

	Greater Tompkins County Municipal Health Insurance Consortium Classic Blue 50/150 City of Cortland		Greater Tompkins County Municipal Health Insurance Consortium Classic Blue Secure- Medicare Supplement M54	Aetna Group Medicare Advantage Plan Proposed
Plan Overview				
Plan ID	Not Applicable		Not Applicable	Not Applicable
Plan Name	GTCMHIC 2022 Classic Blue 50/150		GTCMHIC 2022 Classic Blue Secure	Aetna Group Medicare Advantage Plan
Plan Highlights	Deductible/Co-pay		Medicare Supplement	Group Medicare Advantage Plan
Plan Type	Coinsurance		Medicare Supplement	Group Medicare Advantage Plan
HSA Eligible	Not Applicable		Not Applicable	Not Applicable
Quote Effective	01/01/2022-12/31/2022		01/01/2022- 12/31/2022	7/1/2022 - 12/31/2023
Rate (\$)				
Single	\$1,060.77		\$635.05	\$300.00
Family	\$2,299.18		N/A	N/A
Total Cost	\$2,523,190.44		\$1,709,862.72 Note: Only those 65+ with Medicare would move to the M54	\$532,800 Note: Only those eligible for Medicare by age (65+) or Disability would move to this MAPD Plan
Plan Features				
Primary Care Physician (PCP)	Covered at 80% Subject to Deductible		Covers Medicare deductible and coinsurance	COVERED IN FULL
Referrals	Not Required		Not Required	Not Required
Out of Network Benefits	Covered		Outside of National Medicare Network Not Covered	Same as in-network
Out of Area Benefits	Coverage provided worldwide through BlueCard Network.		Coverage provided worldwide through BlueCard Network.	Coverage provided worldwide for urgent and emergency care, including international waters.
Student/ Dependent Coverage	Qualified dependents are coverage to age 26.		Qualified dependents are coverage to age 26.	Medicare Eligible Retirees
Domestic Partner	Covered		Covered	Medicare Eligible Retirees/Dependents
Healthy Rewards	Not Covered		Not Covered	Covered - Gift Cards for Preventative Service Utilization
Resources for Living	Not Covered		Not Covered	Assist with Finding Resources for Everyday Needs
Healthy Lifestyle Coaching Programs	Not Covered		Not Covered	1 on 1 weekly calls with Health Coach (examples: Dietician, Fitness Program, Weight Loss Program)
24/7 Nurse Line				Access to call a Nurse with any questions 24/7
Meals	Not Covered		Not Covered	Covered up to 14 meals (7 days) following In-Patient Stay
Wellness Incentives	Excellus Blue365 discount program		Excellus Blue365 discount program	Silver Sneakers (For example; Complimentary membership to Cortland YMCA) Membership to Fitness Facilities that participate with Silver Sneakers
Plan Cost-Sharing Highlights				
Primary Care Office Visit	Covered at 80% Subject to Deductible	80% of the allowable rate, subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Specialist Office Visit	Covered at 80%	80% of the allowable rate,	Covers Medicare deductible and coinsurance	COVERED IN FULL
Coinsurance	20%		None	None
Deductible	\$50 Individual/ \$150 Family	\$50 Individual/\$150 Family	\$0.00 Individual	\$0 Individual
Out-of-Pocket Maximum	\$400 Individual/ \$1,200 Family	\$400 Individual/ \$1,200 Family	None	\$0
Lifetime Maximum	None		See specific benefit type	Unlimited unless noted
Inpatient Facility Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Hospital Benefit	Covered in Full Unlimited Days	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, daily copay, lifetime reserve day copay	COVERED IN FULL
Mental Health Care	Covered in Full Unlimited Days	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Substance Use Detoxification	Covered in Full Unlimited Days	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Substance Use Rehabilitation	Covered in Full Unlimited Days	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Substance Use Residential Care	Covered in Full Unlimited Days	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Skilled Nursing Facility	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare daily copay rate	COVERED IN FULL FOR DAYS 1-100 PER BENEFIT PERIOD
Inpatient Physical Rehabilitation	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare daily copay rate Up to 100 days	COVERED IN FULL FOR UNLIMITED DAYS

Maternity Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, daily copay, lifetime reserve day copay	COVERED IN FULL
Routine Newborn Nursery Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare deductible and coinsurance	NOT APPLICABLE
Prosthetics-Implanted Devices	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare deductible and coinsurance	COVERED IN FULL
Inpatient Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Inpatient Hospital Surgery	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, daily copay, lifetime reserve day copay	COVERED IN FULL
Anesthesia	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, daily copay, lifetime reserve day copay	COVERED IN FULL
Inpatient Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
In-Hospital Physician Visits/ Consults	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, daily copay, lifetime reserve day copay	COVERED IN FULL
Outpatient Facility Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Colonoscopy Facility Diagnostic	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Pre-Admission/ Pre-Operative Testing	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Diagnostic X-rays	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Routine X-rays	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Advanced Imaging Services	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Diagnostic Laboratory and Pathology	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Routine Laboratory and Pathology	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Diagnostic Testing	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Radiation Therapy	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Chemotherapy	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Outpatient Facility Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Dialysis	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Mental Health Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Outpatient Facility Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Substance Use Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Pulmonary Rehabilitation	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Cardiac Rehabilitation	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Home Health Care and Hospice Care	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Home Care	Covered in Full - 60 visits per calendar year After basic benefit \$50 deductible 80% Coverage up to 325 visits	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A deductible, copay and coinsurance	COVERED IN FULL

Hospice Care Inpatient	Covered in Full	80% of the allowable rate, subject to balance billing	Covers Medicare Part A deductible, copay and coinsurance	COVERED BY ORIGINAL MEDICARE
Hospice Care Outpatient	Covered in Full	80% of the allowable rate, subject to balance billing	Covers Medicare Part A deductible, copay and coinsurance	COVERED BY ORIGINAL MEDICARE
Outpatient and Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Outpatient Hospital and Ambulatory Surgery	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Office Surgery	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Diagnostic X-rays	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Outpatient and Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Routine X-ray	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Advanced Imaging Services	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Diagnostic Laboratory and Pathology	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Outpatient/ Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Routine Laboratory and Pathology	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Outpatient/ Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Radiation Therapy	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B deductible and coinsurance	COVERED IN FULL
Chemotherapy	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part A or B copay, deductible and coinsurance	COVERED IN FULL
Dialysis	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Mental Health Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Substance Use Treatment	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Maternity Care	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Pulmonary Rehabilitation	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Office Visits- Diagnostic	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Outpatient/ Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Hearing Evaluation Diagnostic	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Chiropractic Care	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Allergy Testing	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Not Covered	COVERED IN FULL
Outpatient/ Office Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Allergy Treatment including Serum	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Not Covered	COVERED IN FULL
Hearing Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Hearing Evaluation Routine (1 per plan year)	Not Covered	Not Covered	Not Covered	COVERED IN FULL
Adult Hearing Aids	Not Covered	Not Covered	Rider: Adult aids covered at 50% coinsurance. Limit \$3,500 Maximum 2 every 3 years	HEARING AID REIMBURSEMENT - \$1,200 PER YEAR
Pediatric Hearing Aid Age Limit	19		19	There is no age limit for Medicare eligible members-all will receive the full \$1,200 benefit.

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Pediatric Hearing Aid	Not Covered	Not Covered	Not Covered	
Rehab and Habilitation Services- Outpatient Facility	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Physical Rehabilitaton	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Occupational Rehabilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Speech Rehabilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED INF FULL
Physical Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Rehab and Habilitation & Professional Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Occupational Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Speech Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Physical Rehabilitaton	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Occupational Rehabilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Speech Rehabilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Physical Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Occupational Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Speech Habilitation	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Preventive Healthcare Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Adult Routine Physical Exams	Covered in Full 1 per year	Not Covered	Not Covered Medicare Wellness Exams Covered in Full	COVERED IN FULL 1 PER YEAR
Adult Immunizations	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Equivalent to Medicare Supplement Coverage	COVERED IN FULL
Well Child Visits	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Not Applicable	NOT APPLICABLE
Routine GYN Exam	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Preventive Healthcare Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Family Planning Service	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Mammography	Covered in Full	Covered in Full at the allow rate; Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Preventive Healthcare Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Pap Smear	Covered in Full	Covered in Full at the allow rate; Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL

Prostate Cancer Screening	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Colonscopy	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Other Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Treatment of Diabetes Insulin and Supplies	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance Insulin not covered.	COVERED IN FULL
Other Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Durable Medical Equipment (DME)	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Orthotics	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Foot Orthotics	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Prosthetics- External Benefit	80% Coverage Subject to	80% Coverage of allowable rate	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Medical Supplies	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Acupuncture	Not Covered	Not Covered	Covers remainder after Medicare payment	COVERED IN FULL (12 VISITS IN 90 DAYS FOR CHRONIC LOWER BACK PAIN)THIS IS THE SAME
Dental Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Adult Dental Care	Not Covered	Not Covered	Not Covered	Medicare dental services are covered regardless of age (Accidental/Medical)
Emergency Services	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Emergency Room Care- Facility waived if admitted to hospital	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Emgerency Room Care- Professional	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Ambulance-Pre-Hospital Emergency Services Transportation (Ground or Water)	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Air Ambulance	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Urgent Care Center- Facility	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Non-Emergency Transportation	Not Covered	Not Covered	Not Covered	24 TRIPS WITH 60 MILES ALLOWED PER TRIP (TRIPS TO OFFICE VISITS, PHARMACIES, ETC.)
Urgent Care Center- Professional Services	Covered in Full	Covered in Full at the allow rate; Subject to balance billing	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Vision Benefits	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Adult Routine Vision Exam (Annual) (Limited 1 Exam Per Year)	Not Covered	Not Covered	Rider: \$20 copay. 1 per calendar year	COVERED IN FULL
Adult Diagnostic Vision	80% Coverage Subject to Deductible	80% Coverage of allowable rate Subject to Deductible Subject to balance	Covers Medicare Part B copay, deductible and coinsurance	COVERED IN FULL
Adult Eyewear	Not Covered	Not Covered	Rider: \$100 Allowance	\$100 ALLOWANCE PER 12 MONTHS
Pediatric Routine Vision Exam	Not Covered	Not Covered	Not Covered	IF MEDICARE ELIGLBE, COVERED IN FULL
Pediatric Eyewear (1 Paid per Contract year,	Not Covered	Not Covered	Not Covered	\$100 reimbursement every 12 months is available to all eligible members regardless of age,
Pharmacy Coverage	In- Network	Out of Network	In- Network	In- Network/Out-of-Network (Same)
Retail Pharmacy	Tier 1: \$10	Not Covered	Tier 1: \$15	Tier 1: \$9
(limited to a 30 day supply)	Tier 2: \$25	Not Covered	Tier 2: \$30	Tier 2: \$25
	Tier 3: \$40	Not Covered	Tier 3: \$45	Tier 3: \$40
Mail-Order Pharmacy	Tier 1: \$20	Not Covered	Tier 1: \$30	Tier 1: \$18 (RETAIL OR MAIL-ORDER)

(limited to a 90-day supply)	Tier 2: \$50	Not Covered	Tier 2: \$60	Tier 2: \$50 (RETAIL OR MAIL-ORDER)
	Tier 3: \$80	Not Covered	Tier 3: \$90	Tier 3: \$80 (RETAIL OR MAIL-ORDER)
Step Therapy	Applicable		Applicable	NOT APPLICABLE
Prior Authorization	Applicable		Applicable	APPLICABLE
Madatory Mail-Order for Maintenance Medications	Not Applicable		Not Applicable	NOT APPLICABLE
Non Part D Supplemental Benefits:				Agents used for cosmetic purposes or hair growth, Agents used to promote fertility, Agents when used for anorexia, weight loss, or weight gain, Agents when used for the symptomatic relief of cough and colds, Agents when used for the treatment of sexual or erectile dysfunction (EDI), Prescription vitamins and minerals products, except prenatal vitamins and flouride preparations.