PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

Data Report for Contract H2261, Plan 023 - 1 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
Organization Type	Local CCP
Plan Name	Medicare HMO Blue FlexRx (HMO-POS)
Plan Geographic Name	Massachusetts except Berkshire Dukes and Nantucket
Plan Details	
Plan Type	HMOPOS
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)?	Yes
Does this plan offer Out-of-Network Services (OON)?	Not Applicable
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
Point of Service (POS)	
Select the POS benefit type:	Mandatory

Does this POS benefit service the United States and its territories? If no, please briefly describe geographic limitations in the following area.	Yes
Does this POS benefit include all practitioners who are state-licensed or state-certified and eligible to be paid by Medicare to furnish the services?	Yes
Contract Year 2025 Medicare-defined MOOP Limits (HMOPOS 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 POS 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
Point-Of-Service (POS)	Yes
Inpatient Hospital Psychiatric(1b)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Skilled Nursing Facility (SNF)(2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Cardiac Rehabilitation Services(3-1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	

In Network (INN)	Required
Point-Of-Service (POS)	Yes
Pulmonary Rehabilitation Services(3-3)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
SET for PAD Services(3-4)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Emergency Services(4a)	
In Network (INN)	Required
Urgently Needed Services(4b)	
In Network (INN)	Required
Partial Hospitalization(5)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Home Health Services(6)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Primary Care Physician Services(7a)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Chiropractic Services(7b)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Occupational Therapy Services(7c)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Physician Specialist Services(7d)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Podiatry Services(7f)	

In Network (INN)	Required
Point-Of-Service (POS)	Yes
Other Health Care Professional(7g)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Individual Sessions for Psychiatric Services(7h1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Group Sessions for Psychiatric Services(7h2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Additional Telehealth Benefits(7j)	
In Network (INN)	Yes
Opioid Treatment Program Services(7k)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Diagnostic Procedures/Tests(8a1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Lab Services(8a2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Diagnostic Radiological Services(8b1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Therapeutic Radiological Services(8b2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Outpatient X-Ray Services(8b3)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Outpatient Hospital Services(9a1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes

Observation Services(9a2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Individual Sessions for Outpatient Substance Abuse(9c1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Outpatient Blood Services(9d)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Ground Ambulance Services(10a1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Air Ambulance Services(10a2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Durable Medical Equipment (DME)(11a)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Prosthetic Devices(11b1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Medical Supplies(11b2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Diabetic Supplies(11c1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Dialysis Services(12)	

In Network (INN)	Required
Point-Of-Service (POS)	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Kidney Disease Education Services(14d)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Glaucoma Screening(14e1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Diabetes Self-Management Training(14e2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Barium Enemas(14e3)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Digital Rectal Exams(14e4)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
EKG following Welcome Visit(14e5)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Medicare Part B Insulin Drugs(15-1)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Other Medicare Part B Drugs(15-3)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Medicare Dental Services(16a)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Eye Exams(17a)	
In Network (INN)	Required

Point-Of-Service (POS)	Yes
Eyewear(17b)	
In Network (INN)	Required
Point-Of-Service (POS)	Yes
Hearing Exams(18a)	
In Network (INN)	Required
Point-Of-Service (POS)	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
Point-Of-Service (POS)	Yes
Meal Benefit(13c)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Annual Physical Exam(14b)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Health Education(14c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory

Point-Of-Service (POS)	Yes
Fitness Benefit(14c4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Enhanced Disease Management(14c5)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Remote Access Technologies (including Web/Phone-based technologies	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Wigs for Hair Loss Related to Chemotherapy(14c15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Weight Management Programs(14c16)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Home infusion bundled services(15)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Oral Exams(16b1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Dental X-Rays(16b2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes
Prophylaxis (cleaning)(16b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Point-Of-Service (POS)	Yes

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
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?	No
Point of Service (POS)	
Is there a POS maximum plan benefit coverage?	No
Does this plan have a POS deductible?	No
Annual Plan Deductible	
Does this plan have an In-Network plan deductible?	No
Does this plan have an Out-of-Network Network plan deductible?	No
Does this plan have a combined (In-Network and Out-of-Network) deductible?	No
Max Enrollee Cost Limit	
Does this plan have an In-Network MOOP?	Yes
What type of In-Network MOOP does your plan offer?	Lower
In Network MOOP Amount	$4100.00
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?	Yes
Out-of-Network MOOP Amount	$5750.00
Select the Service Categories that apply to the Out-of-Network Maximum Enrollee Out-of-Pocket cost:	Out-of-Network Medicare-covered benefits

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost Amount apply to all the Out-of-Network Medicare-covered plan services?	Yes
Does this plan have an Combined (In-Network and Out-of-Network) MOOP?	No
Medicare Services	
Inpatient Hospital-Acute(1a)	
In-Network	Yes
Out-of-Network	Yes
Inpatient Hospital Psychiatric(1b)	
In-Network	Yes
Out-of-Network	Yes
Skilled Nursing Facility (SNF)(2)	
In-Network	Yes
Out-of-Network	Yes
Cardiac Rehabilitation Services(3-1)	
In-Network	Yes
Out-of-Network	Yes
Intensive Cardiac Rehabilitation Services(3-2)	
In-Network	Yes
Out-of-Network	Yes
Pulmonary Rehabilitation Services(3-3)	
In-Network	Yes
Out-of-Network	Yes
SET for PAD Services(3-4)	
In-Network	Yes
Out-of-Network	Yes
Emergency Services(4a)	
In-Network	Yes
Urgently Needed Services(4b)	
In-Network	Yes
Partial Hospitalization(5)	
In-Network	Yes
Out-of-Network	Yes
Home Health Services(6)	
In-Network	Yes

Out-of-Network	Yes
Primary Care Physician Services(7a)	
In-Network	Yes
Out-of-Network	Yes
Chiropractic Services(7b)	
In-Network	Yes
Out-of-Network	Yes
Occupational Therapy Services(7c)	
In-Network	Yes
Out-of-Network	Yes
Physician Specialist Services(7d)	
In-Network	Yes
Out-of-Network	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In-Network	Yes
Out-of-Network	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In-Network	Yes
Out-of-Network	Yes
Podiatry Services(7f)	
In-Network	Yes
Out-of-Network	Yes
Other Health Care Professional(7g)	
In-Network	Yes
Out-of-Network	Yes
Individual Sessions for Psychiatric Services(7h1)	
In-Network	Yes
Out-of-Network	Yes
Group Sessions for Psychiatric Services(7h2)	
In-Network	Yes
Out-of-Network	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	
In-Network	Yes
Out-of-Network	Yes
Additional Telehealth Benefits(7j)	
In-Network	Yes
Opioid Treatment Program Services(7k)	

In-Network	Yes
Out-of-Network	Yes
Diagnostic Procedures/Tests(8a1)	
In-Network	Yes
Out-of-Network	Yes
Lab Services(8a2)	
In-Network	Yes
Out-of-Network	Yes
Diagnostic Radiological Services(8b1)	
In-Network	Yes
Out-of-Network	Yes
Therapeutic Radiological Services(8b2)	
In-Network	Yes
Out-of-Network	Yes
Outpatient X-Ray Services(8b3)	
In-Network	Yes
Out-of-Network	Yes
Outpatient Hospital Services(9a1)	
In-Network	Yes
Out-of-Network	Yes
Observation Services(9a2)	
In-Network	Yes
Out-of-Network	Yes
Ambulatory Surgical Center (ASC) Services(9b)	
In-Network	Yes
Out-of-Network	Yes
Individual Sessions for Outpatient Substance Abuse(9c1)	
In-Network	Yes
Out-of-Network	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	
In-Network	Yes
Out-of-Network	Yes
Outpatient Blood Services(9d)	
In-Network	Yes
Out-of-Network	Yes
Ground Ambulance Services(10a1)	
In-Network	Yes

Out-of-Network	Yes
Air Ambulance Services(10a2)	
In-Network	Yes
Out-of-Network	Yes
Durable Medical Equipment (DME)(11a)	
In-Network	Yes
Out-of-Network	Yes
Prosthetic Devices(11b1)	
In-Network	Yes
Out-of-Network	Yes
Medical Supplies(11b2)	
In-Network	Yes
Out-of-Network	Yes
Diabetic Supplies(11c1)	
In-Network	Yes
Out-of-Network	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	
In-Network	Yes
Out-of-Network	Yes
Dialysis Services(12)	
In-Network	Yes
Out-of-Network	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In-Network	Yes
Out-of-Network	Yes
Kidney Disease Education Services(14d)	
In-Network	Yes
Out-of-Network	Yes
Glaucoma Screening(14e1)	
In-Network	Yes
Out-of-Network	Yes
Diabetes Self-Management Training(14e2)	
In-Network	Yes
Out-of-Network	Yes
Barium Enemas(14e3)	
In-Network	Yes
Out-of-Network	Yes

Digital Rectal Exams(14e4)	
In-Network	Yes
Out-of-Network	Yes
EKG following Welcome Visit(14e5)	
In-Network	Yes
Out-of-Network	Yes
Medicare Part B Insulin Drugs(15-1)	
In-Network	Yes
Out-of-Network	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In-Network	Yes
Out-of-Network	Yes
Other Medicare Part B Drugs(15-3)	
In-Network	Yes
Out-of-Network	Yes
Medicare Dental Services(16a)	
In-Network	Yes
Out-of-Network	Yes
Eye Exams(17a)	
In-Network	Yes
Out-of-Network	Yes
Eyewear(17b)	
In-Network	Yes
Out-of-Network	Yes
Hearing Exams(18a)	
In-Network	Yes
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)
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)
Is prior authorization required for any Out-of-Network service categories?	No
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)
Is referral required for any Out-of-Network service categories?	No
Visitor Travel	
Does this plan offer the US Visitor/Travel Program (V/T)?	No
Cost Share Groups	
Point of Service (POS) Groups	
Group Name	Group #1
Copayment	No
Coinsurance	0% - 20%
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)
	Occupational Therapy Services(7c)
	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)
	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)
	Individual Sessions for Outpatient Substance Abuse(9c1)
	Group Sessions for Outpatient Substance Abuse(9c2)
	Outpatient Blood Services(9d)
	Durable Medical Equipment (DME)(11a)
	Prosthetic Devices(11b1)
	Medical Supplies(11b2)
	Diabetic Supplies(11c1)
	Diabetic Therapeutic Shoes/Inserts(11c2)
	Dialysis Services(12)
	Kidney Disease Education Services(14d)
Non-Medicare:	Outpatient Blood Services(9d)
	Medicare Part B Rx Drugs(15)

Notes	Group 1 - 9a2 Observation Services - $0 for Observation services on same day as ER visit. 20% for all other services
Group Name	Group #2
Copayment	$45.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Non-Medicare:	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Prophylaxis (cleaning)(16b4)
Group Name	Group #3
Copayment	$200.00
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	Group #4
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Opioid Treatment Program Services(7k)
	Eyewear(17b)
Non-Medicare:	Health Education(14c1)
	Enhanced Disease Management(14c5)

	Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)
Group Name	Group #5
Copayment	No
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	$150.00
Periodicity	Every Year
Status	Completed
Non-Medicare:	Fitness Benefit(14c4)
	Weight Management Programs(14c16)
Group Name	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	$65.00
Coinsurance	20%
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	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 Dental Services(16a)
Notes	For Medicare-covered Preventive Services (Group 7 - 14a, 14e), the P.O.S. cost share will be $65 or 20% depending on the service. Copays/Coinsurances for these services are as follows: Abdominal aortic aneurysm screening 20% Annual wellness visit $65 Screening Barium Enema 20% Bone mass measurement 20% Breast cancer screening (mammograms) 20% Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) $65 Cardiovascular disease testing 20% Cervical and vaginal cancer screening 20% Colorectal cancer screening $65 for each office visit to a physician and 20% when the services are performed in a hospital or ambulatory surgical center.
Group Name	Group #8
Copayment	No
Coinsurance	40%
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Diagnostic Radiological Services(8b1)
Group Name	Group #9
Copayment	$65.00

Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Primary Care Physician Services(7a)
	Chiropractic Services(7b)
	Physician Specialist Services(7d)
	Podiatry Services(7f)
	Other Health Care Professional(7g)
	Eye Exams(17a)
	Hearing Exams(18a)
Non-Medicare:	Annual Physical Exam(14b)
Notes	Medicare-covered Vision care is $65 for each office visit to a physician
Group Name	Group #10
Copayment	No
Coinsurance	20%
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Medicare Part B Chemotherapy/Radiation Drugs(15-2)
	Other Medicare Part B Drugs(15-3)
	Medicare Part B Insulin Drugs(15-1)
Combined Benefits Groups	
No Data Saved for Selected Section, Incomplete or Not Started.	
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	$245.00
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
Point-of-Service (POS) Benefits	
Is there a POS maximum plan benefit coverage?	No
Is there a coinsurance?	Yes
Do you charge the Medicare-defined cost share?	No
Coinsurance	20%
Number of day intervals for Medicare-covered stay	0
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	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	$200.00
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
Point-of-Service (POS) Benefits	
Is there a POS maximum plan benefit coverage?	No
Is there a coinsurance?	Yes
Do you charge the Medicare-defined cost share?	No
Coinsurance	20%
Number of day intervals for Medicare-covered stay	0
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	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	3
Copayment	$0.00
Begin Day	1
End Day	20
Copayment	$140.00
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
Point-of-Service (POS) Benefits	
Is there a coinsurance?	Yes
Do you charge the Medicare-defined cost share?	No
Coinsurance	20%
Number of day intervals for Medicare-covered stay	0
Is there a copayment?	No
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	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	$15.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Intensive Cardiac Rehabilitation Services (3-2) - 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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$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	In-network: You do not pay the ER copayment if you are held overnight at the hospital for observation. For Point -of-Service: 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 stabilized, 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	$60.00
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 $10 copay for Urgent care services received from your PCP, a $35 copay from other in-network providers and $60 copay for Out-of-Network urgent care services. $0 copay applies only 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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1
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?	Yes
Copayment amount	$10.00
Is there a deductible?	No
Point-of-Service (POS) Benefits	
Group	Group #9
Authorization required for this benefit?	No
Referral required for this benefit?	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	$20.00
Is there a medicare covered	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

Point-of-Service (POS) Benefits	
Group - Medicare	Group #9
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$15.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$35.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
Point-of-Service (POS) Benefits	
Group	Group #9
Authorization required for this benefit?	No
Referral required for this benefit?	No

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.
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	$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
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.
Group Sessions for Mental Health Specialty Services (7e2) - Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$10.00
Maximum copayment	$35.00
Is there a medicare covered	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes
Point-of-Service (POS) Benefits	
Group - Medicare	Group #9
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	Lower cost share represents Primary Care Provider (PCP) 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	$10.00
Maximum copayment	$35.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #9
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	Lower cost share represents Primary Care Provider (PCP) services versus specialist 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	$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Group Sessions for Psychiatric Services (7h2) - Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$15.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
Point-of-Service (POS) Benefits	
Group	Group #1

Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$35.00
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.
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
Point-of-Service (POS) Benefits	
Group	Group #4
Authorization required for this benefit?	No
Referral required for this benefit?	No
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?	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 Procedures/Tests (8a1) - Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	Cost share is $0 when services are performed by a network physician or nurse practitioner in the home or at a mobile unit. The maximum applies when the services are performed any setting outside the home.
Lab Services (8a2) - Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	Cost share is $0 when services are performed by a network physician or nurse practitioner in the home or at a mobile unit. The maximum applies when the services are performed any setting outside the home.
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	$200.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #8
Authorization required for this benefit?	No
Referral required for this benefit?	No

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?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$200.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No

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	$210.00
Periodicity	Per stay
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$150.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$10.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Group Sessions for Outpatient Substance Abuse (9c2) - Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #1
Referral required for this benefit?	No
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group - Medicare	Group #1
Group - Non-Medicare	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
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	$200.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	Yes
Point-of-Service (POS) Benefits	
Group	Group #3
Authorization required for this benefit?	No
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
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	$200.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	Yes
Point-of-Service (POS) Benefits	
Group	Group #3
Authorization required for this benefit?	No
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
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	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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No

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	10%
Is there a copayment?	No
Authorization required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Medical Supplies (11b2) - Medicare	
Is there a coinsurance?	Yes
Coinsurance percentage	10%
Is there a copayment?	No
Authorization required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1

Authorization required for this benefit?	No
Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
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?	Yes
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #7
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #7
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #7

Authorization required for this benefit?	No
Referral required for this benefit?	No
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?	Yes
Point-of-Service (POS) Benefits	
Group	Group #7
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #7
Referral required for this benefit?	No
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #7
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group - Non-Medicare	Group #1
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

Point-of-Service (POS) Benefits	
Group	Group #10
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #10
Authorization required for this benefit?	No
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
Point-of-Service (POS) Benefits	
Group	Group #10
Authorization required for this benefit?	No
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	$35.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #7
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$10.00
Maximum copayment	$35.00
Is there a deductible?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Point-of-Service (POS) Benefits	
Group - Medicare	Group #9
Authorization required for this benefit?	No
Referral 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.
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
Point-of-Service (POS) Benefits	
Group - Medicare	Group #4
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.
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	$10.00
Maximum copayment	$35.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group - Medicare	Group #9
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.
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.
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
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
Point-of-Service (POS) Benefits	
Group	Group #9
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
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
Point-of-Service (POS) Benefits	
Group	Group #4
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 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	$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
Point-of-Service (POS) Benefits	
Group	Group #5
Authorization required for this benefit?	No
Referral required for this benefit?	No

Notes	The plan offers a Fitness benefit of up to $150 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
Point-of-Service (POS) Benefits	
Group	Group #4
Authorization required for this benefit?	No
Referral required for this benefit?	No

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare	
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
Point-of-Service (POS) Benefits	
Group	Group #4
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.
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

Point-of-Service (POS) Benefits	
Group	Group #6
Authorization required for this benefit?	No
Referral required for this benefit?	No
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	$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
Point-of-Service (POS) Benefits	
Group	Group #5
Authorization required for this benefit?	No
Referral required for this benefit?	No

Notes	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
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
Point-of-Service (POS) Benefits	
Group	Group #2
Referral required for this benefit?	No
Authorization required for this benefit?	No
Dental X-Rays (16b2) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of X-Rays	2
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
Point-of-Service (POS) Benefits	
Group	Group #2
Authorization required for this benefit?	No
Referral required for this benefit?	No
Prophylaxis (cleaning) (16b4) - 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
Point-of-Service (POS) Benefits	
Group	Group #2
Authorization required for this benefit?	No
Referral required for this benefit?	No
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
Eyewear (17b) - Non-Medicare	
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.
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
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
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
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
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
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.
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 $260 deductible applies only to Tiers 3-5 (which is 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 (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	$260.00
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
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	$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
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	$6.00
Daily Copayment 1-month	$0.19
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	$6.00
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	$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
Standard Mail-Order Cost Sharing	
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	$10.00

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 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	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
Standard Mail-Order Cost Sharing	
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	$84.00
Long Term Care	
Select days for long-term care supply	31

Copayment 1-month supply	$47.00
Daily Copayment 1-month	$1.52
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	$47.00
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	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
Standard Mail-Order Cost Sharing	
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	$190.00
Long Term Care	
Select days for long-term care supply	31
Copayment 1-month supply	$100.00
Daily Copayment 1-month	$3.23

Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	$100.00
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	28%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	28%
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	28%

Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	28%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	28%
Rx Tier 5 Post OOP - Specialty Tier	
Cost-Share Structure	Copayment
Copayment	$0.00
Rx Attestations	
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	$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
Rx Insulin Tier 2 - 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	$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
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.	