Per stay.		$0-$335 copay	40% of cost
	Ambulatory Surgical Center:		$0-$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.		$130 copay	$130 copay
Urgently Needed Services:			$50 copay	$50 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)

H3404-003-001
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:	$25 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.		$499–$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** combined yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.*		$0 copay	20%-40% of cost

*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.

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

Summary of benefits

Blue Medicare PPO Enhanced℠ (PPO)

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:		$350 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 21–100:		$218 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)

H3404-003-001
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:	12 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 Drug Benefit Stages

H3404-003-001
H3404-003-002

Yearly Deductible Stage:	**Tiers 1, 2 and 6:** $0 **Tiers 3, 4 and 5:** $100 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 **$2,100**. 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 $2,100.** 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.

*Certain limits apply. 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.
**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)

H3404-003-001
H3404-003-002

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:	25% of cost	25% of cost	25% of cost	25% of cost	25% of cost
Tier 4 – Non-Preferred Drugs:	31% of cost	31% of cost	31% of cost	31% of cost	31% of cost
Tier 5 – Specialty Tier Drugs:**	31% of cost	N/A	N/A	31% of cost	N/A
Tier 6 – Select Care Drugs:***	$0 copay	$0 copay	$0 copay	$1 copay	$1 copay
Insulins:† Tier 3:	$35 copay	$105 copay	$105 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.
***Tier 6 drugs include vaccines and select generic medications used to treat high blood pressure, diabetes and high cholesterol.
†Cost-sharing for covered Part D insulins will not exceed the lesser of $35 or 25% of the drug's cost 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.

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*
Medicare-Covered 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 Brand	$0 copay	40% of cost
		Non-Preferred Brands***	20% of cost	40% of cost
Fitness:	Gym memberships at in-network facilities and unlimited access to the digital platform. Must use designated provider (SilverSneakers).		$0 copay	Not covered
PPO Travel Program:	Extended network in the U.S.		Included	40% of cost
Over-the-Counter Products Allowance:	001: $40 per quarter	Must use participating retail locations or designated catalog; no rollover.	$0 copay	Not covered
	002: $30 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 Support Services:	60 hours per year. Hours do not rollover.		$0 copay	Not covered
Personal Emergency Response System:	Wearable device with fast access to emergency services.		$0 copay	Not covered

*Certain limits apply. 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.
**May require prior authorization. ***With a medical exception.
Note: This chart shows your portion of the costs.