PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

Data Report for Contract H2230, Plan 017 BCBS OF MASSACHUSETTS HMO BLUE, INC.	
Contract Year:	2025
Requested By:	
Plan Characteristics	
General Information	
Organization Legal Name	BCBS OF MASSACHUSETTS HMO BLUE, INC.
Organization Marketing Name	Blue Cross Blue Shield of Massachusetts
Organization Type	Local CCP
Plan Name	Medicare PPO Blue SaverRx (PPO)
Plan Geographic Name	Massachusetts except Berkshire Dukes and Nantucket
Plan Details	
Plan Type	Local PPO
Is this a network plan?	Not Applicable
Is this an Employer-Only Plan?	No
Does this plan offer Prescription drugs (Rx)?	Yes
Does this plan offer Point of Service (POS)?	Not Applicable
Does this plan offer Out-of-Network Services (OON)?	Yes
Does this plan offer Value Based Insurance Design (VBID)?	Not Available
Plan Attributes	
Select Enrollee type:	Part A & Part B
Does this Plan have a CMS-approved Continuation Area?	No
Contract Year 2025 Medicare-defined MOOP Limits (Local PPO Plan)	
Lower MOOP Limit	$0 - $4150 In-network and $0 - $6200 Combined
Intermediate MOOP Limit	$4151 - $6750 In-network and $4151 - $10100 Combined

Mandatory MOOP Limit	$6751 - $9350 In-network and $6751 - $14000 Combined
Standard Bid	
Does this plan offer a standard bid for In-Network service categories?	No
Does this plan offer a standard bid for Out-of-Network service categories?	No
Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	No
Benefit Offerings	
Medicare Services	
Inpatient Hospital-Acute(1a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Inpatient Hospital Psychiatric(1b)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Skilled Nursing Facility (SNF)(2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Cardiac Rehabilitation Services(3-1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Pulmonary Rehabilitation Services(3-3)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
SET for PAD Services(3-4)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Emergency Services(4a)	
In Network (INN)	Required
Urgently Needed Services(4b)	
In Network (INN)	Required

Partial Hospitalization(5)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Home Health Services(6)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Primary Care Physician Services(7a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Chiropractic Services(7b)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Occupational Therapy Services(7c)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Physician Specialist Services(7d)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Podiatry Services(7f)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Other Health Care Professional(7g)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Individual Sessions for Psychiatric Services(7h1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Group Sessions for Psychiatric Services(7h2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	

In Network (INN)	Required
Out-Of-Network (OON)	Yes
Additional Telehealth Benefits(7j)	
In Network (INN)	Yes
Opioid Treatment Program Services(7k)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Diagnostic Procedures/Tests(8a1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Lab Services(8a2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Diagnostic Radiological Services(8b1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Therapeutic Radiological Services(8b2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Outpatient X-Ray Services(8b3)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Outpatient Hospital Services(9a1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Observation Services(9a2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Individual Sessions for Outpatient Substance Abuse(9c1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes

Outpatient Blood Services(9d)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Ground Ambulance Services(10a1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Air Ambulance Services(10a2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Durable Medical Equipment (DME)(11a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Prosthetic Devices(11b1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Medical Supplies(11b2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Diabetic Supplies(11c1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Dialysis Services(12)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Kidney Disease Education Services(14d)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Glaucoma Screening(14e1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Diabetes Self-Management Training(14e2)	

In Network (INN)	Required
Out-Of-Network (OON)	Yes
Barium Enemas(14e3)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Digital Rectal Exams(14e4)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
EKG following Welcome Visit(14e5)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Medicare Part B Insulin Drugs(15-1)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Other Medicare Part B Drugs(15-3)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Medicare Dental Services(16a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Eye Exams(17a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Eyewear(17b)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Hearing Exams(18a)	
In Network (INN)	Required
Out-Of-Network (OON)	Yes
Non-Medicare Services	
Additional Days for Inpatient Hospital-Acute(1a1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Additional Days for Inpatient Hospital Psychiatric(1b1)	

In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Worldwide Emergency Coverage(4c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Worldwide Urgent Coverage(4c2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Worldwide Emergency Transportation(4c3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Three(3) pint Deductible Waived(9d)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Over-the-Counter (OTC) Items(13b)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Meal Benefit(13c)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Annual Physical Exam(14b)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Health Education(14c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Fitness Benefit(14c4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Enhanced Disease Management(14c5)	
In Network (INN)	Required

Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Remote Access Technologies (including Web/Phone-based technologies	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Wigs for Hair Loss Related to Chemotherapy(14c15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Weight Management Programs(14c16)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Home infusion bundled services(15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Oral Exams(16b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Dental X-Rays(16b2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Other Diagnostic Dental Services(16b3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Prophylaxis (cleaning)(16b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Restorative Services(16c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory

Out-Of-Network (OON)	Yes
Endodontics(16c2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Periodontics(16c3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Prosthodontics, removable(16c4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Maxillofacial Prosthetics(16c5)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Implant Services(16c6)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Prosthodontics, fixed(16c7)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Oral and Maxillofacial Surgery(16c8)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Adjunctive General Services(16c10)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Routine Eye Exams(17a1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes

Contact Lenses(17b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Eyeglasses (lenses and frames)(17b2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Eyeglass lenses(17b3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Eyeglass frames(17b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Routine Hearing Exams(18a1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Fitting/Evaluation for Hearing Aid(18a2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Prescription Hearing Aids (all types)(18b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Out-Of-Network (OON)	Yes
Plan Level Cost Sharing	
Plan Level Cost Sharing	
Tiered Cost Sharing	
Does this plan have tiered cost sharing for Medicare covered services?	No
Does this plan have tiered cost sharing for Non-Medicare covered services?	No
Reductions in Cost Sharing	

Does your plan offer Reductions in Cost Sharing?	No
Combined Supplemental Benefits	
Do you offer Combined Supplemental Benefits?	Yes
Annual Plan Deductible LPPO/RPPO	
Do you offer a Deductible?	No
Deductible for LPPO/RPPO Mandatory Supplemental Benefits	
Do you offer a mandatory enhanced benefit enrollee deductible amount?	No
LPPO/RPPO Max Enrollee Cost Limit	
Does this plan have an In-Network MOOP?	Yes
What type of In-Network MOOP does your plan offer?	Intermediate
In-Network MOOP Amount	$5600.00
Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does this plan have an Out-of-Network MOOP?	No
Does this plan have a Combined(In-Network and Out-of-Network) MOOP?	Yes
Combined MOOP Amount	$8950.00
Select the Service Categories that apply to the Combined Maximum Enrollee Out-of-Pocket cost:	In-Network Medicare-covered benefits
	Out-of-Network Medicare-covered benefits
Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?	Yes
Medicare Services	
Inpatient Hospital-Acute(1a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Inpatient Hospital Psychiatric(1b)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Skilled Nursing Facility (SNF)(2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Cardiac Rehabilitation Services(3-1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Intensive Cardiac Rehabilitation Services(3-2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Pulmonary Rehabilitation Services(3-3)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
SET for PAD Services(3-4)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Emergency Services(4a)	
In-Network	Yes
Combined In-Network	Yes
Urgently Needed Services(4b)	

In-Network	Yes
Combined In-Network	Yes
Partial Hospitalization(5)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Home Health Services(6)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Primary Care Physician Services(7a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Chiropractic Services(7b)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Occupational Therapy Services(7c)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Physician Specialist Services(7d)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Podiatry Services(7f)	
In-Network	Yes
Combined In-Network	Yes

Combined Out-of-Network	Yes
Other Health Care Professional(7g)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Individual Sessions for Psychiatric Services(7h1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Group Sessions for Psychiatric Services(7h2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Additional Telehealth Benefits(7j)	
In-Network	Yes
Combined In-Network	Yes
Opioid Treatment Program Services(7k)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Diagnostic Procedures/Tests(8a1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Lab Services(8a2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Diagnostic Radiological Services(8b1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Therapeutic Radiological Services(8b2)	

In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Outpatient X-Ray Services(8b3)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Outpatient Hospital Services(9a1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Observation Services(9a2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Ambulatory Surgical Center (ASC) Services(9b)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Individual Sessions for Outpatient Substance Abuse(9c1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Outpatient Blood Services(9d)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Ground Ambulance Services(10a1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Air Ambulance Services(10a2)	
In-Network	Yes

Combined In-Network	Yes
Combined Out-of-Network	Yes
Durable Medical Equipment (DME)(11a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Prosthetic Devices(11b1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Medical Supplies(11b2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Diabetic Supplies(11c1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Dialysis Services(12)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Kidney Disease Education Services(14d)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Glaucoma Screening(14e1)	
In-Network	Yes
Combined In-Network	Yes

Combined Out-of-Network	Yes
Diabetes Self-Management Training(14e2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Barium Enemas(14e3)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Digital Rectal Exams(14e4)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
EKG following Welcome Visit(14e5)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Medicare Part B Insulin Drugs(15-1)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Other Medicare Part B Drugs(15-3)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Medicare Dental Services(16a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Eye Exams(17a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes

Eyewear(17b)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Hearing Exams(18a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Prior Authorization & Referral	
Prior Authorization	
Is prior authorization required for any In-Network service categories?	Yes
Select the In-Network service categories that require prior authorization:	Inpatient Hospital-Acute(1a)
	Additional Days for Inpatient Hospital-Acute(1a1)
	Inpatient Hospital Psychiatric(1b)
	Additional Days for Inpatient Hospital Psychiatric(1b1)
	Skilled Nursing Facility (SNF)(2)
	Partial Hospitalization(5)
	Physician Specialist Services(7d)
	Individual Sessions for Mental Health Specialty Services(7e1)
	Group Sessions for Mental Health Specialty Services(7e2)
	Individual Sessions for Psychiatric Services(7h1)
	Group Sessions for Psychiatric Services(7h2)
	Diagnostic Procedures/Tests(8a1)
	Diagnostic Radiological Services(8b1)
	Therapeutic Radiological Services(8b2)
	Outpatient Hospital Services(9a1)
	Ambulatory Surgical Center (ASC) Services(9b)
	Individual Sessions for Outpatient Substance Abuse(9c1)

	Group Sessions for Outpatient Substance Abuse(9c2)
	Ground Ambulance Services(10a1)
	Air Ambulance Services(10a2)
	Durable Medical Equipment (DME)(11a)
	Diabetic Supplies(11c1)
	Diabetic Therapeutic Shoes/Inserts(11c2)
	Medicare-covered Zero Dollar Preventive Services(14a)
	Medicare Part B Chemotherapy/Radiation Drugs(15-2)
	Other Medicare Part B Drugs(15-3)
	Occupational Therapy Services(7c)
	Physical Therapy and Speech-Language Pathology Services(7i)
	Lab Services(8a2)
Is prior authorization required for any Out-of-Network service categories?	No
Referral	
Is referral required for any In-Network service categories?	No
Is referral required for any Out-of-Network service categories?	No
Visitor Travel	
Does this plan offer the US Visitor/Travel Program (V/T)?	Yes
Select the type of benefit:	Mandatory
Select the geographic area:	Other-please define in the marketing materials
Cost Share Groups	
Out of Network (OON) Groups	
Group Name	Out of Network Group 1
Copayment	No
Coinsurance	20%
Deductible	No

Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Durable Medical Equipment (DME)(11a)
	Prosthetic Devices(11b1)
	Medical Supplies(11b2)
	Dialysis Services(12)
	Medicare Part B Insulin Drugs(15-1)
Group Name	Out of Network Group 2
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Opioid Treatment Program Services(7k)
	Outpatient Blood Services(9d)
	Diabetic Supplies(11c1)
	Diabetic Therapeutic Shoes/Inserts(11c2)
	Medicare-covered Zero Dollar Preventive Services(14a)
	Glaucoma Screening(14e1)
	Diabetes Self-Management Training(14e2)
	Barium Enemas(14e3)
	Digital Rectal Exams(14e4)
	EKG following Welcome Visit(14e5)
	Medicare Part B Chemotherapy/Radiation Drugs(15-2)
	Other Medicare Part B Drugs(15-3)
	Eyewear(17b)
Non-Medicare:	Outpatient Blood Services(9d)

	Meal Benefit(13c)
	Annual Physical Exam(14b)
	Health Education(14c1)
	Enhanced Disease Management(14c5)
	Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)
	Medicare Part B Rx Drugs(15)
	Contact Lenses(17b1)
	Eyeglasses (lenses and frames)(17b2)
	Eyeglass lenses(17b3)
	Eyeglass frames(17b4)
Notes	When Diabetes Self-Management training is performed during an office visit, an office visit will apply. Routine eyewear: $200 every 2 years toward the cost of lenses, frames, contact lenses.

Group Name	Out of Network Group 3
Copayment	$45.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Non-Medicare:	Routine Eye Exams(17a1)
	Routine Hearing Exams(18a1)
	Fitting/Evaluation for Hearing Aid(18a2)

Group Name	Group #4
Copayment	$40.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No

Periodicity	N/A
Status	Completed
Medicare:	Individual Sessions for Mental Health Specialty Services(7e1)
	Group Sessions for Mental Health Specialty Services(7e2)
	Individual Sessions for Psychiatric Services(7h1)
	Group Sessions for Psychiatric Services(7h2)
	Individual Sessions for Outpatient Substance Abuse(9c1)
	Group Sessions for Outpatient Substance Abuse(9c2)
Group Name	Group #5
Copayment	$375.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Ground Ambulance Services(10a1)
	Air Ambulance Services(10a2)
Group Name	Out of Network Group 6
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	$500.00
Periodicity	Every Year
Status	Completed
Non-Medicare:	Wigs for Hair Loss Related to Chemotherapy(14c15)
Group Name	Group #7
Copayment	No
Coinsurance	45%

Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Cardiac Rehabilitation Services(3-1)
	Intensive Cardiac Rehabilitation Services(3-2)
	Pulmonary Rehabilitation Services(3-3)
	SET for PAD Services(3-4)
	Partial Hospitalization(5)
	Home Health Services(6)
	Chiropractic Services(7b)
	Occupational Therapy Services(7c)
	Physical Therapy and Speech-Language Pathology Services(7i)
	Diagnostic Procedures/Tests(8a1)
	Lab Services(8a2)
	Therapeutic Radiological Services(8b2)
	Outpatient X-Ray Services(8b3)
	Outpatient Hospital Services(9a1)
	Observation Services(9a2)
	Ambulatory Surgical Center (ASC) Services(9b)
	Kidney Disease Education Services(14d)
Group Name	Group #8
Copayment	$25.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Primary Care Physician Services(7a)
Group Name	Group #9
Copayment	$699.00 - $999.00

Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Non-Medicare:	Prescription Hearing Aids (all types)(18b1)
Notes	Hearing aids: $699 copay for a standard hearing aid or $999 copay for a premium hearing aid received from a contracted hearing aid provider.
Group Name	Group #10
Copayment	$60.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Non-Medicare:	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Other Diagnostic Dental Services(16b3)
	Prophylaxis (cleaning)(16b4)
Group Name	Group #11
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	$55.00
Periodicity	Every 3 months
Status	Completed
Non-Medicare:	Over-the-Counter (OTC) Items(13b)
Group Name	Group #12
Copayment	$375.00
Coinsurance	No

Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Diagnostic Radiological Services(8b1)
Group Name	Group #13
Copayment	$25.00 - $95.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Physician Specialist Services(7d)
	Podiatry Services(7f)
	Other Health Care Professional(7g)
	Eye Exams(17a)
	Hearing Exams(18a)
	Medicare Dental Services(16a)
Notes	For Podiatry services, Other Health Care Professionals, Medicare-covered eye exams, and Hearing Exams (OON Group 13 – 7f, 7g, 17a,18a) the lower cost share represents a primary care provider visit and the maximum cost share applies to a Physician specialist visit. For Physician Specialist Services (7d) and Medicare covered Dental services (16a), the maximum cost-share will apply.
Group Name	Group #14
Copayment	No
Coinsurance	No
Deductible	No

Maximum Plan Benefit Coverage amount	$500.00
Periodicity	Every Year
Status	Completed
Non-Medicare:	Fitness Benefit(14c4)
Group Name	Group #15
Copayment	No
Coinsurance	50%
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Non-Medicare:	Restorative Services(16c1)
	Endodontics(16c2)
	Periodontics(16c3)
	Prosthodontics, removable(16c4)
	Maxillofacial Prosthetics(16c5)
	Implant Services(16c6)
	Prosthodontics, fixed(16c7)
	Oral and Maxillofacial Surgery(16c8)
	Adjunctive General Services(16c10)
Group Name	Group #16
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	$250.00
Periodicity	Every Year
Status	Completed
Non-Medicare:	Weight Management Programs(14c16)
Combined Benefits Groups	
Group Name	Dental/Vision/Hearing Expense Allowance
Mode of delivery	Debit Card
Maximum Plan Benefit Coverage amount	$600.00

Periodicity	Every Year
Shared Visit/Trips Limits	No
Status	Completed
Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Other Diagnostic Dental Services(16b3)
	Prophylaxis (cleaning)(16b4)
	Restorative Services(16c1)
	Endodontics(16c2)
	Periodontics(16c3)
	Prosthodontics, removable(16c4)
	Maxillofacial Prosthetics(16c5)
	Implant Services(16c6)
	Prosthodontics, fixed(16c7)
	Oral and Maxillofacial Surgery(16c8)
	Adjunctive General Services(16c10)
	Routine Eye Exams(17a1)
	Contact Lenses(17b1)
	Eyeglasses (lenses and frames)(17b2)
	Eyeglass lenses(17b3)
	Eyeglass frames(17b4)
	Routine Hearing Exams(18a1)
	Fitting/Evaluation for Hearing Aid(18a2)
	Prescription Hearing Aids (all types)(18b1)
Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Do you offer Combined Supplemental Benefits with a shared visit/trips limits?	No

Notes	Members will have an allowance to use towards dental, vision and hearing out-of-pocket expenses. This can include copayments for the covered dental, vision, and hearing services, as well as other out-of-pocket expenses associated with vision hardware purchases.
Group Name	Combined Supplemental Benefits 1
Mode of delivery	Reimbursement
Maximum Plan Benefit Coverage amount	$1500.00
Periodicity	Every Year
Shared Visit/Trips Limits	No
Status	Completed
Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Other Diagnostic Dental Services(16b3)
	Prophylaxis (cleaning)(16b4)
	Restorative Services(16c1)
	Endodontics(16c2)
	Periodontics(16c3)
	Prosthodontics, removable(16c4)
	Maxillofacial Prosthetics(16c5)
	Implant Services(16c6)
	Prosthodontics, fixed(16c7)
	Oral and Maxillofacial Surgery(16c8)
	Adjunctive General Services(16c10)
Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Do you offer Combined Supplemental Benefits with a shared visit/trips limits?	No

Reduction in Cost Sharing Groups	
No Data Saved for Selected Section, Incomplete or Not Started.	
Optional Supplemental Packages	
No Data Saved for Selected Section, Incomplete or Not Started.	
VBID	
Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Does this plan offer Special Supplemental Benefits for Chronically Ill?	No
VBID/MA UF/SSBCI Reduction in Cost Sharing Packages (19a)	
No Data Saved for Selected Section, Incomplete or Not Started.	
VBID/MA UF/SSBCI Additional Benefits Packages (19b)	
No Data Saved for Selected Section, Incomplete or Not Started.	
Benefit Details	
Inpatient Hospital-Acute (1a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	$385.00
Begin Day	1
End Day	7
Copayment	$0.00
Begin Day	8
End Day	90

Day intervals for Medicare-covered lifetime reserve days	1
Copayment	$0.00
Begin Day	1
End Day	60
Is there a deductible?	No
Periodicity	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share?	No
Copayment	$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	$440.00
Begin Day	1
End Day	7
Copayment	$0.00
Begin Day	8
End Day	90
Is there a deductible?	No
Inpatient Hospital Psychiatric (1b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No

Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	$300.00
Begin Day	1
End Day	5
Copayment	$0.00
Begin Day	6
End Day	90
Day intervals for Medicare-covered lifetime reserve days	1
Copayment	$0.00
Begin Day	1
End Day	60
Is there a deductible?	No
Periodicity	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share?	No
Copayment	$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	$400.00
Begin Day	1
End Day	5
Copayment	$0.00
Begin Day	6
End Day	90
Is there a deductible?	No
Notes	Includes mental health care services that require a hospital stay.

Skilled Nursing Facility (SNF) (2) - Medicare	
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Days	0
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Number of day intervals for Medicare-covered stay	2
Copayment	$0.00
Begin Day	1
End Day	20
Copayment	$170.00
Begin Day	21
End Day	100
Periodicity	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Is there a coinsurance?	Yes
Do you charge the Medicare-defined cost share?	No
Coinsurance	40%
Number of day intervals for Medicare-covered stay	0
Is there a copayment?	No
Is there a deductible?	No
Cardiac and Pulmonary Rehabilitation Services (3) - Medicare	

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Cardiac Rehabilitation Services (3-1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$35.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Intensive Cardiac Rehabilitation Services (3-2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$35.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Pulmonary Rehabilitation Services (3-3) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$15.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
SET for PAD Services (3-4) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$15.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Emergency Services (4a) - Medicare	

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$95.00
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	Yes
Select either days or hours within which admission must occur for waiver	Hours
Enter number of hours	24
Does the cost sharing count towards any plan-level deductible?	No
Notes	In-network: You do not pay the ER copayment if you are held overnight at the hospital for observation. For Out-of-network: You do not pay the ER copayment if you are held overnight at the hospital for observation. If you get inpatient care at a non-plan hospital after your emergency condition is stablized, your cost is the cost sharing you would pay at a plan hospital.
Urgently Needed Services (4b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max

Minimum copayment	$0.00
Maximum copayment	$55.00
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No
Does the cost sharing count towards any plan-level deductible?	No
Notes	For In-Network Urgent Care, you pay a $0 copay for Urgent care services received from your PCP, a $45 copay from other in-network providers and $55 copay for Out-of-Network urgent care services. $0 copay applies to covered services performed in the home by a network provider.
Partial Hospitalization (5) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$55.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Home Health Services (6) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Group #7
Primary Care Physician Services (7a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Out-of-Network (OON) Benefits	
Group	Group #8
Chiropractic Services (7b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a medicare covered coinsurance?	No
Is there a medicare covered copayment?	Yes
Copayment amount	$20.00
Is there a medicare covered deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Group #7
Occupational Therapy Services (7c) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$20.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7

Physician Specialist Services (7d) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #13
Notes	$0 copay applies only to covered services performed in the home by a network provider. Higher copay is for covered services that are not the home.

Mental Health Specialty Services (7e) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Individual Sessions for Mental Health Specialty Services (7e1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Notes	$0 copay applies only to covered services performed in the home by a network provider. Higher copay is for covered services that are not the home.

Group Sessions for Mental Health Specialty Services (7e2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Podiatry Services (7f) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a medicare covered deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Group #13
Notes	Lower cost share represents Provider of Choice (POC) services versus specialists services.
Other Health Care Professional (7g) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Group #13
Notes	Lower cost share represents Provider of Choice (POC) services versus specialists services
Psychiatric Services (7h) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Individual Sessions for Psychiatric Services (7h1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Group Sessions for Psychiatric Services (7h2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Physical Therapy and Speech-Language Pathology Services (7i) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$20.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Additional Telehealth Benefits (7j) - Medicare	

Medicare-covered benefits that may have Additional Telehealth Benefits available	Urgently Needed Services(4b)
	Primary Care Physician Services(7a)
	Occupational Therapy Services(7c)
	Physician Specialist Services(7d)
	Individual Sessions for Mental Health Specialty Services(7e1)
	Group Sessions for Mental Health Specialty Services(7e2)
	Individual Sessions for Psychiatric Services(7h1)
	Group Sessions for Psychiatric Services(7h2)
	Physical Therapy and Speech-Language Pathology Services(7i)
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	$0 copay for Health Risk Assessment via telehealth. Telehealth copays for remaining service categories match their respective in-person copayment.
Opioid Treatment Program Services (7k) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No

Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Diagnostic Procedures/Tests/Lab Services (8a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a copayment?	No
Is there a deductible?	No
Diagnostic Procedures/Tests (8a1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Lab Services (8a2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a copayment?	Yes
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is there a deductible?	No
Diagnostic Radiological Services (8b1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$365.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Group #12
Notes	Members daily out-of-pocket cost is capped at the diagnostic radiological services copay.
Therapeutic Radiological Services (8b2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$60.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Outpatient X-Ray Services (8b3) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$10.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Outpatient Hospital Services (9a1) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$275.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Observation Services (9a2) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

Is there a copayment?	Yes
Copayment amount	$325.00
Periodicity	Per stay
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Ambulatory Surgical Center (ASC) Services (9b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$200.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Outpatient Substance Abuse (9c) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Group Sessions for Outpatient Substance Abuse (9c2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$30.00
Authorization required for this benefit?	Yes

Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #4
Outpatient Blood Services (9d) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Out of Network Group 2
Group - Non-Medicare	Out of Network Group 2
Ambulance Services (10a) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Is this Copayment waived if admitted to hospital?	Yes
Notes	The maximum copay per trip will apply. When the ambulance service meets Medicare guidelines you do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospital and/or skilled nursing facilities.
Ground Ambulance Services (10a1) - Medicare	
Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes

Copayment amount	$375.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	Yes
Out-of-Network (OON) Benefits	
Group	Group #5
Notes	The maximum copay per trip will apply. When the ambulance service meets Medicare guidelines you do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospital and/or skilled nursing facilities.
Air Ambulance Services (10a2) - Medicare	
Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$375.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	Yes
Out-of-Network (OON) Benefits	
Group	Group #5

Notes	The maximum copay per trip will apply. When the ambulance service meets Medicare guidelines you do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospital and/or skilled nursing facilities.
Durable Medical Equipment (DME) (11a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Is there a deductible?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 1
Prosthetics/Medical Supplies (11b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Prosthetic Devices (11b1) - Medicare	
Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 1

Medical Supplies (11b2) - Medicare	
Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 1
Diabetic Supplies and Services (11c) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Do you limit Diabetic supplies and services to those from specified manufacturers?	Yes
Diabetic Supplies (11c1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Dialysis Services (12) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Out of Network Group 1
Medicare-covered Zero Dollar Preventive Services (14a) - Medicare	
I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing	TRUE
Referral required for this benefit?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Kidney Disease Education Services (14d) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #7
Glaucoma Screening (14e1) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Diabetes Self-Management Training (14e2) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Barium Enemas (14e3) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Digital Rectal Exams (14e4) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
EKG following Welcome Visit (14e5) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No

Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Medicare Part B Rx Drugs (15) - Medicare	
I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.	TRUE
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B
	Part D to Part B
Out-of-Network (OON) Benefits	
Group - Non-Medicare	Out of Network Group 2
Medicare Part B Insulin Drugs (15-1) - Medicare	
Is there a coinsurance?	Yes with a min & max
Minimum coinsurance	0%
Maximum coinsurance	20%
Maximum effective cost-sharing amount per month	$35.00
Is there a copayment?	No
Does the Part B drugs – Insulin cost sharing count towards any plan-level deductible?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 1

Notes	Member will pay lessor of applicable coinsurance and $35 copayment cap
Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare	
Is there a coinsurance?	Yes with a min & max
Minimum coinsurance	0%
Maximum coinsurance	20%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Notes	Member will pay lessor of the maximum coinsurance or the adjusted coinsurance for certain Part B rebatable drugs as required by the Inflation Reduction Act
Other Medicare Part B Drugs (15-3) - Medicare	
Is there a coinsurance?	Yes with a min & max
Minimum coinsurance	0%
Maximum coinsurance	20%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Notes	Member will pay lessor of the maximum coinsurance or the adjusted coinsurance for certain Part B rebatable drugs as required by the Inflation Reduction Act
Medicare Dental Services (16a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$45.00
Is there a deductible?	No
Authorization required for this benefit?	No

Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #13
Eye Exams (17a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a deductible?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Group #13
Notes	For Medicare-covered eye exams, lower copay reflects services provided by primary care provider and higher copay reflects specialists services.
Eyewear (17b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Out of Network Group 2
Notes	You pay nothing for Medicare-covered standard eyeglasses or contact lenses, and for covered standard contact lenses due to keratoconus.
Hearing Exams (18a) - Medicare	

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$0.00
Maximum copayment	$45.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group - Medicare	Group #13
Notes	For Medicare-covered hearing exams, lower copay reflects services provided by primary care provider and higher copay reflects specialists services.
Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare	
Is this benefit unlimited?	Yes
Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Additional Days for Inpatient Hospital Psychiatric (1b1) - Non-Medicare	
Is this benefit unlimited?	Yes
Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	Yes
Notes	Includes mental health care services that require a hospital stay.
Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare	
Is there a maximum plan benefit coverage?	No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Worldwide Emergency Coverage (4c1) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$90.00
Is this Copayment waived if admitted to hospital?	Yes
Worldwide Urgent Coverage (4c2) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$90.00
Is this Copayment waived if admitted to hospital?	Yes
Worldwide Emergency Transportation (4c3) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	$90.00
Is this Copayment waived if admitted to hospital?	Yes
Notes	Emergency transportation such as emergency ambulance to the nearest appropriate facility that can provide care is covered by the plan.
Over-the-Counter (OTC) Items (13b) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	Yes
Maximum plan benefit coverage amount	$55.00
Periodicity	Every 3 Months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.	TRUE
Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Out-of-Network (OON) Benefits	
Group	Group #11
Meal Benefit (13c) - Non-Medicare	
Select the type of primarily health related meals benefit offered(Check all that apply):	Immediately following surgery or inpatient hospitalization
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2

Notes	After a discharge from an inpatient stay at a hospital or post outpatient surgery, members may be eligible for fully-prepared, home-delivered meals to help recover from illness/injuries and or manage health conditions. Up to 2 meals per weekday, up to 40 days per calendar year.
Annual Physical Exam (14b) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Notes	Annual Physical Exam services will include the following: bodily systems examinations, such as heart, lung, head and neck, and neurological system. Measurement and recording of vital signs such as blood pressure, heart rate, and respiratory rate. And, a complete prescription medication review, and a review of any recent hospitalizations
Other Defined Supplemental Benefits (14c) - Non-Medicare	
Is there a deductible?	No
Health Education (14c1) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Notes	Included is health education information in telephonic and print formats with live interactive support from qualified nurses and/or other qualified health care professionals to close gaps in care, coordinate health care professionals to close gaps in care, coordinate care and encourage adoption of healthy behaviors to improve self-care skills and health outcomes. Benefit also includes cognitive behavioral therapy that focuses on helping people with mental health conditions, such as anxiety, depression, sleep disorders etc via online modules and coaching.
Fitness Benefit (14c4) - Non-Medicare	
Indicate the type(s) of fitness benefits offered(check all that apply):	Physical Fitness
Is there a maximum plan benefit coverage amount?	Yes
Max plan benefit amount	$500.00
Periodicity	Every Year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No

Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #14
Notes	The plan offers a Fitness benefit of up to $500 each calendar year to participate in a qualified fitness program. A qualified fitness program is a full-service health club that provides a variety of cardiovascular and strength-training equipment for fitness and/or a participating Council on Aging (COA) site with instructor-led group classes for cardiovascular and strength-training such as yoga, pilates, zumba, kickboxing, and indoor cycling. A qualified fitness program also includes pool-only facilities. A qualified fitness program also includes virtual/online fitness memberships, subscriptions, programs, or classes that provide cardiovascular and strength training using a digital platform. Also covered is Home Fitness Equipment like stationary bikes, weights, exercise bands, treadmills, fitness machines. Home Fitness Equipment will not cover items
Enhanced Disease Management (14c5) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Remote Access Technologies (including Web/Phone-based technologies	
Select the type of Remote Access Technologies offered	Nursing Hotline
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance Nursing Hotline?	No
Is there a copayment Nursing Hotline?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Notes	With the Blue Care Line, members can speak with a registered nurse 24 hours a day, 7 days a week. Experienced professionals are always available to offer expert answers to medical questions. Members simply explain the situation, detail their symptoms, and our nurses will provide guidance.
Wigs for Hair Loss Related to Chemotherapy (14c15) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	Yes
Maximum amount	$500.00
Periodicity	Every Year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Out of Network Group 6
Notes	Wigs are covered up to $500 per calendar year when hair loss is due to: chemotherapy, radiation therapy, treatment of cancer or leukemia. Wigs are not covered when hair loss is due to male pattern baldness, female pattern baldness or natural or premature aging. You pay any balance in excess of the $500 limit.
Weight Management Programs (14c16) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	Yes
Maximum amount	$250.00
Periodicity	Every Year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #16

Notes	The plan offers a Weight Loss benefit of up to $250 each calendar year to use toward a qualified weight loss program. A qualified weight loss program is a hospital-based or a non-hospital-based weight loss program that focuses on weight loss by modifying eating and physical activity habits and that requires participation in behavioral/lifestyle counseling with nutritionists, registered dieticians, exercise physiologists or other certified health professionals in multiple sessions throughout enrollment in the program. Program delivery and counseling may be in-person, over the phone, or online. Meal provisions are not covered.
Diagnostic and Preventive Dental (16b) - Non-Medicare	
Is there a maximum plan benefit coverage?	Yes
Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services?	Both in-network and out-of-network services
Maximum amount	$1500.00
Periodicity	Every Year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No

Oral Exams (16b1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	3
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #10
Notes	One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures. Periodic or routine oral exams 3 times per calendar year. Emergency exams.
Dental X-Rays (16b2) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of X-Rays	7
Periodicity	Other, Describe
Description	Full mouth X-rays, 7 or more films, or panoramic X-ray with bitewing X-rays once every 60 months. Bitewing X-rays once every 6 months. Single-tooth X-rays as needed.
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #10
Other Diagnostic Dental Services (16b3) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe

Description	Study models and casts used in planning treatment, once each 60 months
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #10
Prophylaxis (cleaning) (16b4) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	3
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #10
Notes	Routine cleaning, scaling, and polishing of the teeth 3 times per calendar year.
Comprehensive Dental (16c) - Non-Medicare	
Service maximum plan benefit coverage:	Yes
Select the maximum plan benefit coverage type	Covered under Diagnostic and Preventive Dental (16b)
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Restorative Services (16c1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Silver and white fillings: once per tooth in 12 months. Inlays: once per tooth in 60 months.

Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Endodontics (16c2) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Root canals and retreatment of prior root canal on permanent teeth: once per tooth.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Periodontics (16c3) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Periodontal scaling and root planning: once per quadrant per 24 months. Periodontal Surgery: once per quadrant per 36 months. Maintenance following active periodontal therapy: once within three months
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	

Group	Group #15
Prosthodontics, removable (16c4) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes Section for 16c4 for comprehensive list
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Due to the character limit in the Periodicity section, the periodicity limits are outlined below: -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing

Maxillofacial Prosthetics (16c5) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes Section for 16c5 for comprehensive list
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Due to the character limit in the Periodicity section, the periodicity limits are outlined below: -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Implant Services (16c6) - Non-Medicare	

Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes Section for 16c6 for comprehensive list
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Due to the character limit in the Periodicity section, the periodicity limits are outlined below: -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Prosthodontics, fixed (16c7) - Non-Medicare	
Is this benefit unlimited?	No

Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes Section for 16c7 for comprehensive list
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Due to the character limit in the Periodicity section, the periodicity limits are outlined below: -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Oral and Maxillofacial Surgery (16c8) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1

Periodicity	Other, Describe
Description	See Notes Section for 16c8 for comprehensive list
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Due to the character limit in the Periodicity section, the periodicity limits are outlined below: -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Adjunctive General Services (16c10) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage	50%

Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #15
Notes	Services to treat root sensitivity, emergency dental care to relieve acute pain (palliative care), emergency dental care to control a dental condition that requires immediate care to prevent permanent harm, general anesthesia for covered oral surgery.
Eye Exams (17a) - Non-Medicare	
Is there a maximum plan benefit coverage?	No
Is there a deductible?	No
Routine Eye Exams (17a1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 3
Eyewear (17b) - Non-Medicare	
Is there a maximum plan benefit coverage?	Yes
Select the maximum plan benefit coverage type	Plan-specified amount per period
Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services	Both in-network and out-of-network services

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	$200.00
Periodicity	Every 2 Years
Is there a deductible?	No
Notes	You pay all costs after $200 for routine spectacle lenses, frames, fittings, dispensing fees and contact lenses every 24 months.
Contact Lenses (17b1) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Eyeglasses (lenses and frames) (17b2) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Eyeglass lenses (17b3) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Eyeglass frames (17b4) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	No

Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 2
Hearing Exams (18a) - Non-Medicare	
Is there a maximum plan benefit coverage?	No
Is there a deductible?	No
Routine Hearing Exams (18a1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 3
Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Out of Network Group 3
Notes	Each hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following hearing aid purchase and only with the purchase of a hearing aid.
Prescription Hearing Aids (18b) - Non-Medicare	
Service maximum plan benefit coverage:	No

Service maximum enrollee out-of-pocket cost (MOOP):	No
Is there a deductible?	No
Prescription Hearing Aids (all types) (18b1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate quantity for Hearing Aids	2
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	$699.00
Maximum copayment	$999.00
Referral required for this benefit?	No
Authorization required for this benefit?	No
Out-of-Network (OON) Benefits	
Group	Group #9
Notes	Lower copay is for standard hearing aid option and higher copay is for premium hearing aid option.
Rx	
Rx Characteristics	
Medicare-defined Part D Deductible amount	$590.00
Medicare-defined Part D Coinsurance amount	25%
Medicare-defined Part D Annual Out-of-Pocket cost threshold	$2000.00
Cap for one-month supply of each Part D-covered insulin	$35
Rx Setup	
Select the type of drug benefit	Enhanced Alternative
Retail	Standard/Preferred Retail
Mail-Order	Standard Mail-Order
Long-Term Care	Yes
Out-of-Network	Yes
Sponsor attests that it will comply with 42 CFR 423.154	Yes

Does this plan offer free first fill (i.e. $0 copayment) for any drugs? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 7, 2024 at 11:59 am Eastern Time.	No
Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 7, 2024 at 11:59 am Eastern Time.	No
Tiering	
Number of tiers in the Part D benefit	5
Does this plan offer a tier model with an optional tier	No
Select Formulary Tier Model	Preferred Generic, Generic, Preferred Brand, Non-Preferred Drug, Specialty Tier
What is your Formulary Exceptions Tier?	Tier 4 - Non-Preferred Drug
Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?	No
Rx Cost Share	
Does this plan offer reduced Part D cost sharing as part of your supplemental Part D benefit?	Yes
Indicate the area(s) throughout the Part D benefit where the increase in actuarial value of benefits is reflected (select all that apply):	Reduced Deductible, Reduced Initial Coverage Phase cost shares

Reduced Cost Sharing Notes:	Through the $0 deductible, flat-dollar copayments on Tiers 1 and 2, and coinsurances for Tiers 3, 4, and 5 that comply with both CY 2025 Final Part D Bidding Instructions and (in the case of Tier 5) Annual Updates for Part D Specialty Tier Calculation, the actuarial value for this plan exceeds the Defined Standard actuarial value. The BPT shows the actuarial equivalence tests on Worksheet 5, section VI are met.
Does this plan charge the Medicare-defined Part D deductible amount (Deductible does not apply for covered insulin drugs and adult vaccines)?	No Deductible
Indicate the Out-of-Network (OON) cost sharing structure for this plan:	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable
""Does this plan cover excluded drugs as part of supplemental coverage (e.g., drugs used to treat erectile dysfunction)? (If you select "Yes" to "Do you cover excluded drugs as part of your supplemental coverage (e.g., drugs used to treat erectile dysfunction)?", you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 7, 2024 at 11:59 am Eastern Time.)""	No
How does this plan apply cost sharing in the Initial Coverage Phase?	Cost-Share Tiers
How does this plan apply cost sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?	No cost sharing

Rx Tier Locations	
Standard/Preferred Retail	
Select the 1-month location supply for all tiers offered:	30
Do you offer 2-Month supply?	Yes
Indicate each tier for which the location supply applies: (Select all that apply)	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug
Select the 2-month location supply for all tiers offered:	60
Do you offer 3-Month supply?	Yes
Indicate each tier for which the location supply applies: (Select all that apply)	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug
Standard Mail-Order	
Do you offer 1-Month supply?	Yes
Indicate each tier for which the location supply applies: (Select all that apply)	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug, Tier 5 - Specialty Tier
Do you offer 2-Month supply?	Yes
Indicate each tier for which the location supply applies: (Select all that apply)	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug
Do you offer 3-Month supply?	Yes
Indicate each tier for which the location supply applies: (Select all that apply)	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug

Rx Tier 1 - Preferred Generic	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes

Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	100
Standard Mail-Order	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	100
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 1 Initial Coverage Phase - Preferred Generic	
Cost-Share Structure	Copayment
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$10.00
Daily Copayment 1-month	$0.33
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$20.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	$30.00
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$0.00
Daily Copayment 1-month	$0.00
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$0.00
3-Month Supply	

Select days for 3-month supply	100
Copayment 3-month supply	$0.00
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$0.00
Daily Copayment 1-month	$0.00
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$0.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	$0.00
Long Term Care	
Select days for long-term care supply	31
Copayment 1-month supply	$10.00
Daily Copayment 1-month	$0.32
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	$10.00
Rx Tier 1 Post OOP - Preferred Generic	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Tier 2 - Generic	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	

Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	100
Standard Mail-Order	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	100
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 2 Initial Coverage Phase - Generic	
Cost-Share Structure	Copayment
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$20.00
Daily Copayment 1-month	$0.67
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$40.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	$60.00
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$10.00
Daily Copayment 1-month	$0.33
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$20.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	$30.00

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	$10.00
Daily Copayment 1-month	$0.33
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	$20.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	$20.00
Long Term Care	
Select days for long-term care supply	31
Copayment 1-month supply	$20.00
Daily Copayment 1-month	$0.65
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	$20.00
Rx Tier 2 Post OOP - Generic	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Tier 3 - Preferred Brand	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Select days for 2-month supply	60

Select days for 3-month supply	90
Standard Mail-Order	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 3 Initial Coverage Phase - Preferred Brand	
Cost-Share Structure	Coinsurance
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	24%
Average Expected Cost-Sharing Amount	$101.03
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	24%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	24%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	24%
Average Expected Cost-Sharing Amount	$101.24
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	24%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	24%

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	24%
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	24%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	24%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	24%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	24%
Rx Tier 3 Post OOP - Preferred Brand	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Tier 4 - Non-Preferred Drug	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Standard Mail-Order	

Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 4 Initial Coverage Phase - Non-Preferred Drug	
Cost-Share Structure	Coinsurance
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	49%
Average Expected Cost-Sharing Amount	$99.28
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	49%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	49%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	49%
Average Expected Cost-Sharing Amount	$51.95
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	49%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	49%

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	49%
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	49%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	49%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	49%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	49%
Rx Tier 4 Post OOP - Non-Preferred Drug	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Tier 5 - Specialty Tier	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Standard Mail-Order	
Select days for 1-month supply	30
Long Term Care	

Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 5 Initial Coverage Phase - Specialty Tier	
Cost-Share Structure	Coinsurance
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	33%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	33%
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	33%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	33%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	33%
Rx Tier 5 Post OOP - Specialty Tier	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Attestations	
I attest that the values entered have been reviewed by the plan's certifying actuary and are accurate.	Yes

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.	Yes
Rx Insulin	
Indicate which tiers have insulin drugs (Select all that apply):	Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug, Tier 5 - Specialty Tier
Rx Insulin Tier 1 - Preferred Generic	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	$10.00
Copayment 2-month supply	$20.00
Copayment 3-month supply	$30.00
Preferred Retail	
Copayment 1-month supply	$0.00
Copayment 2-month supply	$0.00
Copayment 3-month supply	$0.00
Standard Mail-Order	
Copayment 1-month supply	$0.00
Copayment 2-month supply	$0.00
Copayment 3-month supply	$0.00
Long-Term Care	
Copayment 1-month supply	$10.00
Out-of-Network	

Copayment 1-month supply	$10.00
Rx Insulin Tier 2 - Generic	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	$20.00
Copayment 2-month supply	$40.00
Copayment 3-month supply	$60.00
Preferred Retail	
Copayment 1-month supply	$10.00
Copayment 2-month supply	$20.00
Copayment 3-month supply	$30.00
Standard Mail-Order	
Copayment 1-month supply	$10.00
Copayment 2-month supply	$20.00
Copayment 3-month supply	$20.00
Long-Term Care	
Copayment 1-month supply	$20.00
Out-of-Network	
Copayment 1-month supply	$20.00
Rx Insulin Tier 3 - Preferred Brand	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$105.00
Preferred Retail	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$105.00
Standard Mail-Order	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$70.00
Long-Term Care	
Copayment 1-month supply	$35.00
Out-of-Network	
Copayment 1-month supply	$35.00

Rx Insulin Tier 4 - Non-Preferred Drug	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$105.00
Preferred Retail	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$105.00
Standard Mail-Order	
Copayment 1-month supply	$35.00
Copayment 2-month supply	$70.00
Copayment 3-month supply	$70.00
Long-Term Care	
Copayment 1-month supply	$35.00
Out-of-Network	
Copayment 1-month supply	$35.00
Rx Insulin Tier 5 - Specialty Tier	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	$35.00
Preferred Retail	
Copayment 1-month supply	$35.00
Standard Mail-Order	
Copayment 1-month supply	$35.00
Long-Term Care	
Copayment 1-month supply	$35.00
Out-of-Network	
Copayment 1-month supply	$35.00
Rx Notes	
No Data Saved for Selected Section, Incomplete or Not Started.	
Rx VBID	
No Data Saved for Selected Section, Incomplete or Not Started.	