2024 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, 2024 – December 31, 2024**.

Plans:

Medical Only (HMO-POS): H3449-012 Essential (HMO): H3449-027-001, H3449-027-002 Essential Plus (HMO-POS): H3449-023-001, H3449-023-002, H3449-023-004, H3449-023-005 Choice (HMO): H3449-026 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 **Medicare.BlueCrossNC.com/forms-library** and click on the Evidence of Coverage tab.
- 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 a HMO-POS (Point of Service) plan, you can go outside the network for your dental benefits. For dental services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.
- 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 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 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 Medicare.BlueCrossNC.com or contact your Blue Cross NC Authorized Independent Agent.

(B), SM are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. All other marks and names are property of their respective owners. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.





Plan Offering and Premium by County

Blue Medicare Medical Only (HMO-POS) is available in all 100 North Carolina counties.

Alamance Catav				emium: \$0
AlexanderChathAlleghanyCherceAnsonChowAsheClayAveryCleveBeaufortColumBertieCraveBladenCumbBrunswickCurritBuncombeDareBurkeDavieCabarrusDavieCaldwellDuplinCamdenDurha	ham Gaston okee Gates van Graham Granville land Greene nbus Guilford on Halifax berland Harnett uck Haywood Henderson son Hertford Hoke n Hyde am Iredell combe Jackson	Jones Lee Lenoir Lincoln Macon Madison Martin McDowell McDowell Mecklenburg Mitchell Montgomery Moore Nash New Hanover Northampton Onslow Orange	Pamlico Pasquotank Pender Perquimans Person Pitt Polk Randolph Richmond Robeson Rockingham Rowan Rutherford Sampson Scotland Stanly Stokes	Surry Swain Transylvania Tyrrell Union Vance Wake Warren Washington Watauga Wayne Wilkes Wilson Yadkin Yancey



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.



Blue Medicare Medical Only "(HMO-POS)

H3449-012

You must also continue to pay your Medicare Part B premium.	\$0
Monthly reduction.	\$50 monthly
This plan has no medical deductible.	\$0
Does not include prescription drugs.	\$3,900
What You Should Know	
Days 1–5:	\$295 copay
Days 6–90:	\$0 copay
Days 91 and beyond:	\$0 сорау
Outpatient Hospital: Per stay.	\$275 copay
Ambulatory Surgical Center:	\$225 copay
Primary:	\$0 сорау
Specialist:	\$25 copay
Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay
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
	\$60 copay
	Medicare Part B premium. Monthly reduction. This plan has no medical deductible. Does not include prescription drugs. What You Should Know Days 1–5: Days 6–90: Days 91 and beyond: Outpatient Hospital: Per stay. Ambulatory Surgical Center: Primary: Specialist: Any additional preventive services approved by Medicare during the contract year will be covered. 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



Blue Medicare Medical Only "(HMO-POS)

H3449-012

Benefits	What You Should Kn	PCP Office	Any Other Setting	
	Diagnostic Tests and	Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 сорау	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
Imaging:*		All Other Services:	\$0 сорау	\$75 copay
	Therapeutic Radiological Services:		\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 сорау	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.	\$25 copay	
Hearing Services:	Routine Hearing Exam:	One per year. Must use designated providers.	\$0 сорау	
	Hearing Aids:	One per ear, per year. Must use designated providers.	\$699–\$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.		
	Comprehensive and Preventive Dental:**	\$2,000 yearly allowance for services including oral exams, cleanings, X-rays, fillings, extractions and dentures.	\$0 copay***	

*May require prior authorization.

**Certain limits apply. Combined yearly allowance. For services obtained out-of-network, you will be responsible for 20% plus additional costs up to the provider billed amount.

***Must use designated providers.



Blue Medicare Medical Only "(HMO-POS)

H3449-012

Benefits		What You Should Know	
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$25 copay
	Prescription Eyewear Allowance:		
Vision Services:	Medicare-CoveredFor the diagnosis and treatmentEye Exam:of illnesses and injuries of the		\$25 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
	Inpatient:* (Cost share	Days 1–5:	\$295 copay
Mental Health Services:	applies per day. Benefit period applied per admission.)	Days 6–90:	\$0 copay
	Outpatient: (Mental health [*] and substance use.)	Individual and group sessions.	\$25 copay
Skilled	(Cost share applies per day. Benefit period applied per admission.)	Days 1–20:	\$0 copay
Nursing		Days 21–60:	\$203 copay
Facility:*	aumission.)	Days 61–100:	\$0 copay
	Physical and Speech Langua	age Therapy:	\$25 copay
Outpatient Rehabilitation	Occupational Therapy:		\$25 copay
Services:	Cardiac Rehab Services:	\$0 copay	
	Pulmonary Rehab Services:		\$15 copay
Ambulance Services:*	Covers medically necessary gr	\$250 copay	
Transportation:	24 one-way rides to health-rela	\$0 copay	
Medicare	Part B Insulins: 30-day supp	\$35 copay	
Drugs:**	Part B Drugs: ^{**} Chemotherapy and Other Part B Drugs:		0–20% of cost

*May require prior authorization. **May require prior authorization. Based on Inflation Reduction Act mandates. Note: This chart shows your portion of the costs.



Blue Medicare Medical Only (HMO-POS)							
Other Covered Benefits							
Benefit	What You Should Kno	w					
Podiatry Services:	Foot care.		\$25 copay				
	Durable Medical Equi and Supplies:*	pment	20% of cost				
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:		20% of cost				
and Supplies:	Diabetes Supplies:*	Preferred Brands	\$0 copay				
		Non-Preferred Brands**	20% of cost				
Healthy Aging and Exercise Program:	Must use participating	Must use participating facilities.					
Over-the-Counter Products Allowance:		Must use participating retail locations. Funds do not roll over quarter-to-quarter.					
Meals Benefit:	Two meals per day for 1- post-discharge.	4 days	\$0 copay				
Support for Caregivers:		Support and resources for non-professional caregivers.					
In-Home Assistance:	60 hours per year.	\$0 copay					
Personal Emergency Response System:	Wearable device with f to emergency services	\$0 copay					
Home Safety Devices:*	Two devices per year.		\$0 сорау				

*May require prior authorization. **With a medical exception. ***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours. **†**Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.



Plan Offering and Premium by County

001

Blue Medicare Essential (HMO) is available in all 100 North Carolina counties.

Blue Medicare Essential [™] (HMO)		H3449-027-001	Monthly Pre	mium: \$0	
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin
Blue Medic	are Essentia	™(HMO)	H3449-027-002	Monthly Pre	mium: \$0
Alexander Alleghany Anson Ashe Avery Beaufort Bertie Bladen Brunswick Cabarrus Caldwell Camden Carteret Caswell	Cherokee Chowan Clay Cleveland Columbus Craven Cumberland Currituck Dare Duplin Edgecombe Franklin Gates Graham	Granville Greene Halifax Harnett Henderson Hertford Hoke Hyde Jackson Johnston Jones Lee Lenoir Lincoln	Macon Madison Martin McDowell Mitchell Montgomery Moore Nash New Hanover Northampton Onslow Pamlico Pasquotank Pender	Perquimans Person Pitt Polk Richmond Robeson Rowan Sampson Scotland Stanly Stokes Surry Swain Transylvania	Tyrrell Union Vance Warren Washington Watauga Wayne Wilson Yancey

Counties where Blue Medicare Essen-Blue Medicare Essential (HMO) is available tial (HMO) is available: in all 100 North Carolina counties. 002

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.



Blue Medicare Essential (HMO)

H3449-027-001 H3449-027-002

Monthly Premium:	You must also continue to pay your Medicare Part B premium.		\$0
Part B Premium Reduction:	Monthly reduction.		\$60 monthly
Annual Deductible:	This plan has no medical deductible.		\$0
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.		\$8,300
Benefits	What You Should Know		
Inpatient Hospital Care:*	Days 1–5:		\$335 copay
(Cost share applies per day. Benefit period applied	Days 6–90:		\$0 copay
per admission.)	Days 91 and beyond:		\$0 сорау
	Outractions Hoositals Day story	001:	\$295 copay
Outpatient Services:*	Outpatient Hospital: Per stay.	002:	\$345 copay
	Ambulatory Surgical Center:	\$275 copay	
	Primony	001:	\$5 copay
Doctor Visit:	Primary:	002:	\$10 copay
	Specialist:		\$45 copay
Preventive Care:	Any additional preventive services ap by Medicare during the contract year be covered.	\$0 copay	
Emergency Care:	If you are admitted to the hospital wi hours, you do not have to pay your s the cost for emergency care. Emerge services are covered worldwide.	\$100 copay	
Urgently Needed Services:			\$55 copay



Blue Medicare Essential[®](HMO)

H3449-027-001 H3449-027-002

Benefits		What You Should Know	PCP Office	Any Other Setting
Diagnostic	Diagnostic Tests ar	nd Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
Imaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiological Services:		\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.	\$45 copay	
Hearing Services:	Routine Hearing Exam:	One per year. Must use designated providers.	\$0 сорау	
	Hearing Aids:	One per ear, per year. Must use designated providers.	\$699–\$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.		
	Preventive Dental:	Oral exams, cleanings, X-rays and screenings.**	\$0 copay	

*May require prior authorization. **Certain limits apply. Must use designated providers. Note: This chart shows your portion of the costs.



Blue Medicare Essential (HMO)

H3449-027-001 H3449-027-002

Benefits		What You Should Know	H3449-027-002
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$25 copay
	Prescription Eyewear Allowance:	\$100 yearly allowance.	\$0 copay
Vision Services:	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	\$25 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	Days 1–5:	\$300 copay
	day. Benefit period applied per admission.)	Days 6–90:	\$0 copay
	Outpatient: (Mental health [*] and substance use.)	Individual and group sessions.	\$40 copay
		Days 1–20:	\$0 сорау
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay
		Days 61–100:	\$0 сорау
	Physical and Speech Language Therapy:		\$25 copay
Outpatient Rehabilitation Services:	Occupational Therapy:	\$25 copay	
	Cardiac Rehab Services:	\$0 сорау	
	Pulmonary Rehab Services:		\$15 copay

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



Blue Medicar	H3449-027-001 H3449-027-002	
Benefits	What You Should Know	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:		Not covered
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

Part D, Prescription Drug Benefit StagesH3449-027-0H3449-027-0H3449-027-0				
	Tiers 1, 2, 3 and 6: \$0 Tiers 4 and 5: \$375			
Annual Deductible:	This is the set amount that you pay before your plan begi of the cost. Your deductible does not apply to covered ins most adult Part D vaccines.			
Initial Coverage Limit (ICL):	Begins after you pay your yearly deductible. You remain in this stage until your costs on covered drugs reach \$5,030 . ¹ The amount you pay in this stage is shown in the chart on the next page.			
Coverage Gap:	Begins when your total year-to-date costs on covered \$5,030. In this stage, you'll pay 25% of the cost for your of dispensing and administration fees, until your total year-to \$8,000 . ² Tier 6 drugs are fully covered in the Coverage Ga copayment at Preferred pharmacies or a \$3 copayment at (non-preferred) pharmacies.	drugs, excluding b-date costs reach ap; there's a \$0		
Catastrophic Coverage:	Begins when your total year-to-date costs on covered \$8,000. During this stage, your plan will pay the full cost to Part D drugs.	-		

*May require prior authorization.

^{**}May require prior authorization. Based on Inflation Reduction Act mandates.1 Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.

² Total year-to-date includes drug costs that only you have paid.

Note: This chart shows your portion of the costs.



Blue Medicare Essential (HMO)

H3449-027-001 H3449-027-002

-	otion Drug Coverage CL)	verage Preferred Retail Pharmacies		Preferred Mail Order	(Non-Pi	dard eferred) nacies
		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 Ge	neric Drugs:	\$0	\$0	\$0	\$15	\$45
(Tier 1)		copay	copay	copay	copay	copay
Generic Druç	js:	\$6	\$18	\$0	\$20	\$60
(Tier 2)		copay	copay	copay	copay	copay
Preferred Bra	and Drugs:	\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferre	ed Drugs:	\$99	\$297	\$198	\$100	\$300
(Tier 4)		copay	copay	copay	copay	copay
Specialty Tie (Tier 5)	er Drugs:	27% of cost	N/A	N/A	27% of cost	N/A
Select Care I	Drugs:	\$0	\$0	\$0	\$3	\$3
(Tier 6)		copay	copay	copay	copay	copay
	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 Non-Preferred Retail Pharmacies for 31 days instead of 30 days. Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ. Note: This chart shows your portion of the costs.



Blue Medicare Essen	H3449-027-001 H3449-027-002					
Other Covered Benefits						
Benefit	What You Should Kno	w				
Podiatry Services:	Foot care.		\$45 copay			
	Durable Medical Equipand Supplies:*	pment	20% of cost			
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:	20% of cost				
and Supplies.	Diabetes Supplies:*	Preferred Brands	\$0 copay			
	Diabetes Supplies:	Non-Preferred Brands**	20% of cost			
Healthy Aging and Exercise Program:	Must use participating f	acilities.	\$0 copay***			
Meals Benefit:	Two meals per day for 1 post-discharge.	14 days	\$0 copay			
Support for Caregivers:	Support and resources non-professional caregi	\$0 сорау				
Personal Emergency Response System:	Wearable device with f to emergency services.	\$0 сорау				
Home Safety Devices: [†]	Two devices per year.		\$0 copay			

***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours. +Devices must be ordered from approved product list using designated provider.

^{*}May require prior authorization. **With a medical exception.



Plan Offerings and Premiums by County

Blue Medicare Essential Plus (HMO-POS) is available in all 100 North Carolina counties.

Blue Medica	are Essential	Plus [™] (нмо-роз	i) H3449-023-001	Monthly Pre	mium: \$0
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	lredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin
Blue Medica	are Essential	Plus [®] (HMO-POS	i) H3449-023-002	Monthly Pre	mium: \$0
Alexander Brunswick Cabarrus Caswell Cumberland	Currituck Franklin Harnett Henderson Hoke	Jackson Johnston Lenoir Macon Madison	McDowell Mitchell Moore New Hanover Person	Polk Rowan Stokes Surry Swain	Transylvania Union Yancey
Blue Medica	are Essential	Plus [®] (нмо-роз) H3449-023-004	Monthly Pre	mium: \$0
Anson Camden Carteret	Cherokee Clay Craven	Dare Granville Montgomery	Onslow Pasquotank Perquimans	Stanly Vance Warren	
Blue Medica	are Essential	Plus [™] (нмо-роз	³⁾ H3449-023-005	Monthly Pre	mium: \$0
Alleghany Ashe Avery Beaufort Bertie Bladen Caldwell	Chowan Cleveland Columbus Duplin Edgecombe Gates Graham	Greene Halifax Hertford Hyde Jones Lee Lincoln	Martin Nash Northampton Pamlico Pender Pitt	Richmond Robeson Sampson Scotland Tyrrell	Washington Watauga Wayne Wilson
Counties where Blue Essential Plus (HMO- is available: 001 002 004			Blue Medicare Es available in all 10		

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.



Blue Medicare Essential Plus [®] (HMO-POS) H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-004 H3449-023-005				
Monthly Premium:	You must also continue to pay your Medicare Part B premium.		\$0	
Deductible:	These plans have no medical deductible.		\$0	
Annual Maximum	Dece not include properintion drugs	001: 002:	\$3,500	
Out-of-Pocket:	Does not include prescription drugs.	004: 005:	\$4,900	
Benefits	What You Should Know			
Inpatient Hospital Care:*	Days 1–5:		\$335 copay	
(Cost share applies per day. Benefit period applied per admission.)	Days 6–90:		\$0 copay	
	Days 91 and beyond:		\$0 copay	
Outpatient Services:*	Outpatient Hospital: Per stay.		\$295 copay	
Outpatient Services.	Ambulatory Surgical Center:		\$275 copay	
	Primary:		\$0 copay	
Doctor Visit:			• • -	
	Specialist:	002:	\$15 copay	
	Specialist:	002: 004: 005:	\$15 copay \$25 copay	
Preventive Care:	Specialist: Any additional preventive services approved by Medicare during the contract year will be covered.	004:		
Preventive Care: Emergency Care:	Any additional preventive services approved by Medicare during the contract year will	004:	\$25 copay	



Blue Medicare Essential Plus (HMO-POS)

H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005

Benefits		What You Should Know	PCP Office	Any Other Setting
	Diagnostic Tests and	Procedures:	\$0 copay	\$25 copay
	Lab Services:		\$0 copay	\$5 copay
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay
Imaging:*		All Other Services:	\$0 copay	\$75 copay
	Therapeutic Radiological Services:		\$0 copay	Lesser of 20% of cost or \$60 copay
	X-rays:		\$0 copay	\$15 copay
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat hearing and balance issues.	001: 002:	\$15 copay
Hearing			004: 005:	\$25 copay
Services:	Routine Hearing Exam:	One per year. Must use designated providers.		\$0 copay
	Hearing Aids:	One per ear, per year. Must use designated providers.		\$699–\$999 copay
	Medicare-Covered	Medicare may pay for certain services when you're in a	001: 002:	\$15 copay
Dental	Dental Services:*	hospital and need emergency or complicated dental procedures.	004: 005:	\$25 copay
Services:	Comprehensive and Preventive Dental:	\$2,000 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% plus 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 the Evidence of Coverage for more information.

***Must use designated providers.



Blue H3449-023-001 H3449-023-002 H3449-023-002 H3449-023-004 H3449-023-004 H3449-023-004 H3449-023-005					
	Routine Eye and	One of each per	001: 002:	\$15 copay	
	Contact Lens Exams:	calendar year.	004: 005:	\$25 copay	
	Prescription Eyewear Allowance	\$300 yearly allowance.		\$0 copay	
Vision Services:	Medicare-Covered	For the diagnosis and treatment of illnesses	001: 002:	\$15 copay	
	Eye Exam:	and injuries of the eye.	004: 005:	\$25 copay	
	Glaucoma Screening and Diabetic Eye Exam:	For people who are at high risk of glaucoma or have diabetes.		\$0 сорау	
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.		20% of cost	
	Inpatient:* (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:		\$300 copay	
Mental		Days 6–90:		\$0 copay	
Health Services:	Outpatient: (Mental health [*] and	Individual and group sessions.	001: 002:	\$15 copay	
	substance use.)		004: 005:	\$25 copay	
Skilled	(Cast abore applies per	Days 1–20:		\$0 copay	
Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:		\$203 copay	
r donity.		Days 61–100:			
	Physical and Speech Language Therapy:			\$10 copay	
Outpatient					
	Occupational Therapy:			\$10 copay	
Outpatient Rehabilitation Services:	Occupational Therapy: Cardiac Rehab Services:			\$10 copay \$0 copay	



Blue Medicare	e Essential Plus [®] (HMO-POS) What You Should Know	H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:	24 one-way rides to health-related locations.	\$0 copay
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

R Part D, Pres	H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005			
	Tiers 1, 2, 3 and 6: \$0 Tiers 4 and	5 : \$150		
Annual Deductible: This is the set amount that you pay before your plan begins to p share of the cost. Your deductible does not apply to covered insproducts and most adult Part D vaccines.				
Initial Coverage Limit (ICL):	Begins after you pay your yearly deductible. You remain in this stage until your costs on covered drugs reach \$5,030 . ¹ The amount you pay in this stage is shown in the chart on the next page.			
Coverage Gap:	Begins when your total year-to-date cost \$5,030. In this stage, you'll pay 25% of the of excluding dispensing and administration fee costs reach \$8,000 . ² Tier 6 drugs are fully co there's a \$0 copayment at Preferred pharma Standard (non-preferred) pharmacies.	cost of your drugs, s, until your total year-to-date overed in the Coverage Gap;		
Catastrophic Coverage:	Begins when your total year-to-date cost \$8,000. During this stage, your plan will pay Part D drugs.	u		

^{*}May require prior authorization. **May require prior authorization. Based on Inflation Reduction Act mandates.

¹ Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year. 2 Total year-to-date includes drug costs that only you have paid.



Blue Medicare Essential Plus[®](HMO-POS)

H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005

	otion Drug Coverage CL)	Preferre Pharm		Preferred Mail Order	(Non-Pı	idard referred) nacies
		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 Ge	neric Drugs:	\$0	\$0	\$0	\$15	\$45
(Tier 1)		copay	copay	copay	copay	copay
Generic Drug	js:	\$6	\$18	\$0	\$20	\$60
(Tier 2)		copay	copay	copay	copay	copay
Preferred Bra	and Drugs:	\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferre	ed Drugs:	\$99	\$297	\$198	\$100	\$300
(Tier 4)		copay	copay	copay	copay	copay
Specialty Tie (Tier 5)	er Drugs:	30% of cost	N/A	N/A	30% of cost	N/A
Select Care I	Drugs:	\$0	\$0	\$0	\$3	\$3
(Tier 6)		copay	copay	copay	copay	copay
Insulins:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days. Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ. Note: This chart shows your portion of the costs.



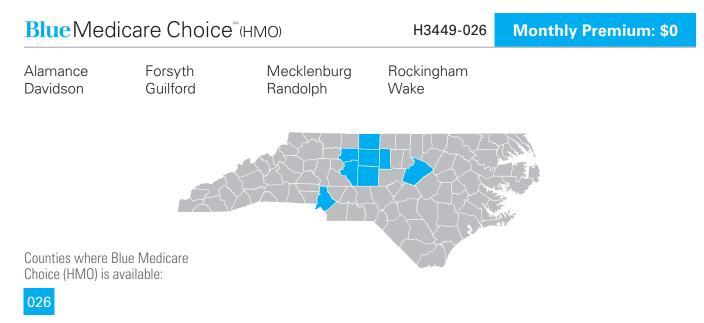
Blue Medicare Essential Plus [®] (HMO-POS) H3449-023-001 H3449-023-002 H3449-023-004 H3449-023-005					
Other Covered Benefits					
Benefit	What You Shou	ld Know			
Podiatry Services:	Foot care.		001: 002:	\$15 сорау	
			004: 005:	\$25 copay	
	Durable Medica and Supplies:*	l Equipment		20% of cost	
Medical Equipment	Diabetic Shoes Inserts:	or		20% of cost	
and Supplies:	Diabetes	Preferred Brands		\$0 copay	
	Supplies:*	Non-Preferred Brands**		20% of cost	
Healthy Aging and Exercise Program:	Must use particip	pating facilities.		\$0 copay***	
			001:	\$120 quarterly	
Over-the-Counter	Must use particip	pating retail locations.	002:	\$95 quarterly	
Products Allowance:	Funds do not roll	over quarter-to-quarter.	004:	\$90 quarterly	
			005:	\$95 quarterly	
Meals Benefit:	Two meals per da post-discharge.	ay for 14 days		\$0 сорау	
Support for Caregivers:	Support and resonation non-professional			\$0 copay	
In-Home Assistance:	60 hours per yea	ır.		\$0 copay	
Personal Emergency Response System:	Wearable device to emergency se	with fast access prvices.		\$0 сорау	
Home Safety Devices:*	Two devices per	year.		\$0 copay	

*May require prior authorization. **With a medical exception.

***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours. +Devices must be ordered from approved product list using designated provider. Note: This chart shows your portion of the costs.



Plan Offering and Premium by County



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.



Blue Medicare Choice [®] (HMO) H3449-026				
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	\$0		
Deductible:	This plan has no medical deductible.	\$0		
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	\$2,800		
Benefits	What You Should Know			
Inpatient Hospital Care: * (Cost share applies per day. Benefit period applied per admission.)	Days 1–5:	\$295 copay		
	Days 6–90:	\$0 copay		
	Days 91 and beyond:	\$0 copay		
	Outpatient Hospital: Per stay.	\$295 copay		
Outpatient Services:*	Ambulatory Surgical Center:	\$275 copay		
Doctor Visit:	Primary:	\$0 copay		
	Specialist:	\$10 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.	\$135 copay		

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



Blue Medicare Choice[®](HMO)

PCP Any Other **Benefits** What You Should Know Office Setting **Diagnostic Tests and Procedures:** \$0 copay \$15 copay Lab Services: \$0 copay \$5 copay Lesser of **MRI, CT and Other** 20% of cost or \$0 copay **Nuclear Medicine:** \$150 copay Diagnostic Diagnostic Radiological Services/ PET: \$0 copay \$300 copay Services: Labs/ Imaging:* All Other Services: \$0 copay \$75 copay Lesser of **Therapeutic Radiological Services:** 20% of cost or \$0 copay \$60 copay X-rays: \$0 copay \$15 copay **Medicare-Covered** Exams to diagnose and treat hearing and \$10 copay **Hearing Exam:** balance issues. Hearing **Routine Hearing** One per year. Must use designated providers. \$0 copay Services: Exam: One per ear, per year. Must use designated \$699-\$999 **Hearing Aids:** providers. copay Medicare may pay for certain services when **Medicare-Covered** you're in a hospital and need emergency or \$10 copay **Dental Services:*** complicated dental procedures. Dental Services: Oral exams, cleanings, X-rays and **Preventive Dental:** \$0 copay screenings.*

*May require prior authorization.

**Certain limits apply. Must use designated providers.

Note: This chart shows your portion of the costs.

H3449-026



Blue Medicare Choice[®](HMO)

H3449-026

Benefits		What You Should Know		
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$10 copay	
	Prescription Eyewear Allowance:	\$200 yearly allowance.	\$0 copay	
Vision Services:	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	\$10 сорау	
	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	Inpatient:* (Cost share applies per	Days 1–5:	\$295 copay	
	day. Benefit period applied per admission.)	Days 6–90:	\$0 copay	
Services:	Outpatient: (Mental health [*] and substance use.)	Individual and group sessions.	\$10 copay	
		Days 1–20:	\$0 copay	
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay	
i donity:		Days 61–100:	\$0 сорау	
	Physical and Speech Lang	\$10 сорау		
Outpatient Rehabilitation	Occupational Therapy:	\$10 сорау		
Services:	Cardiac Rehab Services:	Cardiac Rehab Services:		
	Pulmonary Rehab Service	S:	\$20 copay	



Blue Medicare	H3449-026	
Benefits	What You Should Know	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$275 copay
Transportation:		Not Covered
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

F _x	Part D, Prescriptio	n Drug Benefit Stages
-----------------------	---------------------	-----------------------

H3449-026

	All Tiers: \$0
Annual Deductible:	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 Limit (ICL):	Begins after you pay your yearly deductible. You remain in this stage until your costs on covered drugs reach \$5,030 . ¹ The amount you pay in this stage is shown in the chart on the next page.
Coverage Gap:	Begins when your total year-to-date costs on covered drugs exceed \$5,030. In this stage, you'll pay 25% of the cost for your drugs, excluding dispensing and administration fees, until your total year-to-date costs reach \$8,000 . ² Tier 6 drugs are fully covered in the Coverage Gap; there's a \$0 copayment at Preferred pharmacies or a \$3 copayment at Standard (non-preferred) pharmacies.
Catastrophic Coverage:	Begins when your total year-to-date costs on covered drugs exceed \$8,000. During this stage, your plan will pay the full cost for your covered Part D drugs.

*May require prior authorization.

^{**}May require prior authorization. Based on Inflation Reduction Act mandates.

¹ Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.

² Total year-to-date includes drug costs that only you have paid.

Note: This chart shows your portion of the costs.



Blue Medicare Choice[®](HMO)

H3449-026

Prescription Drug Initial Coverage Limit (ICL)			d Retail nacies	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 Ge	eneric Drugs:	\$0	\$0	\$0	\$15	\$45
(Tier 1)		copay	copay	copay	copay	copay
Generic Drug	gs:	\$6	\$18	\$0	\$20	\$60
(Tier 2)		copay	copay	copay	copay	copay
Preferred Brand Drugs:		\$45	\$135	\$90	\$47	\$141
(Tier 3)		copay	copay	copay	copay	copay
Non-Preferred Drugs:		\$99	\$297	\$198	\$100	\$300
(Tier 4)		copay	copay	copay	copay	copay
Specialty Tier Drugs : (Tier 5)		33% of cost	N/A	N/A	33% of cost	N/A
Select Care I	Drugs:	\$0	\$0	\$0	\$3	\$3
(Tier 6)		copay	copay	copay	copay	copay
Insulins:	Tier 3:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay
inounity.	Tier 4:	\$35 copay	\$105 copay	\$90 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days. Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ. Note: This chart shows your portion of the costs.



Blue Medicare Choice (HMO) H3449-026							
Other Covered Benefits							
Benefit	What You Should	Know					
Podiatry Services:	Foot care.		\$10 copay				
	Durable Medical E and Supplies:*	Equipment	20% of cost				
Medical Equipment and Supplies:	Diabetic Shoes or Inserts:	20% of cost					
and Supplies.	Diabetes	Preferred Brands	\$0 сорау				
	Supplies:*	Non-Preferred Brands**	20% of cost				
Healthy Aging and Exercise Program:	Must use participat	ing facilities.	\$0 copay***				
Over-the-Counter Products Allowance:	Must use participat Funds do not roll ov	ting retail locations. ver quarter-to-quarter.	\$85 quarterly				
Meals Benefit:	Two meals per day post-discharge.	for 14 days	\$0 copay				
Support for Caregivers:	Support and resour non-professional ca	\$0 copay					
Personal Emergency Response System:	Wearable device w emergency service	\$0 copay					
Home Safety Devices:*	Two devices per ye	ear.	\$0 copay				

*May require prior authorization.

**With a medical exception.

***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours.
*Devices must be ordered from approved product list using designated provider.
Network This about about your particip of the sector.



Plan Offerings and Premiums by County

Blue Medica	are Enhanced	™(HMO-POS)	H3449-024-001	Monthly Prem	ium: \$19	
Alamance Buncombe Burke Catawba	Chatham Davidson Davie Durham	Forsyth Gaston Guilford Haywood	Iredell Mecklenburg Orange Randolph	Rockingham Rutherford Wake	Wilkes Yadkin	
Blue Medica	are Enhanced	M(HMO-POS)	H3449-024-002	Monthly Prem	ium: \$34	
Alexander Brunswick Cabarrus Camden Carteret Caswell Cherokee	Clay Craven Cumberland Currituck Dare Franklin Harnett	Henderson Hoke Jackson Johnston Lenoir Macon Madison	McDowell Mitchell Moore New Hanover Onslow Pasquotank Perquimans	Person Polk Rowan Stokes Surry	Swain Transylvania Union Yancey	
Blue Medica	are Enhanced	™(HMO-POS)	H3449-024-003	Monthly Premium: \$45		
Alleghany Anson Ashe Avery Beaufort Bertie Bladen Caldwell	Chowan Cleveland Columbus Duplin Edgecombe Gates Graham Granville	Greene Halifax Hertford Hyde Jones Lee Lincoln Martin	Montgomery Nash Northampton Pamlico Pender Pitt Richmond	Robeson Sampson Scotland Stanly Tyrrell Vance	Warren Washington Watauga Wayne Wilson	
Counties where Blue Medicare						
	Enhanced (HMO-POS) is available: Blue Medicare Enhanced (HMO-POS) is					

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.



Blue Medicare Enhanced [®] (HMO-POS) H3449-024-001 H3449-024-002 H3449-024-003						
			\$19			
Monthly Premium:	You must also continue to pay your Medicare Part B premium.	002:	\$34			
		003:	\$45			
Deductible:	These plans have no medical deductible.		\$0			
		001:	\$3,150			
Annual Maximum Out-of-Pocket Amount:	Does not include prescription drugs.	002:	\$3,150			
		003:	\$3,400			
Benefits	What You Should Know					
Inpatient Hospital Care:*	Days 1–5:	\$335 copay				
(Cost share applies per day. Benefit period applied	Days 6–90:	\$0 copay				
per admission.)	Days 91 and beyond:	\$0 copay				
Outpatient Services:*	Outpatient Hospital: Per stay.		\$295 copay			
outputient connect.	Ambulatory Surgical Center:	\$200 copay				
Doctor Visit:	Primary:		\$0 сорау			
	Specialist:	\$15 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.		\$135 copay			
Urgently Needed Services:			\$60 copay			

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



Blue Medicare Enhanced[®](HMO-POS)

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

				110440 024 000	
Benefits		What You Should Know	PCP Office	Any Other Setting	
	Diagnostic Tests and	Procedures:	\$0 copay	\$25 copay	
	Lab Services:		\$0 copay	\$5 copay	
Diagnostic	Diagnostic	MRI, CT and Other Nuclear Medicine:	\$0 copay	Lesser of 20% of cost or \$150 copay	
Services/ Labs/	Radiological Services:	PET:	\$0 copay	\$300 copay	
Imaging:*	All Other Services:		\$0 copay	\$75 copay	
	Therapeutic Radiological Services:		\$0 copay	Lesser of 20% of cost or \$60 copay	
	X-rays:		\$0 сорау	\$15 copay	
	Medicare-Covered Hearing Exam:	Exams to diagnose and treat h balance issues.	nearing and	\$15 copay	
Hearing Services:	Routine Hearing Exam:	One per year. Must use desig providers.	nated	\$0 copay	
	Hearing Aids:	One per ear, per year. Must use designated providers.		\$699–\$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.		\$15 copay	
	Comprehensive and Preventive Dental:	\$2,000 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% plus 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 the Evidence of Coverage for more information.

***Must use designated providers.



Blue Medicare Enhanced[®](HMO-POS)

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

Benefits		What You Should Know	H3449-024-003
	Routine Eye and Contact Lens Exams:	One of each per calendar year.	\$15 copay
	Prescription Eyewear Allowance:	\$300 yearly allowance.	\$0 copay
Vision Services:	Medicare-Covered Eye Exam:	For the diagnosis and treatment of illnesses and injuries of the eye.	\$15 copay
	Glaucoma Screening and Diabetic Eye Exam:	For people who are at high risk of glaucoma or have diabetes.	\$0 сорау
	Eyewear After Cataract Surgery:	One pair of eyeglasses or one pair of contact lenses.	20% of cost
	Inpatient:* (Cost share applies per	Days 1–5:	\$300 copay
Mental Health	day. Benefit period applied per admission.)	Days 6–90:	\$0 copay
Services:	Outpatient: (Mental health [*] and substance use.)	Individual and group sessions.	\$15 copay
		Days 1–20:	\$0 copay
Skilled Nursing Facility:*	(Cost share applies per day. Benefit period applied per admission.)	Days 21–60:	\$203 copay
r donrey.	- FF F	Days 61–100:	\$0 copay
	Physical and Speech Lar	\$10 copay	
Outpatient Rehabilitation	Occupational Therapy:		\$10 copay
Services:	Cardiac Rehab Services:		\$0 copay
	Pulmonary Rehab Servio	\$20 copay	



Blue Medicare Benefits	H3449-024-001 H3449-024-002 H3449-024-003	
Ambulance Services:*	Covers medically necessary ground and air ambulance services.	\$250 copay
Transportation:	24 one-way rides to health-related locations.	\$0 copay
Medicare Part B	Part B Insulins: 30-day supply.	\$35 copay
Drugs:**	Chemotherapy and Other Part B Drugs:	0–20% of cost

RPart D, Prescription Drug Benefit StagesH3449-024-0H3449-024-0H3449-024-0H3449-024-0H3449-024-0					
	All Tiers: \$0				
Annual Deductible:	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 Limit (ICL):	Begins after you pay your yearly deductible. You remain your costs on covered drugs reach \$5,030 . ¹ The amount you is shown in the chart on the next page.	-			
Coverage Gap:	Begins when your total year-to-date costs on covered da \$5,030. In this stage, you'll pay 25% of the cost for your dru dispensing and administration fees, until your total year-to-d \$8,000 . ² Tier 6 drugs are fully covered in the Coverage Gap; copayment at Preferred pharmacies or a \$1 copayment at S (non-preferred) pharmacies.	igs, excluding ate costs reach there's a \$0			
Catastrophic Coverage:	Begins when your total year-to-date costs on covered d \$8,000. During this stage, your plan will pay the full cost for Part D drugs.	-			

*May require prior authorization.

- 2 Total year-to-date includes drug costs that only you have paid.
- Note: This chart shows your portion of the costs.

^{**}May require prior authorization. Based on Inflation Reduction Act mandates.

¹ Total year-to-date includes drug costs paid by you and any Part D plan from the beginning of the calendar year.



Blue Medicare Enhanced (HMO-POS)

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

	otion Drug overage CL)	Preferred Retail Pharmacies		Preferred Mail Order	(Non-Pı	dard eferred) nacies
		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 Ge (Tier 1)	neric Drugs:	\$0 copay	\$0 copay	\$0 copay	\$15 copay	\$45 copay
Generic Drug (Tier 2)	js:	\$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
insuins.	Tier 4:	\$35 copay	\$105 copay	\$105 copay	\$35 copay	\$105 copay

*Long-term care pharmacy benefit is covered the same as Non-Preferred Retail Pharmacies for 31 days instead of 30 days. Note: Two-month (60-day) supplies may also be available. Non-Preferred Mail Order costs may differ. Note: This chart shows your portion of the costs.



Blue Medicare Enhanced	H3449-024-001 H3449-024-002 H3449-024-003			
Benefit	What You Sh	ould Know		
Podiatry Services:	Foot care.			\$15 copay
	Durable Med and Supplies	ical Equipment :: [*]		20% of cost
Medical Equipment	Diabetic Sho	es or Inserts:		20% of cost
and Supplies:	Diabetes	Preferred Brands		\$0 copay
	Supplies:*	Non-Preferred Brands	* *	20% of cost
Healthy Aging and Exercise Program:	Must use part	Must use participating facilities.		
	001:		001:	\$105 quarterly
Over-the-Counter Products Allowance:				\$105 quarterly
	over quarter-to-quarter		003:	\$95 quarterly
Meals Benefit:	2 meals per d 14 days post-o			\$0 сорау
Support for Caregivers:		Support and resources for non-professional caregivers.		
In-Home Assistance:	60 hours per year.			\$0 сорау
Personal Emergency Response System:		Wearable device with fast access to emergency services.		
Home Safety Devices: [†]	Two devices p	per year.		\$0 copay

*May require prior authorization.

**With a medical exception.

***This program includes the Standard network. Premium network may have monthly costs. Some facilities may offer limited hours. +Devices must be ordered from approved product list using designated provider.