

## PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

Data Report for Contract H2261, Plan 005 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 HMO Blue PlusRx (HMO)
Plan Geographic Name	Massachusetts except Berkshire Dukes and Nantucket

#### Plan Details

Plan Type	HMO
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)?	No
Does this plan offer Out-of-Network Services (OON)?	No
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 (HMO Plan)

Lower MOOP Limit	\$0 - \$4150 In-network
Intermediate MOOP Limit	\$4151 - \$6750 In-network
Mandatory MOOP Limit	\$6751 - \$9350 In-network

### Standard Bid

Does this plan offer a standard bid for In-Network service categories?	No
Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan offer a standard bid for Visitor Travel Program V/T?	No
<b>Benefit Offerings</b>	
Medicare Services	
Inpatient Hospital-Acute(1a)	
In Network (INN)	Required
Inpatient Hospital Psychiatric(1b)	
In Network (INN)	Required
Skilled Nursing Facility (SNF)(2)	
In Network (INN)	Required
Cardiac Rehabilitation Services(3-1)	
In Network (INN)	Required
Intensive Cardiac Rehabilitation Services(3-2)	
In Network (INN)	Required
Pulmonary Rehabilitation Services(3-3)	
In Network (INN)	Required
SET for PAD Services(3-4)	
In Network (INN)	Required
Emergency Services(4a)	
In Network (INN)	Required
Urgently Needed Services(4b)	
In Network (INN)	Required
Partial Hospitalization(5)	
In Network (INN)	Required
Home Health Services(6)	
In Network (INN)	Required
Primary Care Physician Services(7a)	
In Network (INN)	Required
Chiropractic Services(7b)	
In Network (INN)	Required
Occupational Therapy Services(7c)	
In Network (INN)	Required

Physician Specialist Services(7d)	
In Network (INN)	Required
Individual Sessions for Mental Health Specialty Services(7e1)	
In Network (INN)	Required
Group Sessions for Mental Health Specialty Services(7e2)	
In Network (INN)	Required
Podiatry Services(7f)	
In Network (INN)	Required
Other Health Care Professional(7g)	
In Network (INN)	Required
Individual Sessions for Psychiatric Services(7h1)	
In Network (INN)	Required
Group Sessions for Psychiatric Services(7h2)	
In Network (INN)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	
In Network (INN)	Required
Additional Telehealth Benefits(7j)	
In Network (INN)	Yes
Opioid Treatment Program Services(7k)	
In Network (INN)	Required
Diagnostic Procedures/Tests(8a1)	
In Network (INN)	Required
Lab Services(8a2)	
In Network (INN)	Required
Diagnostic Radiological Services(8b1)	
In Network (INN)	Required
Therapeutic Radiological Services(8b2)	
In Network (INN)	Required
Outpatient X-Ray Services(8b3)	
In Network (INN)	Required
Outpatient Hospital Services(9a1)	
In Network (INN)	Required
Observation Services(9a2)	
In Network (INN)	Required
Ambulatory Surgical Center (ASC) Services(9b)	
In Network (INN)	Required
Individual Sessions for Outpatient Substance Abuse(9c1)	

In Network (INN)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	
In Network (INN)	Required
Outpatient Blood Services(9d)	
In Network (INN)	Required
Ground Ambulance Services(10a1)	
In Network (INN)	Required
Air Ambulance Services(10a2)	
In Network (INN)	Required
Durable Medical Equipment (DME)(11a)	
In Network (INN)	Required
Prosthetic Devices(11b1)	
In Network (INN)	Required
Medical Supplies(11b2)	
In Network (INN)	Required
Diabetic Supplies(11c1)	
In Network (INN)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	
In Network (INN)	Required
Dialysis Services(12)	
In Network (INN)	Required
Medicare-covered Zero Dollar Preventive Services(14a)	
In Network (INN)	Required
Kidney Disease Education Services(14d)	
In Network (INN)	Required
Glaucoma Screening(14e1)	
In Network (INN)	Required
Diabetes Self-Management Training(14e2)	
In Network (INN)	Required
Barium Enemas(14e3)	
In Network (INN)	Required
Digital Rectal Exams(14e4)	
In Network (INN)	Required
EKG following Welcome Visit(14e5)	
In Network (INN)	Required
Medicare Part B Insulin Drugs(15-1)	
In Network (INN)	Required

Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In Network (INN)	Required
Other Medicare Part B Drugs(15-3)	
In Network (INN)	Required
Medicare Dental Services(16a)	
In Network (INN)	Required
Eye Exams(17a)	
In Network (INN)	Required
Eyewear(17b)	
In Network (INN)	Required
Hearing Exams(18a)	
In Network (INN)	Required
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
Meal Benefit(13c)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Annual Physical Exam(14b)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory

Health Education(14c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Fitness Benefit(14c4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Enhanced Disease Management(14c5)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Remote Access Technologies (including Web/Phone-based technologies)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Wigs for Hair Loss Related to Chemotherapy(14c15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Weight Management Programs(14c16)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Home infusion bundled services(15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Oral Exams(16b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Dental X-Rays(16b2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Prophylaxis (cleaning)(16b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Routine Eye Exams(17a1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Contact Lenses(17b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Eyeglasses (lenses and frames)(17b2)	

In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Eyeglass lenses(17b3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Eyeglass frames(17b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Routine Hearing Exams(18a1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Prescription Hearing Aids (all types)(18b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
<b>Plan Level Cost Sharing</b>	
<b>Plan Level Cost Sharing</b>	
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?	No
<b>Annual Plan Deductible</b>	
Does this plan have an In-Network plan deductible?	No
<b>Max Enrollee Cost Limit</b>	
Does this plan have an In-Network MOOP?	Yes

What type of In-Network MOOP does your plan offer?	Lower
In Network MOOP Amount	\$3800.00
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
<b>Medicare Services</b>	
<b>Inpatient Hospital-Acute(1a)</b>	
In-Network	Yes
<b>Inpatient Hospital Psychiatric(1b)</b>	
In-Network	Yes
<b>Skilled Nursing Facility (SNF)(2)</b>	
In-Network	Yes
<b>Cardiac Rehabilitation Services(3-1)</b>	
In-Network	Yes
<b>Intensive Cardiac Rehabilitation Services(3-2)</b>	
In-Network	Yes
<b>Pulmonary Rehabilitation Services(3-3)</b>	
In-Network	Yes
<b>SET for PAD Services(3-4)</b>	
In-Network	Yes
<b>Emergency Services(4a)</b>	
In-Network	Yes
<b>Urgently Needed Services(4b)</b>	
In-Network	Yes
<b>Partial Hospitalization(5)</b>	
In-Network	Yes
<b>Home Health Services(6)</b>	
In-Network	Yes
<b>Primary Care Physician Services(7a)</b>	
In-Network	Yes
<b>Chiropractic Services(7b)</b>	
In-Network	Yes

Occupational Therapy Services(7c)	
In-Network	Yes
Physician Specialist Services(7d)	
In-Network	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In-Network	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In-Network	Yes
Podiatry Services(7f)	
In-Network	Yes
Other Health Care Professional(7g)	
In-Network	Yes
Individual Sessions for Psychiatric Services(7h1)	
In-Network	Yes
Group Sessions for Psychiatric Services(7h2)	
In-Network	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	
In-Network	Yes
Additional Telehealth Benefits(7j)	
In-Network	Yes
Opioid Treatment Program Services(7k)	
In-Network	Yes
Diagnostic Procedures/Tests(8a1)	
In-Network	Yes
Lab Services(8a2)	
In-Network	Yes
Diagnostic Radiological Services(8b1)	
In-Network	Yes
Therapeutic Radiological Services(8b2)	
In-Network	Yes
Outpatient X-Ray Services(8b3)	
In-Network	Yes
Outpatient Hospital Services(9a1)	
In-Network	Yes
Observation Services(9a2)	
In-Network	Yes
Ambulatory Surgical Center (ASC) Services(9b)	

In-Network	Yes
Individual Sessions for Outpatient Substance Abuse(9c1)	
In-Network	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	
In-Network	Yes
Outpatient Blood Services(9d)	
In-Network	Yes
Ground Ambulance Services(10a1)	
In-Network	Yes
Air Ambulance Services(10a2)	
In-Network	Yes
Durable Medical Equipment (DME)(11a)	
In-Network	Yes
Prosthetic Devices(11b1)	
In-Network	Yes
Medical Supplies(11b2)	
In-Network	Yes
Diabetic Supplies(11c1)	
In-Network	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	
In-Network	Yes
Dialysis Services(12)	
In-Network	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In-Network	Yes
Kidney Disease Education Services(14d)	
In-Network	Yes
Glaucoma Screening(14e1)	
In-Network	Yes
Diabetes Self-Management Training(14e2)	
In-Network	Yes
Barium Enemas(14e3)	
In-Network	Yes
Digital Rectal Exams(14e4)	
In-Network	Yes
EKG following Welcome Visit(14e5)	
In-Network	Yes

<b>Medicare Part B Insulin Drugs(15-1)</b>	
In-Network	Yes
<b>Medicare Part B Chemotherapy/Radiation Drugs(15-2)</b>	
In-Network	Yes
<b>Other Medicare Part B Drugs(15-3)</b>	
In-Network	Yes
<b>Medicare Dental Services(16a)</b>	
In-Network	Yes
<b>Eye Exams(17a)</b>	
In-Network	Yes
<b>Eyewear(17b)</b>	
In-Network	Yes
<b>Hearing Exams(18a)</b>	
In-Network	Yes
<b>Prior Authorization &amp; Referral</b>	
<b>Prior Authorization</b>	
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)
	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)
Additional Telehealth Benefits(7j)
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)
Dialysis Services(12)
Medicare-covered Zero Dollar Preventive Services(14a)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Lab Services(8a2)

**Referral**

Is referral required for any In-Network service categories? Yes

Select the In-Network service categories that requires a referral:

- Physician Specialist Services(7d)
- Podiatry Services(7f)
- Physical Therapy and Speech-Language Pathology Services(7i)
- Additional Telehealth Benefits(7j)
- Barium Enemas(14e3)

**Visitor Travel**

Does this plan offer the US Visitor/Travel Program (V/T)?	No
<b>Cost Share Groups</b>	
<b>Combined Benefits Groups</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>Reduction in Cost Sharing Groups</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>Optional Supplemental Packages</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>VBID</b>	
Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Does this plan offer Special Supplemental Benefits for Chronically III?	No
<b>VBID/MA UF/SSBCI Reduction in Cost Sharing Packages (19a)</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>VBID/MA UF/SSBCI Additional Benefits Packages (19b)</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>Benefit Details</b>	
<b>Inpatient Hospital-Acute (1a) - Medicare</b>	
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	\$125.00
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
<b>Inpatient Hospital Psychiatric (1b) - Medicare</b>	
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	\$125.00
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
Notes	Includes mental health care services that require a hospital stay.
<b>Skilled Nursing Facility (SNF) (2) - Medicare</b>	
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	3
Copayment	\$0.00
Begin Day	1
End Day	20
Copayment	\$100.00
Begin Day	21
End Day	44
Copayment	\$0.00
Begin Day	45
End Day	100

Periodicity	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Cardiac and Pulmonary Rehabilitation Services (3) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
<b>Cardiac Rehabilitation Services (3-1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$5.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Intensive Cardiac Rehabilitation Services (3-2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$5.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Pulmonary Rehabilitation Services (3-3) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$5.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>SET for PAD Services (3-4) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$5.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Emergency Services (4a) - Medicare</b>	
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	\$140.00
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	<p>You do not pay the ER copayment if you are held overnight at the hospital for observation.</p> <p>If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.</p>
<b>Urgently Needed Services (4b) - Medicare</b>	
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	\$30.00
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	Lower copay applies to PCP and to covered services performed in the home by a network provider. Higher copay is for specialists for services not in the home.

**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

**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

**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

**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	\$15.00
Is there a medicare covered deductible?	No

Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Occupational Therapy Services (7c) - Medicare</b>	
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	\$15.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Physician Specialist Services (7d) - Medicare</b>	
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	\$30.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
Notes	\$0 copay and no referral required applies only to covered services performed in the home by a network provider. Higher copay is for covered services that are not the home.
<b>Mental Health Specialty Services (7e) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
<b>Individual Sessions for Mental Health Specialty Services (7e1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00

Maximum copayment	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
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.
<b>Group Sessions for Mental Health Specialty Services (7e2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Podiatry Services (7f) - Medicare</b>	
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	\$30.00
Is there a medicare covered deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes
Notes	Lower cost share represents PCP services versus specialists services.
<b>Other Health Care Professional (7g) - Medicare</b>	
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	\$30.00
Is there a deductible?	No

Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	Lower cost share represents PCP services versus specialists services.
<b>Psychiatric Services (7h) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
<b>Individual Sessions for Psychiatric Services (7h1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Group Sessions for Psychiatric Services (7h2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Physical Therapy and Speech-Language Pathology Services (7i) - Medicare</b>	
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	\$15.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
<b>Additional Telehealth Benefits (7j) - Medicare</b>	
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	\$30.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
Notes	\$0 copay for Health Risk Assessment via telehealth. Telehealth copays for remaining service categories match their respective in-person copayment.
<b>Opioid Treatment Program Services (7k) - Medicare</b>	
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
<b>Diagnostic Procedures/Tests/Lab Services (8a) - Medicare</b>	
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

<b>Diagnostic Procedures/Tests (8a1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Lab Services (8a2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare</b>	
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
<b>Diagnostic Radiological Services (8b1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$150.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes	Members daily out-of-pocket cost is capped at the diagnostic radiological services copay.
<b>Therapeutic Radiological Services (8b2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Outpatient X-Ray Services (8b3) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$5.00
Authorization required for this benefit?	No

Referral required for this benefit?	No
<b>Outpatient Hospital Services (9a1) - Medicare</b>	
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	\$150.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Observation Services (9a2) - Medicare</b>	
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
<b>Ambulatory Surgical Center (ASC) Services (9b) - Medicare</b>	
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	\$100.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Outpatient Substance Abuse (9c) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
<b>Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes

Copayment amount	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Group Sessions for Outpatient Substance Abuse (9c2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
<b>Outpatient Blood Services (9d) - Medicare</b>	
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
<b>Ambulance Services (10a) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Is this Copayment waived if admitted to hospital?	Yes
Notes	<p>The maximum copay per trip will apply.</p> <p>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.</p>
<b>Ground Ambulance Services (10a1) - Medicare</b>	

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	\$150.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	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.

**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	\$150.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	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.
<b>Durable Medical Equipment (DME) (11a) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Coinsurance percentage	10%
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
<b>Prosthetics/Medical Supplies (11b) - Medicare</b>	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
<b>Prosthetic Devices (11b1) - Medicare</b>	
Is there a coinsurance?	Yes
Coinsurance percentage	10%
Is there a copayment?	No
Authorization required for this benefit?	No
<b>Medical Supplies (11b2) - Medicare</b>	
Is there a coinsurance?	Yes
Coinsurance percentage	10%
Is there a copayment?	No

Authorization required for this benefit?	No
<b>Diabetic Supplies and Services (11c) - Medicare</b>	
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
<b>Diabetic Supplies (11c1) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
<b>Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
<b>Dialysis Services (12) - Medicare</b>	
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?	Yes
Referral required for this benefit?	No
<b>Medicare-covered Zero Dollar Preventive Services (14a) - Medicare</b>	
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
<b>Kidney Disease Education Services (14d) - Medicare</b>	

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
<b>Glaucoma Screening (14e1) - Medicare</b>	
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
<b>Diabetes Self-Management Training (14e2) - Medicare</b>	
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
<b>Barium Enemas (14e3) - Medicare</b>	
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?	Yes
<b>Digital Rectal Exams (14e4) - Medicare</b>	

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
<b>EKG following Welcome Visit (14e5) - Medicare</b>	
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
<b>Medicare Part B Rx Drugs (15) - Medicare</b>	
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
<b>Medicare Part B Insulin Drugs (15-1) - Medicare</b>	
Is there a coinsurance?	Yes with a min & max

Minimum coinsurance	0%
Maximum coinsurance	10%
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
Notes	Member will pay lessor of applicable coinsurance and \$35 copayment cap
<b>Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare</b>	
Is there a coinsurance?	Yes with a min & max
Minimum coinsurance	0%
Maximum coinsurance	10%
Is there a copayment?	No
Authorization required for this benefit?	Yes
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
<b>Other Medicare Part B Drugs (15-3) - Medicare</b>	
Is there a coinsurance?	Yes with a min & max
Minimum coinsurance	0%
Maximum coinsurance	10%
Is there a copayment?	No
Authorization required for this benefit?	Yes
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
<b>Medicare Dental Services (16a) - Medicare</b>	
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	\$30.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Eye Exams (17a) - Medicare</b>	
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	\$30.00
Is there a deductible?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Notes	For Medicare-covered eye exams, lower copay reflects services provided by primary care provider and higher copay reflects specialists services.
<b>Eyewear (17b) - Medicare</b>	
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
Notes	You pay nothing for Medicare-covered standard eyeglasses or contact lenses, and for covered standard contact lenses due to keratoconus.
<b>Hearing Exams (18a) - Medicare</b>	

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	\$30.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	For Medicare-covered hearing exams, lower copay reflects services provided by primary care provider and higher copay reflects specialists services.
<b>Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare</b>	
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
<b>Additional Days for Inpatient Hospital Psychiatric (1b1) - Non-Medicare</b>	
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.
<b>Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare</b>	
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
<b>Worldwide Emergency Coverage (4c1) - Non-Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$75.00
Is this Copayment waived if admitted to hospital?	Yes
<b>Worldwide Urgent Coverage (4c2) - Non-Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$75.00
Is this Copayment waived if admitted to hospital?	Yes
<b>Worldwide Emergency Transportation (4c3) - Non-Medicare</b>	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$75.00
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.
<b>Meal Benefit (13c) - Non-Medicare</b>	
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
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.
<b>Annual Physical Exam (14b) - Non-Medicare</b>	
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
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. A complete prescription medication review. And, a review of any recent hospitalizations
<b>Other Defined Supplemental Benefits (14c) - Non-Medicare</b>	
Is there a deductible?	No
<b>Health Education (14c1) - Non-Medicare</b>	
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
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 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.
<b>Fitness Benefit (14c4) - Non-Medicare</b>	
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	\$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

Notes	<p>The plan offers a Fitness benefit of up to \$250 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</p>
<b>Enhanced Disease Management (14c5) - Non-Medicare</b>	
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
<b>Remote Access Technologies (including Web/Phone-based technologies</b>	
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
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.
<b>Wigs for Hair Loss Related to Chemotherapy (14c15) - Non-Medicare</b>	
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

Notes	Wigs are covered up to a \$500 maximum per calendar year when hair loss is due to:chemotherapy, radiation therapy, orthe treatment of cancer or leukemia. Wigs are not covered when hair loss is due to male pattern baldness, female pattern baldness, natural or premature aging. You pay any balance in excess of the \$500 limit.
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**Weight Management Programs (14c16) - Non-Medicare**

Is there a maximum plan benefit coverage amount?	Yes
Maximum amount	\$150.00
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

Notes	<p>The plan offers a Weight Loss benefit of up to \$150 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.</p>
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**Diagnostic and Preventive Dental (16b) - 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 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	2
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
<b>Dental X-Rays (16b2) - Non-Medicare</b>	
Is this benefit unlimited?	No
Indicate number of X-Rays	2
Periodicity	Other, Describe
Description	One set of bitewings twice per calendar year.
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
<b>Prophylaxis (cleaning) (16b4) - Non-Medicare</b>	
Is this benefit unlimited?	No
Indicate number of visits	2
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
<b>Eye Exams (17a) - Non-Medicare</b>	
Is there a maximum plan benefit coverage?	No
Is there a deductible?	No
<b>Routine Eye Exams (17a1) - Non-Medicare</b>	
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
<b>Eyewear (17b) - Non-Medicare</b>	
Is there a maximum plan benefit coverage?	Yes
Select the maximum plan benefit coverage type	Plan-specified amount per period

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.
<b>Contact Lenses (17b1) - Non-Medicare</b>	
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
<b>Eyeglasses (lenses and frames) (17b2) - Non-Medicare</b>	
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
<b>Eyeglass lenses (17b3) - Non-Medicare</b>	
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
<b>Eyeglass frames (17b4) - Non-Medicare</b>	
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
<b>Hearing Exams (18a) - Non-Medicare</b>	
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

**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
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

Notes	Lower copay is for standard hearing aid option and higher copay is for premium hearing aid option.
<b>Rx</b>	
<b>Rx Characteristics</b>	
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
<b>Rx Setup</b>	
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
<b>Tiering</b>	

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
<b>Rx Cost Share</b>	
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 \$200 deductible applies only to Tiers 3-5 (which is also less than the Defined Standard), flat-dollar copays on Tiers 1-4 that comply with the CY 2025 Final Part D Bidding Instructions, and Tier 5 coinsurance that complies with both CY 2025 Final Part D Bidding Instructions and Annual Updates for Part D Specialty Tier Calculation, the actuarial 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, Enter Amount
Enter Deductible Amount	\$200.00
Does the Deductible apply to all tiers?	No
Indicate each tier for which the deductible will NOT apply (select all that apply, please note that the deductible will not apply to any of the drugs on each tier selected):	Tier 1 - Preferred Generic, Tier 2 - Generic
Is the cost sharing for drugs to which the deductible does not apply the same as the Initial Coverage Phase cost sharing?	Yes
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

<b>Rx Tier Locations</b>	
<b>Standard/Preferred Retail</b>	
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
<b>Standard Mail-Order</b>	
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
<b>Rx Tier 1 - Preferred Generic</b>	
<b>Tier Drug Type(s)</b>	
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
<b>Rx Tier 1 Initial Coverage Phase - Preferred Generic</b>	
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	\$6.00
Daily Copayment 1-month	\$0.20
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$12.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$18.00
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
<b>Standard Mail-Order Cost Sharing</b>	
<b>1-Month Supply</b>	
Select days for 1-month supply	30
Copayment 1-month supply	\$0.00
Daily Copayment 1-month	\$0.00
<b>2-Month Supply</b>	
Select days for 2-month supply	60
Copayment 2-month supply	\$0.00
<b>3-Month Supply</b>	
Select days for 3-month supply	100
Copayment 3-month supply	\$0.00
<b>Long Term Care</b>	
Select days for long-term care supply	31
Copayment 1-month supply	\$6.00
Daily Copayment 1-month	\$0.19
<b>Out of Network</b>	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$6.00
<b>Rx Tier 1 Post OOP - Preferred Generic</b>	
Cost-Share Structure	Copayment
Copayment	\$0.00
<b>Rx Tier 2 - Generic</b>	
<b>Tier Drug Type(s)</b>	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
<b>Standard/Preferred Retail</b>	

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
<b>Rx Tier 2 Initial Coverage Phase - Generic</b>	
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	\$5.00
Daily Copayment 1-month	\$0.17
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$10.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$15.00

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
<b>Standard Mail-Order Cost Sharing</b>	
<b>1-Month Supply</b>	
Select days for 1-month supply	30
Copayment 1-month supply	\$5.00
Daily Copayment 1-month	\$0.17
<b>2-Month Supply</b>	
Select days for 2-month supply	60
Copayment 2-month supply	\$10.00
<b>3-Month Supply</b>	
Select days for 3-month supply	100
Copayment 3-month supply	\$10.00
<b>Long Term Care</b>	
Select days for long-term care supply	31
Copayment 1-month supply	\$10.00
Daily Copayment 1-month	\$0.32
<b>Out of Network</b>	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$10.00
<b>Rx Tier 2 Post OOP - Generic</b>	
Cost-Share Structure	Copayment
Copayment	\$0.00
<b>Rx Tier 3 - Preferred Brand</b>	
<b>Tier Drug Type(s)</b>	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
<b>Standard/Preferred Retail</b>	
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
<b>Rx Tier 3 Initial Coverage Phase - Preferred Brand</b>	
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	\$47.00
Daily Copayment 1-month	\$1.57
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$94.00
3-Month Supply	
Select days for 3-month supply	90
Copayment 3-month supply	\$141.00
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	\$42.00
Daily Copayment 1-month	\$1.40
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$84.00
3-Month Supply	
Select days for 3-month supply	90
Copayment 3-month supply	\$126.00

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
<b>Standard Mail-Order Cost Sharing</b>	
<b>1-Month Supply</b>	
Select days for 1-month supply	30
Copayment 1-month supply	\$42.00
Daily Copayment 1-month	\$1.40
<b>2-Month Supply</b>	
Select days for 2-month supply	60
Copayment 2-month supply	\$84.00
<b>3-Month Supply</b>	
Select days for 3-month supply	90
Copayment 3-month supply	\$84.00
<b>Long Term Care</b>	
Select days for long-term care supply	31
Copayment 1-month supply	\$47.00
Daily Copayment 1-month	\$1.52
<b>Out of Network</b>	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$47.00
<b>Rx Tier 3 Post OOP - Preferred Brand</b>	
Cost-Share Structure	Copayment
Copayment	\$0.00
<b>Rx Tier 4 - Non-Preferred Drug</b>	
<b>Tier Drug Type(s)</b>	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
<b>Standard/Preferred Retail</b>	
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
<b>Rx Tier 4 Initial Coverage Phase - Non-Preferred Drug</b>	
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	\$100.00
Daily Copayment 1-month	\$3.33
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$200.00
3-Month Supply	
Select days for 3-month supply	90
Copayment 3-month supply	\$300.00
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	\$95.00
Daily Copayment 1-month	\$3.17
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$190.00
3-Month Supply	
Select days for 3-month supply	90
Copayment 3-month supply	\$285.00

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
<b>Standard Mail-Order Cost Sharing</b>	
<b>1-Month Supply</b>	
Select days for 1-month supply	30
Copayment 1-month supply	\$95.00
Daily Copayment 1-month	\$3.17
<b>2-Month Supply</b>	
Select days for 2-month supply	60
Copayment 2-month supply	\$190.00
<b>3-Month Supply</b>	
Select days for 3-month supply	90
Copayment 3-month supply	\$190.00
<b>Long Term Care</b>	
Select days for long-term care supply	31
Copayment 1-month supply	\$100.00
Daily Copayment 1-month	\$3.23
<b>Out of Network</b>	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$100.00
<b>Rx Tier 4 Post OOP - Non-Preferred Drug</b>	
Cost-Share Structure	Copayment
Copayment	\$0.00
<b>Rx Tier 5 - Specialty Tier</b>	
<b>Tier Drug Type(s)</b>	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
<b>Standard/Preferred Retail</b>	
Select days for 1-month supply	30
<b>Standard Mail-Order</b>	

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
<b>Rx Tier 5 Initial Coverage Phase - Specialty Tier</b>	
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	29%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	29%
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	29%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	29%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	29%
<b>Rx Tier 5 Post OOP - Specialty Tier</b>	
Cost-Share Structure	Copayment
Copayment	\$0.00
<b>Rx Attestations</b>	

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
<b>Rx Insulin</b>	
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
<b>Rx Insulin Tier 1 - Preferred Generic</b>	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	\$6.00
Copayment 2-month supply	\$12.00
Copayment 3-month supply	\$18.00
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	\$6.00
Out-of-Network	

Copayment 1-month supply	\$6.00
<b>Rx Insulin Tier 2 - Generic</b>	
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	\$5.00
Copayment 2-month supply	\$10.00
Copayment 3-month supply	\$15.00
Standard Mail-Order	
Copayment 1-month supply	\$5.00
Copayment 2-month supply	\$10.00
Copayment 3-month supply	\$10.00
Long-Term Care	
Copayment 1-month supply	\$10.00
Out-of-Network	
Copayment 1-month supply	\$10.00
<b>Rx Insulin Tier 3 - Preferred Brand</b>	
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

<b>Rx Insulin Tier 4 - Non-Preferred Drug</b>	
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
<b>Rx Insulin Tier 5 - Specialty Tier</b>	
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
<b>Rx Notes</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	
<b>Rx VBID</b>	
No Data Saved for Selected Section, Incomplete or Not Started.	