

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

Data Report for Contract H2261, Plan 024 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 SaverRx (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
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
Point-Of-Service (POS)	Yes
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
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
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
Point-Of-Service (POS)	Yes
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
Point-Of-Service (POS)	Yes
Eyewear(17b)	
In Network (INN)	Required
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
Over-the-Counter (OTC) Items(13b)	
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
Point-Of-Service (POS)	Yes
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
In-Home Support Services(14c21)	
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
Other Diagnostic Dental Services(16b3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Prophylaxis (cleaning)(16b4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Restorative Services(16c1)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Endodontics(16c2)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Periodontics(16c3)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Prosthodontics, removable(16c4)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Maxillofacial Prosthetics(16c5)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory

Implant Services(16c6)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Prosthodontics, fixed(16c7)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Oral and Maxillofacial Surgery(16c8)	
In Network (INN)	Required
Optional/Mandatory / Both	Mandatory
Adjunctive General Services(16c10)	
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
Plan Level Cost Sharing	

Plan Level Cost Sharing	
Tiered Cost Sharing	
Does this plan have tiered cost sharing for Medicare covered services?	No
Does this plan have tiered cost sharing for Non-Medicare covered services?	No
Reductions in Cost Sharing	
Does your plan offer Reductions in Cost Sharing?	No
Combined Supplemental Benefits	
Do you offer Combined Supplemental Benefits?	Yes
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?	Intermediate
In Network MOOP Amount	\$6200.00
Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

Does this plan have an Out-of-Network MOOP?	No
Does this plan have an Combined (In-Network and Out-of-Network) MOOP?	Yes
What type of Combined (In-Network and Out-of-Network) MOOP does your plan offer?	Intermediate
Combined (In-Network and Out-of-Network) MOOP Amount	\$6200.00
Select the Service Categories that apply to the Combined Maximum Enrollee Out-of-Pocket cost:	In-Network Medicare-covered benefits Out-of-Network Medicare-covered benefits
Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?	Yes
Medicare Services	
Inpatient Hospital-Acute(1a)	
In-Network	Yes
Combined In-Network	Yes
Inpatient Hospital Psychiatric(1b)	
In-Network	Yes
Combined In-Network	Yes
Skilled Nursing Facility (SNF)(2)	
In-Network	Yes
Combined In-Network	Yes
Cardiac Rehabilitation Services(3-1)	
In-Network	Yes
Combined In-Network	Yes
Intensive Cardiac Rehabilitation Services(3-2)	
In-Network	Yes
Combined In-Network	Yes
Pulmonary Rehabilitation Services(3-3)	

In-Network	Yes
Combined In-Network	Yes
SET for PAD Services(3-4)	
In-Network	Yes
Combined In-Network	Yes
Emergency Services(4a)	
In-Network	Yes
Combined In-Network	Yes
Urgently Needed Services(4b)	
In-Network	Yes
Combined In-Network	Yes
Partial Hospitalization(5)	
In-Network	Yes
Combined In-Network	Yes
Home Health Services(6)	
In-Network	Yes
Combined In-Network	Yes
Primary Care Physician Services(7a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Chiropractic Services(7b)	
In-Network	Yes
Combined In-Network	Yes
Occupational Therapy Services(7c)	
In-Network	Yes
Combined In-Network	Yes
Physician Specialist Services(7d)	
In-Network	Yes
Combined In-Network	Yes
Individual Sessions for Mental Health Specialty Services(7e1)	
In-Network	Yes
Combined In-Network	Yes
Group Sessions for Mental Health Specialty Services(7e2)	
In-Network	Yes
Combined In-Network	Yes
Podiatry Services(7f)	

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

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

In-Network	Yes
Combined In-Network	Yes
Dialysis Services(12)	
In-Network	Yes
Combined In-Network	Yes
Medicare-covered Zero Dollar Preventive Services(14a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Kidney Disease Education Services(14d)	
In-Network	Yes
Combined In-Network	Yes
Glaucoma Screening(14e1)	
In-Network	Yes
Combined In-Network	Yes
Diabetes Self-Management Training(14e2)	
In-Network	Yes
Combined In-Network	Yes
Barium Enemas(14e3)	
In-Network	Yes
Combined In-Network	Yes
Digital Rectal Exams(14e4)	
In-Network	Yes
Combined In-Network	Yes
EKG following Welcome Visit(14e5)	
In-Network	Yes
Combined In-Network	Yes
Medicare Part B Insulin Drugs(15-1)	
In-Network	Yes
Combined In-Network	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	
In-Network	Yes
Combined In-Network	Yes
Other Medicare Part B Drugs(15-3)	
In-Network	Yes
Combined In-Network	Yes
Medicare Dental Services(16a)	

In-Network	Yes
Combined In-Network	Yes
Eye Exams(17a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Eyewear(17b)	
In-Network	Yes
Combined In-Network	Yes
Hearing Exams(18a)	
In-Network	Yes
Combined In-Network	Yes
Combined Out-of-Network	Yes
Prior Authorization & Referral	
Prior Authorization	
Is prior authorization required for any In-Network service categories?	Yes
Select the In-Network service categories that require prior authorization:	Inpatient Hospital-Acute(1a)
	Additional Days for Inpatient Hospital-Acute(1a1)
	Inpatient Hospital Psychiatric(1b)
	Additional Days for Inpatient Hospital Psychiatric(1b1)
	Skilled Nursing Facility (SNF)(2)
	Partial Hospitalization(5)
	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)
	Lab Services(8a2)
	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)
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:	Barium Enemas(14e3)
	Physician Specialist Services(7d)
	Podiatry Services(7f)
	Physical Therapy and Speech-Language Pathology Services(7i)
	Additional Telehealth Benefits(7j)

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	\$65.00
Coinsurance	No
Deductible	No
Maximum Plan Benefit Coverage amount	No
Periodicity	N/A
Status	Completed
Medicare:	Primary Care Physician Services(7a)
	Podiatry Services(7f)
	Other Health Care Professional(7g)
	Medicare-covered Zero Dollar Preventive Services(14a)
	Eye Exams(17a)
	Hearing Exams(18a)
Non-Medicare:	Annual Physical Exam(14b)
Combined Benefits Groups	
Group Name	Combined Supplemental Benefits 1
Mode of delivery	Reimbursement
Maximum Plan Benefit Coverage amount	\$1200.00
Periodicity	Every Year
Shared Visit/Trips Limits	No
Status	Completed
Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Other Diagnostic Dental Services(16b3)
	Prophylaxis (cleaning)(16b4)
	Restorative Services(16c1)
	Endodontics(16c2)

	Periodontics(16c3)
	Prosthodontics, removable(16c4)
	Maxillofacial Prosthetics(16c5)
	Implant Services(16c6)
	Prosthodontics, fixed(16c7)
	Oral and Maxillofacial Surgery(16c8)
	Adjunctive General Services(16c10)
Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Do you offer Combined Supplemental Benefits with a shared visit/trips limits?	No
Group Name	Dental/Vision/Hearing expense allowance
Mode of delivery	Debit Card
Maximum Plan Benefit Coverage amount	\$600.00
Periodicity	Every Year
Shared Visit/Trips Limits	No
Status	Completed
Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:	Prophylaxis (cleaning)(16b4)
	Oral Exams(16b1)
	Dental X-Rays(16b2)
	Other Diagnostic Dental Services(16b3)
	Restorative Services(16c1)
	Endodontics(16c2)
	Periodontics(16c3)
	Prosthodontics, removable(16c4)
	Maxillofacial Prosthetics(16c5)
	Implant Services(16c6)
	Prosthodontics, fixed(16c7)
	Oral and Maxillofacial Surgery(16c8)
	Adjunctive General Services(16c10)

	Routine Eye Exams(17a1)
	Contact Lenses(17b1)
	Eyeglasses (lenses and frames)(17b2)
	Eyeglass lenses(17b3)
	Eyeglass frames(17b4)
	Routine Hearing Exams(18a1)
	Fitting/Evaluation for Hearing Aid(18a2)
	Prescription Hearing Aids (all types)(18b1)
Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Do you offer Combined Supplemental Benefits with a shared visit/trips limits?	No
Notes	Members will have an allowance to use towards dental, vision and hearing out-of-pocket expenses. This can include copayments for the covered dental, vision, and hearing services, as well as other out-of-pocket expenses associated with vision hardware purchases.
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 III?	No
VBID/MA UF/SSBCI Reduction in Cost Sharing Packages (19a)	
No Data Saved for Selected Section, Incomplete or Not Started.	
VBID/MA UF/SSBCI Additional Benefits Packages (19b)	
No Data Saved for Selected Section, Incomplete or Not Started.	
Benefit Details	
Inpatient Hospital-Acute (1a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	\$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	\$385.00
Begin Day	1
End Day	7
Copayment	\$0.00
Begin Day	8
End Day	90
Day intervals for Medicare-covered lifetime reserve days	1
Copayment	\$0.00
Begin Day	1
End Day	60
Is there a deductible?	No
Periodicity	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No

Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Inpatient Hospital Psychiatric (1b) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	\$0.00
Number of day intervals for Medicare-covered stay	2
Copayment	\$300.00
Begin Day	1
End Day	5
Copayment	\$0.00
Begin Day	6
End Day	90
Day intervals for Medicare-covered lifetime reserve days	1
Copayment	\$0.00
Begin Day	1
End Day	60
Is there a deductible?	No
Periodicity	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes	Includes mental health care services that require a hospital stay.
Skilled Nursing Facility (SNF) (2) - Medicare	

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Days	0
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Number of day intervals for Medicare-covered stay	2
Copayment	\$0.00
Begin Day	1
End Day	20
Copayment	\$200.00
Begin Day	21
End Day	100
Periodicity	Original Medicare
Authorization required for this benefit?	Yes
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	\$35.00
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	\$35.00
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
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
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	\$125.00
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>
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Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00
Maximum copayment	\$55.00
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No
Does the cost sharing count towards any plan-level deductible?	No

Notes	<p>For Urgent Care, you pay a \$0 copay in-network and a \$55 copay out-of-network for Urgent care services received from your PCP. You pay a \$40 copay from other providers and a \$0 copay applies to covered services performed in the home by a network provider.</p>
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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
Point-of-Service (POS) Benefits	
Group	Group #1
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 deductible?	No
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	\$20.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
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	\$40.00
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.
Mental Health Specialty Services (7e) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Individual Sessions for Mental Health Specialty Services (7e1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00
Maximum copayment	\$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

Notes	\$0 copay applies only to covered services performed in the home by a network provider. Higher copay is for covered services that are not the home.
Group Sessions for Mental Health Specialty Services (7e2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Podiatry Services (7f) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00
Maximum copayment	\$40.00
Is there a medicare covered deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes
Point-of-Service (POS) Benefits	
Group - Medicare	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	You pay a \$0 in-network copay and a \$65 out-of-network copay for covered podiatry services furnished by your PCP. You pay a \$40 copayment for other in-network providers.
Other Health Care Professional (7g) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00
Maximum copayment	\$40.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Point-of-Service (POS) Benefits	
Group	Group #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	You pay a \$0 in-network copay and a \$65 out-of-network copay for services furnished by your PCP. You pay a \$40 copay for services from another covered provider.
Psychiatric Services (7h) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Individual Sessions for Psychiatric Services (7h1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Group Sessions for Psychiatric Services (7h2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$30.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Physical Therapy and Speech-Language Pathology Services (7i) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

Is there a copayment?	Yes
Copayment amount	\$20.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes
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	\$40.00
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
Diagnostic Procedures/Tests/Lab Services (8a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a copayment?	No
Is there a deductible?	No
Diagnostic Procedures/Tests (8a1) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Lab Services (8a2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
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	\$310.00
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.
Therapeutic Radiological Services (8b2) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$60.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
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
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	\$300.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
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	\$325.00
Periodicity	Per stay
Is there a deductible?	No
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	\$250.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
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	\$30.00
Authorization required for this benefit?	Yes
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	\$30.00
Authorization required for this benefit?	Yes
Referral 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
Ambulance Services (10a) - Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes

Is this Copayment waived if admitted to hospital?	Yes
Notes	The maximum copay per trip will apply. When the ambulance service meets Medicare guidelines you do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospital and/or skilled nursing facilities.
Ground Ambulance Services (10a1) - Medicare	
Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$375.00
Is there a deductible?	No
Authorization required for non-emergency Medicare services?	Yes
Notes	The maximum copay per trip will apply. When the ambulance service meets Medicare guidelines you do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospital and/or skilled nursing facilities.
Air Ambulance Services (10a2) - Medicare	

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

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Is there a deductible?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
Authorization required for this benefit?	No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?	Yes
Coinsurance percentage	20%
Is there a copayment?	No
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

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes

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

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 #1
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
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
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
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
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
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
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
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
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

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
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	\$40.00
Is there a deductible?	No
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	\$0.00
Maximum copayment	\$40.00
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 #1
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	You pay a \$0 in-network copay and a \$65 out-of-network copay for services furnished by your PCP. You pay a \$40 copay for other covered providers.
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
Notes	You pay nothing for Medicare-covered standard eyeglasses or contact lenses, and for covered standard contact lenses due to keratoconus.
Hearing Exams (18a) - Medicare	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes with a min & max
Minimum copayment	\$0.00
Maximum copayment	\$40.00
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 #1
Authorization required for this benefit?	No
Referral required for this benefit?	No

Notes	You pay a \$0 in-network copay and a \$65 out-of-network copay for services furnished by your PCP. You pay a \$40 copay for other covered providers.
Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare	
Is this benefit unlimited?	Yes
Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Additional Days for Inpatient Hospital Psychiatric (1b1) - Non-Medicare	
Is this benefit unlimited?	Yes
Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	Yes
Notes	Includes mental health care services that require a hospital stay.
Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare	
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Worldwide Emergency Coverage (4c1) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$90.00
Is this Copayment waived if admitted to hospital?	Yes
Worldwide Urgent Coverage (4c2) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes

Copayment amount	\$90.00
Is this Copayment waived if admitted to hospital?	Yes
Worldwide Emergency Transportation (4c3) - Non-Medicare	
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount	\$90.00
Is this Copayment waived if admitted to hospital?	Yes
Notes	Emergency transportation such as emergency ambulance to the nearest appropriate facility that can provide care is covered by the plan.
Over-the-Counter (OTC) Items (13b) - Non-Medicare	
Is there a maximum plan benefit coverage amount?	Yes
Maximum plan benefit coverage amount	\$60.00
Periodicity	Every 3 Months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.	TRUE
Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
Is there a coinsurance?	No
Is there a copayment?	No
Is there a deductible?	No

Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
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 #1
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

Notes	Included in health education information are 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, 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.
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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	\$1500.00
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 \$1500 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>
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
Remote Access Technologies (including Web/Phone-based technologies	
Select the type of Remote Access Technologies offered	Nursing Hotline

Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance Nursing Hotline?	No
Is there a copayment Nursing Hotline?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
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

Notes	Wigs are covered up to a \$500 maximum per calendar year when hair loss is due to: chemotherapy, radiation therapy, or the 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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In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?	Yes
Amount	\$600.00
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>Allowance for in-home support and companion care for assistance with independent daily living activities, such as helping with light chores, errands, and tech-support</p>
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Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?	Yes
Maximum amount	\$1200.00
Periodicity	Every Year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Oral Exams (16b1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	3
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Notes	One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures. Periodic or routine oral exams 3 times per calendar year. Emergency exams.
Dental X-Rays (16b2) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of X-Rays	7
Periodicity	Other, Describe
Description	Full mouth X-rays, 7 or more films, or panoramic X-ray with bitewing X-rays once every 60 months. Bitewing X-rays once every 6 months. Single-tooth X-rays as needed.

Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Other Diagnostic Dental Services (16b3) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Study models and casts used in planning treatment, once each 60 months
Is there a coinsurance?	No
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Prophylaxis (cleaning) (16b4) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	3
Periodicity	Every Year
Is there a coinsurance?	No
Is there a copayment?	No
Referral required for this benefit?	No
Authorization required for this benefit?	No
Notes	Routine cleaning, scaling, and polishing of the teeth 3 times per 12 months.
Comprehensive Dental (16c) - Non-Medicare	
Service maximum plan benefit coverage:	Yes
Select the maximum plan benefit coverage type	Covered under Diagnostic and Preventive Dental (16b)
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Restorative Services (16c1) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1

Periodicity	Other, Describe
Description	Silver and white fillings: once per tooth in 12 months. Inlays: once per tooth in 60 months.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Endodontics (16c2) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Root canals and retreatment of prior root canal on permanent teeth: once per tooth.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Periodontics (16c3) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	Periodontal scaling and root planning: once per quadrant per 24 months. Periodontal Surgery: once per quadrant per 36 months. Maintenance following active periodontal therapy: once within three months
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Prosthodontics, removable (16c4) - Non-Medicare	

Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes for 16c4 for comprehensive list.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	<p>Due to the character limit in the Periodicity section, the periodicity limits are outlined below:</p> <ul style="list-style-type: none"> -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Maxillofacial Prosthetics (16c5) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe

Description	See Notes for 16c5 for comprehensive list.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	<p>Due to the character limit in the Periodicity section, the periodicity limits are outlined below:</p> <ul style="list-style-type: none"> -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Implant Services (16c6) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See notes for 16c6 for a comprehensive list.
Is there a coinsurance?	Yes

Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	<p>Due to the character limit in the Periodicity section, the periodicity limits are outlined below:</p> <ul style="list-style-type: none"> -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Prosthodontics, fixed (16c7) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes for 16c7 for comprehensive list.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No

Referral required for this benefit?	No
Notes	<p>Due to the character limit in the Periodicity section, the periodicity limits are outlined below:</p> <ul style="list-style-type: none"> -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Oral and Maxillofacial Surgery (16c8) - Non-Medicare	
Is this benefit unlimited?	No
Indicate number of visits	1
Periodicity	Other, Describe
Description	See Notes for 16c8 for comprehensive list.
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

Notes	<p>Due to the character limit in the Periodicity section, the periodicity limits are outlined below:</p> <ul style="list-style-type: none"> -Occlusal adjustments, once in 24 months -Reline or rebase dentures; once in 36 months -Repair of partial or complete dentures, crowns and bridges; once in 12 months -Recementing of crowns, inlays, onlays, and fixed bridgework; once in 12 months -Crowns; once per tooth in 60 months -Replacement of crowns; once in 60 months -Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 60 months for each arch -Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing
Adjunctive General Services (16c10) - Non-Medicare	
Is this benefit unlimited?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage	50%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes	<p>Services to treat root sensitivity, emergency dental care to relieve acute pain (palliative care), emergency dental care to control a dental condition that requires immediate care to prevent permanent harm, general anesthesia for covered oral surgery.</p>

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?	No
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Is there a deductible?	No
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Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?	No
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Indicate number of visits	1
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Periodicity	Every Year
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Is there a coinsurance?	No
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Is there a copayment?	No
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Authorization required for this benefit?	No
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Referral required for this benefit?	No
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Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?	Yes
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Select the maximum plan benefit coverage type	Plan-specified amount per period
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Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
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Combined maximum amount	\$200.00
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Periodicity	Every 2 Years
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Is there a deductible?	No
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Notes	You pay all costs after \$200 for routine spectacle lenses, frames, fittings, dispensing fees and contact lenses every 24 months.
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Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?	Yes
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Is there a coinsurance?	No
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Is there a copayment?	No
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Authorization required for this benefit?	No
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Referral required for this benefit?	No
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Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?	Yes
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Is there a coinsurance?	No
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Is there a copayment?	No
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Authorization required for this benefit?	No
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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

<p>Reduced Cost Sharing Notes:</p>	<p>Through the \$0 deductible, flat-dollar copayments on Tiers 1 and 2, and coinsurances for Tiers 3, 4, and 5 that comply with both CY 2025 Final Part D Bidding Instructions and (in the case of Tier 5) Annual Updates for Part D Specialty Tier Calculation, the actuarial for this plan exceeds the Defined Standard actuarial value. The BPT shows the actuarial equivalence tests on Worksheet 5, section VI are met.</p>
<p>Does this plan charge the Medicare-defined Part D deductible amount (Deductible does not apply for covered insulin drugs and adult vaccines)?</p>	<p>No Deductible</p>
<p>Indicate the Out-of-Network (OON) cost sharing structure for this plan:</p>	<p>Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable</p>
<p>""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.)""</p>	<p>No</p>
<p>How does this plan apply cost sharing in the Initial Coverage Phase?</p>	<p>Cost-Share Tiers</p>
<p>How does this plan apply cost sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?</p>	<p>No cost sharing</p>

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	\$8.00
Daily Copayment 1-month	\$0.27
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$16.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$24.00
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	\$8.00
Daily Copayment 1-month	\$0.26
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$8.00
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	\$12.00
Daily Copayment 1-month	\$0.40
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$24.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$36.00
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Copayment 1-month supply	\$2.00
Daily Copayment 1-month	\$0.07
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$4.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$6.00

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	\$2.00
Daily Copayment 1-month	\$0.07
2-Month Supply	
Select days for 2-month supply	60
Copayment 2-month supply	\$4.00
3-Month Supply	
Select days for 3-month supply	100
Copayment 3-month supply	\$4.00
Long Term Care	
Select days for long-term care supply	31
Copayment 1-month supply	\$12.00
Daily Copayment 1-month	\$0.39
Out of Network	
Select days for out of network 1-month supply	30
Copayment 1-month supply	\$12.00
Rx Tier 2 Post OOP - Generic	
Cost-Share Structure	Copayment
Copayment	\$0.00
Rx Tier 3 - Preferred Brand	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Select days for 2-month supply	60

Select days for 3-month supply	90
Standard Mail-Order	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 3 Initial Coverage Phase - Preferred Brand	
Cost-Share Structure	Coinsurance
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	20%
Average Expected Cost-Sharing Amount	\$75.72
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	20%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	20%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	20%
Average Expected Cost-Sharing Amount	\$80.26
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	20%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	20%

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	20%
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	20%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	20%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	20%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	20%
Rx Tier 3 Post OOP - Preferred Brand	
Cost-Share Structure	Copayment
Copayment	\$0.00
Rx Tier 4 - Non-Preferred Drug	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Standard Mail-Order	

Select days for 1-month supply	30
Select days for 2-month supply	60
Select days for 3-month supply	90
Long Term Care	
Select days for long-term care supply	31
Out of Network	
Select days for out of network 1-month supply	30
Rx Tier 4 Initial Coverage Phase - Non-Preferred Drug	
Cost-Share Structure	Coinsurance
Standard/Preferred Retail Cost Sharing	
Standard Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	40%
Average Expected Cost-Sharing Amount	\$83.59
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	40%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	40%
Preferred Retail	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	40%
Average Expected Cost-Sharing Amount	\$41.09
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	40%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	40%

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available with an extended day supply for this tier limited to a 1-month supply for the first fill?	No
Standard Mail-Order Cost Sharing	
1-Month Supply	
Select days for 1-month supply	30
Coinsurance 1-month supply	40%
2-Month Supply	
Select days for 2-month supply	60
Coinsurance 2-month supply	40%
3-Month Supply	
Select days for 3-month supply	90
Coinsurance 3-month supply	40%
Long Term Care	
Select days for long-term care supply	31
Coinsurance 1-month supply	40%
Out of Network	
Select days for out of network 1-month supply	30
Coinsurance 1-month supply	40%
Rx Tier 4 Post OOP - Non-Preferred Drug	
Cost-Share Structure	Copayment
Copayment	\$0.00
Rx Tier 5 - Specialty Tier	
Tier Drug Type(s)	
Generic	Yes
Brand	Yes
Tier Includes	Part D Drugs Only
Standard/Preferred Retail	
Select days for 1-month supply	30
Standard Mail-Order	
Select days for 1-month supply	30
Long Term Care	

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

<p>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.</p>	<p>Yes</p>
<p>Rx Insulin</p>	
<p>Indicate which tiers have insulin drugs (Select all that apply):</p>	<p>Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Drug, Tier 5 - Specialty Tier</p>
<p>Rx Insulin Tier 1 - Preferred Generic</p>	
<p>Standard/Preferred Retail</p>	
<p>Standard Retail</p>	
<p>Copayment 1-month supply</p>	<p>\$8.00</p>
<p>Copayment 2-month supply</p>	<p>\$16.00</p>
<p>Copayment 3-month supply</p>	<p>\$24.00</p>
<p>Preferred Retail</p>	
<p>Copayment 1-month supply</p>	<p>\$0.00</p>
<p>Copayment 2-month supply</p>	<p>\$0.00</p>
<p>Copayment 3-month supply</p>	<p>\$0.00</p>
<p>Standard Mail-Order</p>	
<p>Copayment 1-month supply</p>	<p>\$0.00</p>
<p>Copayment 2-month supply</p>	<p>\$0.00</p>
<p>Copayment 3-month supply</p>	<p>\$0.00</p>
<p>Long-Term Care</p>	
<p>Copayment 1-month supply</p>	<p>\$8.00</p>
<p>Out-of-Network</p>	

Copayment 1-month supply	\$8.00
Rx Insulin Tier 2 - Generic	
Standard/Preferred Retail	
Standard Retail	
Copayment 1-month supply	\$12.00
Copayment 2-month supply	\$24.00
Copayment 3-month supply	\$36.00
Preferred Retail	
Copayment 1-month supply	\$2.00
Copayment 2-month supply	\$4.00
Copayment 3-month supply	\$6.00
Standard Mail-Order	
Copayment 1-month supply	\$2.00
Copayment 2-month supply	\$4.00
Copayment 3-month supply	\$4.00
Long-Term Care	
Copayment 1-month supply	\$12.00
Out-of-Network	
Copayment 1-month supply	\$12.00
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
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Out-of-Network

Copayment 1-month supply	\$35.00
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Rx Insulin Tier 5 - Specialty Tier

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply	\$35.00
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Preferred Retail

Copayment 1-month supply	\$35.00
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Standard Mail-Order

Copayment 1-month supply	\$35.00
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Long-Term Care

Copayment 1-month supply	\$35.00
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Out-of-Network

Copayment 1-month supply	\$35.00
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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

No Data Saved for Selected Section, Incomplete or Not Started.