

AEP 2026 FINAL BENEFIT OVERVIEW

August 25, 2025

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Confidentiality Reminder

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This slide deck focuses on plans and benefits that were filed and approved by CMS for plan year 2026.

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This is NOT to be used or shared with beneficiaries (members or prospective members).

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Elevance Health: Fortune 30 Leader in Medicare, Medicaid & Commercial

Our Purpose:

Improve the health of humanity

Our Mission:

Improving lives and communities.
Simplifying Healthcare. Expecting More.

Our Strategy:

To become a lifetime, trusted health partner

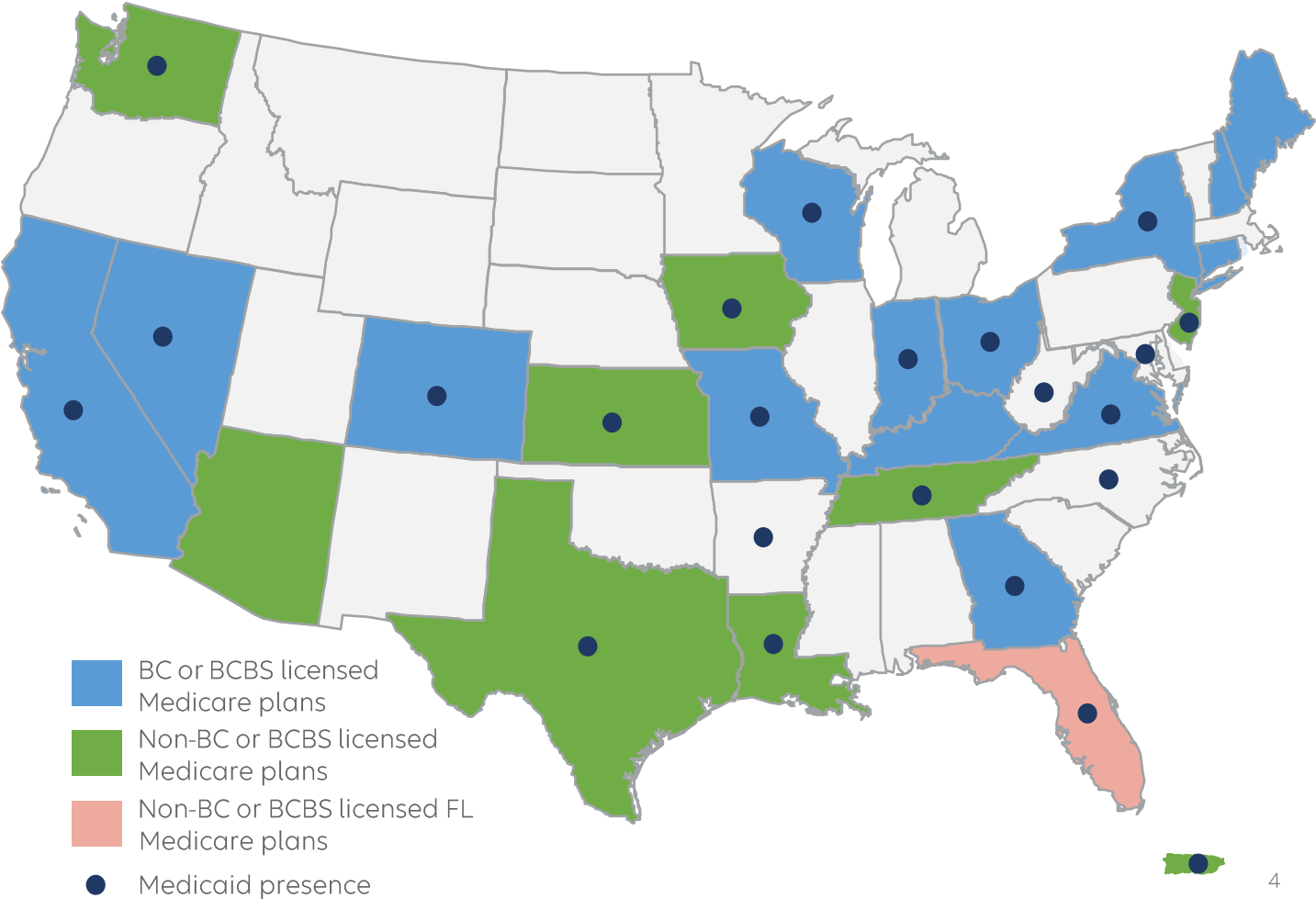
More than
109 million
total consumers served

Q2 2025 - Elevance Health Corporate Fact Sheet

24 Medicare
Markets
Includes Puerto Rico

14 states
BC or BCBS Markets

24 Medicaid
Markets
Includes D.C. and Puerto Rico



Advancing Our Balance of **Stability** & **Growth**

The Medicare Advantage landscape is evolving — driven by rising utilization, moderated rates, and increasing regulatory complexity.

Industry pressures are felt **most acutely in Non-SNP plans** — where rising utilization and moderated rates are challenging stability.

- We are focused on **strategic simplification**, adjusting benefits like **Dental, EE, and EOA** to ensure continued value and competitiveness.

We are the **market leader in C-SNP in the FL MA market and have** invested to drive further growth.

We remain a leader in Medicare and Medicaid — and have leveraged this to generate **above market growth in D-SNP**, driven by a value proposition that's simple, competitive, and consistent:

- **\$0 copays** in every county across our D-SNP footprint.
- Simple combined allowance including **OTC*, Assistive Devices, Healthy Foods and Utilities.**

**In FL, OTC is a separate benefit and not included in combined allowance*

Advancing Our Balance of **Stability** & **Growth**

- **2nd largest D-SNP market share** in our footprint, **2nd largest national Medicaid player**.
- **81-county expansion** enhances our reach across high-opportunity Medicare markets.
- **Focused D-SNP growth** through plan design, service area expansion, and dual-eligible initiatives.
- SNP plans offer simple combined allowance that includes **OTC***, **Assistive Devices, Healthy Foods and Utilities**.
- Continuing to invest strategically in benefits aligned to **member health needs** and **behavior** — **improving access & affordability to care**.
- Positioning ahead of D-SNP alignment with **strong Medicare-Medicaid integration**.



We recognize the critical role **Agencies and Brokers** play in helping beneficiaries find the Medicare plan that best meets their needs - and we remain committed to supporting your success.

*In FL, OTC is a separate benefit and not included in Everyday Options Allowance

Advancing Our Balance of **Stability** & **Growth**

D-SNP

Invest in Alignment & Growth

C-SNP

Targeted growth through
differentiated model of care

Non-SNP

Stable growth prioritizing member
experience and retention



Special Supplemental Benefits for the Chronically Ill (SSBCI)

- Used to deploy non-health related benefits for D-SNP and C-SNP and some non-SNP plans
- Members must meet plan-specified clinical criteria to **qualify for Healthy Foods and/or Utilities** benefits. Not all members will qualify
- **Members are required to obtain a signed Chronic Condition Verification Form from their provider** to qualify for benefits.
- Timely, complete Chronic Condition Verification is required
- Members clinically approved for SSBCI maintain approval for as long as they remain on an eligible Elevance Health Medicare plan

Everyday Options Allowances* (EOA) – Embedded Benefits



Everyday Options Allowances (EOA) to promote healthy living

- **Single card for members to use across offerings** (i.e., OTC, Assistive Devices, Healthy Foods and Utilities)
- Combined allowance increases options and provides greater **flexibility**



Note: SSBCI approval is needed to include Healthy Foods and Utilities spending allowance

*Benefit availability varies by plan

2026 Everyday Options Allowances and Requirements

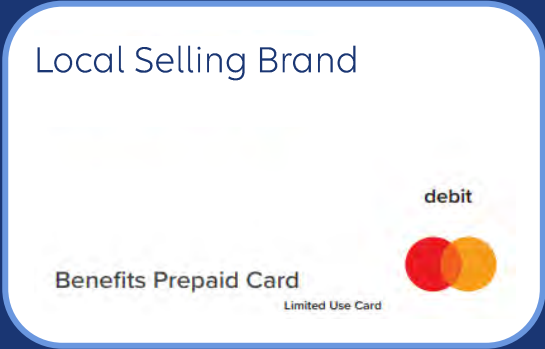
- Combined allowance is easy for members to use – delivering **simplicity, choice, and flexibility** for the benefits that members value most
- EOAs will be prioritized for SNP products to **meet the specific needs of members with chronic conditions to improve member health outcomes**
- Members must be eligible for **Healthy Foods and Utilities**

Benefit	Description	How members use the Benefits Pre-Paid Card	SSBCI
	OTC*: Cold and flu medicine, vitamins and supplements, first aid, pain relief, and more	In-store through retail network or NationsBenefits online store	N/A
	Assistive Devices: Handrails, shower stools, raised toilet seats, temporary mobility ramps, and more	NationsBenefits online store	N/A
	Healthy Foods: Healthy foods including fresh meats and vegetables, dairy items, canned goods, and more	In-store through retail network or NationsBenefits online store	Yes**
	Utilities: Home phone and internet service; electric, gas, water, and sewage bills	Pay bills directly or pay OOP and submit reimbursement	Yes**

*In FL, OTC is a separate benefit and not included in Everyday Options Allowance

**Benefits require that plans meet eligibility criteria for SSBCI

2026 Essential Extras (EE)*



Our plans help members enjoy a healthier life with greater comfort and relief from challenges they may be facing

An extra benefit that members choose during the application process

Choice

Offerings with focus on highest valued benefits that allow members to customize their plan!

5

Up to five benefit options available

Reduces member and agent confusion

3

Offered through three package variations

Improve sales/marketing/communication

*Benefit availability varies by plan

2026 Essential Extras and Requirements

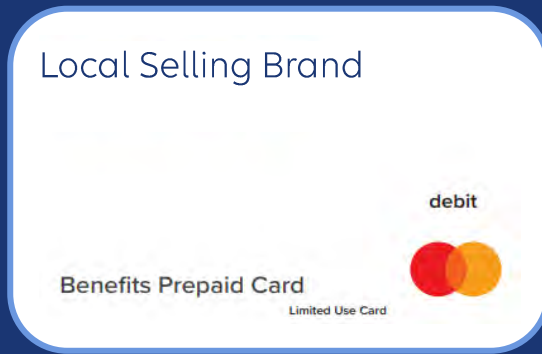
Essential Extras

- Allows members to select a single supplemental benefit* from a defined list based upon plan
- Provides flexibility that will help members tailor their MA plan to their specific needs
- SSBCI Eligibility required to select Healthy Foods or Utilities

Benefit	Description	Pre-Cert	“Low”	“Medium”	“High”
Dental, Vision & Hearing	\$500/Yr. towards Dental/Vision/Hearing	N/A	✓	✓	✓
Transportation (Health related destinations)	60 One-Way Trips	N/A	✓	✓	✓
Assistive Devices	\$500/Yr. towards Assistive Devices	N/A	✓	✓	✓
Utilities	\$150/Qtr. towards Utilities	Yes*		✓	✓
Healthy Foods (Healthy Foods Card)	\$50/Month Healthy Foods Benefit	Yes*			✓

*Requires verification of SSBCI eligibility

Benefits Prepaid Card



NationsBenefits **Access & Experience**

How does it work?

- **A single card where all allowance(s) are loaded** which include the **Everyday Options Allowances and Essential Extras** and works just like a prepaid credit card
- Allowances are added to the card (monthly, quarterly, annually) upon the member's effective date or when benefit is selected
- Members can begin shopping as soon as plan coverage begins*
- Choice of how to access benefits with in-store network retailer, online or phone orders

What can it be used for?

- Use to purchase eligible items within the approved benefit(s) and retailer network for OTC**, Assistive Devices, Healthy Foods, etc.
- Retailers including Walmart, Kroger, Walgreens, CVS, Rite Aid, Giant Eagle
- Walmart Bill Pay can be used to pay Utilities such as gas, electric, phone and sewer

What else?

- Card cannot be converted to cash
- When buying in-store, choose "Credit" at checkout. Avoid debit as it might be declined. Members do NOT need a PIN with their card.
- One Integrated Call Center, all benefits through Member Service number on the card

* Pre-cert needed for Healthy Foods and Utilities

** FL offers OTC with a separate vendor

D-SNP Changes on the Horizon



Increasing the % of dually-eligible individuals receiving Medicare & Medicaid services from the same organization



Starting in 2027

D-SNPs can **only enroll individuals in an aligned D-SNP plan.**

MA organizations with affiliated MCOs can **only offer one D-SNP plan within a service area.**



Beginning in 2030

D-SNPs with an affiliated MCO will have to **disenroll any dual eligible individuals who are not already in the MCO.**

All eligible beneficiaries must be in an aligned plan.

2026 Market Highlights

A decorative graphic consisting of five nested, upward-pointing chevrons (V-shapes) in a light blue color, positioned in the bottom right quadrant of the slide.

Format Key

Key	
☆	Lead plan
Blue Font	New to plan and/or benefit offering
Green Font	Increase to benefit offering
NEW	NEW Plan
D-SNP	Plans on navy grids
C-SNP	Plans on light blue grids
HMO	Plans on aqua blue grids
PPO	Plans on lighter blue grids

Freedom Medi-Medi Full (HMO D-SNP) H5427-087		
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0 - \$16.80
PART B REBATE		\$185
MAX OUT-OF-POCKET		\$1,500
PCP		\$0 copay
SPECIALIST		\$0 copay

Optimum Diamond Rewards (HMO C-SNP) H5594-028		
MEDICAID STATUS		
PREMIUM		\$0
PART B REBATE		\$185
MAX OUT-OF-POCKET		\$1,750
PCP		\$0 copay
SPECIALIST		\$10 copay

Simply More (HMO) H5471-078		
PREMIUM	NEW	\$0
PART B REBATE		N/A
MAX OUT-OF-POCKET		\$3,450
PCP		\$0 copay
SPECIALIST		\$0 copay



Arizona - Medicare Advantage 2026

MARKET HIGHLIGHTS



2025 Proposed Service Area

- Lung and Chronic C-SNPs with Essential Extras, enhanced dental and lower specialist copays are expanding into Maricopa
- Simple and consistent Essential Extras offerings
- Wellpoint CareMore Kidney Care (HMO-POS C-SNP) offers enhanced dental, vision benefits
- CareMore Health will replace the Carelon Health brand
- CareMore Health's clinical model continues to provide the gold standard for care
- Network includes key provider partners including Banner, CareMore Health, Health Cosmos, Oak Street and CenterWell

SERVICE AREA

Coconino, Maricopa, Pima, Pinal, Santa Cruz

Arizona 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,700
PCP	\$0 copay
SPECIALIST	\$0 - \$30 copay
INPATIENT HOSPITAL	\$200 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima, Maricopa

Arizona 2026 Plan Highlights



ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year to PAL, Assistive Devices - \$500 per year
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$107 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay at the CCC, \$30 copay at a PAL; 12 visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Arizona 2026 Plan Highlights

 Wellpoint Lung Care
(HMO-POS C-SNP)
H1423-001

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,700
PCP	\$0 copay
SPECIALIST	\$0 - \$30 copay
INPATIENT HOSPITAL	\$200 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima, Maricopa



Arizona 2026 Plan Highlights



ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year to PAL, Assistive Devices - \$500 per year
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$105 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay at CCC, \$35 copay at PAL; 12 visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Arizona 2026 Plan Highlights (CareMore Health Network)

Wellpoint | CareMore Kidney Care
(HMO-POS C-SNP)
H2593-040

PREMIUM	\$0
PART B GIVEBACK	\$7
MAX OUT-OF-POCKET	\$3,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$125 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$42 / 25% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima



Arizona 2026 Plan Highlights (CareMore Health Network)

Wellpoint | CareMore Kidney Care (HMO-POS C-SNP) H2593-040

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Arizona 2026 Plan Highlights

Wellpoint Lung Care 2 (HMO-POS C-SNP)

H2593-005

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$8,300
PCP	\$0 copay
SPECIALIST	\$0 - \$35 copay
INPATIENT HOSPITAL	\$265 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima



Arizona 2026 Plan Highlights

Wellpoint Lung Care 2 (HMO-POS C-SNP)

H2593-005

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive and 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$42 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay at the CCC, \$35 copay at a PAL; 9 visits per year
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition

Arizona 2026 Plan Highlights

Wellpoint Chronic Care 2 (HMO-POS C-SNP)

H2593-006

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$8,300
PCP	\$0 copay
SPECIALIST	\$0 - \$35 copay
INPATIENT HOSPITAL	\$265 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima



Arizona 2026 Plan Highlights

Wellpoint Chronic Care 2 (HMO-POS C-SNP)

H2593-006

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,200 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive and 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$48 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay at the CCC / \$35 copay at a PAL; 9 visits per year
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition

Arizona 2026 Plan Highlights

Wellpoint | CareMore Home Care 2 (HMO I-SNP) H2593-003

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,500
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$0 copay (days 21 – 100)
RX DEDUCTIBLE	\$340 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Maricopa, Pima

Arizona 2026 Plan Highlights

Wellpoint | CareMore Home Care 2 (HMO I-SNP) H2593-003

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$90 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 8 one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A

Arizona 2026 Plan Highlights

	Wellpoint CareMore Home Care (HMO I-SNP) H1423-008	Wellpoint CareMore Home Care (HMO I-SNP) H1423-007
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$1,500	\$1,500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 5)	\$150 copay (days 1 – 5)
SKILLED NURSING FACILITY	Medicare Fee for Service	\$0
RX DEDUCTIBLE	\$150 (T3 – T5)	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Maricopa	Pima

Arizona 2026 Plan Highlights

Wellpoint | CareMore Home Care (HMO I-SNP) H1423-008

Wellpoint | CareMore Home Care (HMO I-SNP) H1423-007

DENTAL	\$1,500 allowance for preventive and comprehensive services per year \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services	\$1,500 allowance for preventive and comprehensive services per year \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$200 per quarter	\$200 per quarter
FITNESS	N/A	N/A
TRANSPORTATION	\$0 copay – 18 one-way trips per year	\$0 copay – 14 one-way trips per year
PERS	N/A	N/A
PODIATRY	\$0 copay – 4 visits per year	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A	N/A

Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage 1 (HMO – POS)

H1423-004

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,700
PCP	\$0 copay
SPECIALIST	\$0 - \$30 copay
INPATIENT HOSPITAL	\$200 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$125 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima

Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage 1 (HMO – POS) H1423-004

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year to PAL, Assistive Devices - \$500 per year
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, 25% for comprehensive services Out of Network: 20% preventive and 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$95 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year / unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay CCC / \$30 copay PAL; 4 visits per year
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition

Arizona 2026 Plan Highlights

Wellpoint Premium Savings (HMO) H1423-005

PREMIUM	\$0
PART B GIVEBACK	\$54
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 - \$10 copay
SPECIALIST	\$0 - \$30 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	\$125 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima

Arizona 2026 Plan Highlights

Wellpoint Premium Savings (HMO) H1423-005

ESSENTIAL EXTRAS	N/A
DENTAL	N/A
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$79 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 4 one-way trips to PAL per year
PERS	N/A
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition



Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage (HMO – POS)

H1423-009

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,000
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Coconino, Maricopa, Pinal, Santa Cruz

Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage (HMO – POS) H1423-009

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$750 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$65 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	14 post discharge

Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H2593-001

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$8,300
PCP	\$0 copay
SPECIALIST	\$0 - \$35 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 30% / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Pima

Arizona 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H2593-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, 25% for comprehensive services Out of Network: 20% preventive and 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$15 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year / \$0 copay - unlimited trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay to the CCC / \$35 copay to a PAL; 4 visits per year
HEALTHY MEALS	14 post discharge

California - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #2 D-SNP player with largest growth
- Full Dual Exclusively Aligned Enrollment (EAE) D-SNP HMO plans with Everyday Options Allowance (EOA) for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- EAE D-SNP HMO plan expands into Kern and San Francisco. Los Angeles county becomes a separate plan “segment” with richer benefits
- New EAE D-SNP HMO plan in rural counties of Alpine, Amador, Calaveras, El Dorado, Inyo, Mono, Tuolumne
- 9 EAE D-SNP counties added
- CareMore Health will replace the Carelon Health brand
- CareMore Chronic and Lung C-SNP plans in 3 counties with EOA for OTC, Assistive Devices, Healthy Foods and Utilities
- CareMore Health’s clinical model continues to provide the gold standard for care
- Optimized benefit changes on Non-SNP Select and Prime HMO-POS plans

SERVICE AREA

All Counties EXCEPT:

Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Lake, Lassen, Mariposa, Mendocino, Modoc, Nevada, Placer, Plumas, San Benito, Santa Barbara, Santa Cruz, Sierra, Siskiyou, Trinity

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Anthem Dual Advantage (HMO D-SNP) H4471-002	7
Anthem Dual Advantage (HMO D-SNP) H4471-006	1
Anthem Dual Advantage (HMO D-SNP) H4471-007	1
Anthem Dual Advantage (HMO D-SNP) H4471-009	3
Anthem Medicare Advantage (PPO) H8552-029	23

Northern California 2026 Plan Highlights

NEW

 **Anthem Full Dual Advantage Aligned**
(HMO D-SNP) H4471-010-002
(Transitioned H4471-001, 003, 004)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE* T1/T2/T3/T4/T5		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Fresno, Kern, Kings, Madera, Sacramento, San Francisco, Santa Clara, Tulare

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Northern California 2026 Plan Highlights

NEW



Anthem Full Dual Advantage Aligned
(HMO D-SNP) H4471-010-002
 (Transitioned H4471-001, 003, 004)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$425 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$90 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers® \$25 per month allowance
TRANSPORTATION		\$0 copay – 96 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year



Northern California 2026 Plan Highlights

NEW

★ **Anthem Full Dual Advantage Aligned**
(HMO D-SNP)
H4471-011

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE* T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Alpine, Amador, Calaveras, El Dorado, Inyo, Mono, and Tuolumne

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Northern California 2026 Plan Highlights

NEW

★ **Anthem Full Dual Advantage Aligned
(HMO D-SNP)**
H4471-011

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,400 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS		N/A
EVERYDAY OPTIONS ALLOWANCE		\$25 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 24 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge / 2 meals per day for 90 days chronic condition



Northern California 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,500
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 15% / 30% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Sacramento, San Francisco, Yolo



Northern California 2026 Plan Highlights



ESSENTIAL EXTRAS	(Pick 1) Healthy Meals - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$67 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights



Anthem Prime

(HMO-POS)

H4161-010

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$800
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Santa Clara



Northern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$38 per quarter
HEALTH & FITNESS TRACKER	N/A
ACTIVE FITNESS	N/A
TRANSPORTATION	\$0 copay – 36 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,900
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fresno, Kings, Madera, Tulare



Northern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$42 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,200
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$110 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 31% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Alameda, Kern, Marin, San Joaquin, San Mateo, Stanislaus



Northern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$38 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights

**Anthem Kidney Care
(PPO C-SNP)¹**
H8552-028

PREMIUM	\$0 - \$37.10
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$12,450 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$0 copay - 20% coinsurance
INPATIENT HOSPITAL	Medicare FFS
SKILLED NURSING FACILITY	Medicare FFS
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 25% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fresno, Kern, Kings, Madera, Merced, Monterey, San Diego, San Joaquin, San Luis Obispo, Stanislaus, Tulare, Ventura

¹Care Management by DaVita Integrated Kidney Care



Northern California 2026 Plan Highlights

Anthem Kidney Care
(PPO C-SNP)¹
H8552-028

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$60 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 52 one-way trips per year to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 meals post discharge / 90 meals chronic condition

¹Care Management by DaVita Integrated Kidney Care



Northern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-064

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$7,550
PCP	\$10 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$140 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Sacramento, Yolo



Northern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-064

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning per year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$70 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-069

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$7,550
PCP	\$5 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$360 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$160 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 31% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Francisco



Northern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-069

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning per year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	\$0 copay – 6 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A
ACUPUNCTURE	\$0 copay – unlimited visits per year



Northern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-098

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$7,550
PCP	\$15 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$315 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Alameda



Northern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-098

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning per year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A
ACUPUNCTURE	\$0 copay – 12 visits per year



Northern California 2026 Plan Highlights

Anthem Medicare Advantage
(HMO-POS)
H0544-096

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$4,900
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Mateo



Northern California 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H0544-096

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning per year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights

Anthem Medicare Advantage
(HMO-POS)
H0544-108

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,899
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$95 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Santa Clara



Northern California 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H0544-108

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning per year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year \$175 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$38 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 8 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	N/A
ACUPUNCTURE	\$0 copay – 24 visits per year



Northern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-056

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,000
PCP	\$5 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$42 / 25% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fresno, Kings, Madera, Tulare



Northern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-056

ESSENTIAL EXTRAS	N/A
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$90 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Northern California 2026 Plan Highlights

Anthem Medicare Advantage
(HMO-POS)
H0544-095

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Joaquin



Northern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-095

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning every year; In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$42 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 20 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	14 post discharge
ACUPUNCTURE	\$0 copay – 24 visits per year



Northern California 2026 Plan Highlights

Anthem MediBlue Dual Access (PPO D-SNP) H4704-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250 (IN) / \$13,900 (IN & OON)
PCP		\$0 copay - 20% coinsurance
SPECIALIST		\$0 copay - 20% coinsurance
INPATIENT HOSPITAL		\$275 copay (days 1 – 5)
SKILLED NURSING FACILITY		\$0 copay (days 1 – 20) \$196 copay (days 21 – 100)
PART B DEDUCTIBLE		\$0
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Alpine, Amador, Calaveras, El Dorado, Inyo, Mono, Tuolumne

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.

Northern California 2026 Plan Highlights

Anthem MediBlue Dual Access (PPO D-SNP) H4704-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,200 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$50 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		N/A
OVER THE COUNTER		\$38 per quarter
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 12 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Northern California 2026 Plan Highlights

Anthem MediBlue Dual Access (PPO D-SNP) H4704-002

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250 (IN) / \$13,900 (IN & OON)
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$275 copay (days 1 – 5)
SKILLED NURSING FACILITY		\$0 copay (days 1 – 20) \$196 copay (days 21 – 100)
PART B DEDUCTIBLE		\$0
RX DEDUCTIBLE		\$0 - \$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Butte, Napa, Shasta, Solano, Sonoma, Sutter, Tehema, Yuba

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
 If you do not qualify for Extra Help, you pay the coinsurance.



Northern California 2026 Plan Highlights

Anthem MediBlue Dual Access (PPO D-SNP) H4704-002

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		N/A
OVER THE COUNTER		\$205 per quarter
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 14 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		3 meals per day for 14 days chronic condition

Southern California

Southern California 2026 Plan Highlights

NEW

★ **Anthem Full Dual Advantage Aligned**
(HMO D-SNP) H4471-010-001
(Transitioned H4471-001)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
PART B DEDUCTIBLE		\$0
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE* T1/T2/T3/T4/T5		Members pay LIS copay* (T3 - T5) \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Los Angeles

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Southern California 2026 Plan Highlights

NEW

★ **Anthem Full Dual Advantage Aligned**
(HMO D-SNP) H4471-010-001
 (Transitioned H4471-001)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
ACTIVE FITNESS		\$25 per month
TRANSPORTATION		\$0 copay – 96 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge / 2 meals per day for 90 days chronic condition



Southern California 2026 Plan Highlights (CareMore Health Network)

★ **Anthem | CareMore Chronic Care
(HMO-POS C-SNP)**
H4161-014

★ **Anthem | CareMore Lung Care
(HMO-POS C-SNP)**
H4161-016

PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$499	\$499
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$50 copay (days 21 - 100)	\$0 copay (days 1 – 31) \$50 copay (days 32 - 100)
RX DEDUCTIBLE	\$0	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange	Los Angeles, Orange

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Chronic Care
 (HMO-POS C-SNP)
H4161-014

Anthem | CareMore Lung Care
 (HMO-POS C-SNP)
H4161-016

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$4,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services	\$4,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 48 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year	\$0 copay - 22 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition	14 post discharge / 2 meals per day for 90 days chronic condition

Southern California 2026 Plan Highlights (CareMore Health Network)

★ Anthem | CareMore Chronic Care (HMO-POS C-SNP) H4161-015

★ Anthem | CareMore Lung Care (HMO-POS C-SNP) H4161-017

PREMIUM	\$0	\$0
PART B REBATE	\$0	\$0
MAX OUT-OF-POCKET	\$800	\$800
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$25 copay (days 1 - 10)	\$25 copay (days 1 - 10)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$50 copay (days 21 - 100)	\$0 copay (days 1 – 20) \$50 copay (days 21 - 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Bernardino	San Bernardino

Southern California 2026 Plan Highlights (CareMore Health Network)

★ **Anthem | CareMore Chronic Care
(HMO-POS C-SNP)**
H4161-015

★ **Anthem | CareMore Lung Care
(HMO-POS C-SNP)**
H4161-017

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$4,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services	\$4,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A	N/A
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year	\$0 copay - 10 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition	14 post discharge / 2 meals per day for 90 days chronic condition

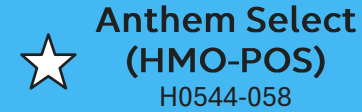
Southern California 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$800
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange

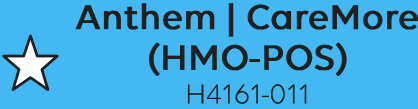


Southern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$500 allowance for preventive and comprehensive services per year In Network: \$0 copay / Out of Network: 25% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$75 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$54 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 2 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	14 post discharge

Southern California 2026 Plan Highlights (CareMore Health Network)



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$25 copay (days 21 – 100)
RX DEDUCTIBLE	\$140 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange



Southern California 2026 Plan Highlights (CareMore Health Network)



ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 25% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$150 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to CCC per year / \$0 copay - 44 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay - 12 visits per year
HEALTHY MEALS	12 post discharge / 3 meals per day for 14 days chronic condition



Southern California 2026 Plan Highlights

 **Anthem Prime**
(HMO-POS)
H4161-002

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$800
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Riverside, San Bernardino



Southern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 20% for comprehensive services Out of Network: 25% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$15 per quarter
FITNESS	N/A
ACTIVE FITNESS	N/A
TRANSPORTATION	\$0 copay – 20 one-way trips per year to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Southern California 2026 Plan Highlights (CareMore Health Network)



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 - 100))
RX DEDUCTIBLE	\$135 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Bernardino



Southern California 2026 Plan Highlights (CareMore Health Network)



ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$130 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to CCC per year
PODIATRY	\$0 copay for CCC - \$10 copay for PAL; 4 visits per year
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition



Southern California 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Diego



Southern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$75 per quarter
FITNESS	N/A
ACTIVE FITNESS	\$25 per month
TRANSPORTATION	\$0 copay – 30 one-way trips per year to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A

Northern California 2026 Plan Highlights



Anthem Prime

(HMO-POS)

H4161-007

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,900
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$300 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$255 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Ventura



Northern California 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam per year \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$32 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Southern California 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP)

H4471-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
PART B DEDUCTIBLE		\$0
RX DEDUCTIBLE		\$0 - \$105 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5		\$0 copay – T1 and T2 Members pay LIS copay* (T3 - T5) \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Ventura County

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Southern California 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H4471-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$80 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		10 post discharge

Southern California 2026 Plan Highlights

Anthem Kidney Care **(PPO C-SNP)¹** H8552-028

PREMIUM	\$0-\$37.10
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$12,450 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$0 copay - 20% coinsurance
INPATIENT HOSPITAL	Medicare FFS
SKILLED NURSING FACILITY	Medicare FFS
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 25% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fresno, Kern, Kings, Madera, Merced, Monterey, San Diego, San Joaquin, San Luis Obispo, Stanislaus, Tulare, Ventura

¹Care Management by DaVita Integrated Kidney Care

Southern California 2026 Plan Highlights

Anthem Kidney Care **(PPO C-SNP)¹** H8552-028

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$60 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 52 one-way trips per year to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 meals post discharge / 90 meals chronic condition

¹Care Management by DaVita Integrated Kidney Care

Southern California 2026 Plan Highlights (CareMore Health Network)

	Anthem CareMore Chronic Care (HMO-POS C-SNP) H0544-004	Anthem CareMore Lung Care (HMO-POS C-SNP) H0544-014
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$800	\$499
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$25 copay (days 21 – 100)	\$0 copay (days 1 - 31) \$25 copay (days 32 – 100)
RX DEDUCTIBLE	\$100 (T3 – T5)	\$100 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$45 / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / \$45 / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange	Los Angeles, Orange

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Chronic Care (HMO-POS C-SNP)

H0544-004

Anthem | CareMore Lung Care (HMO-POS C-SNP)

H0544-014

ESSENTIAL EXTRAS	(Pick 1) Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year	(Pick 1) Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$95 per quarter	\$85 per quarter
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 44 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year	\$0 copay - 22 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A	N/A



Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Chronic Care (HMO-POS C-SNP)

H0544-010

Anthem | CareMore Lung Care (HMO-POS C-SNP)

H0544-019

PREMIUM	\$0	\$0
PART B REBATE	\$0	\$0
MAX OUT-OF-POCKET	\$1,000	\$800
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$25 copay (days 1 – 10)	\$25 copay (days 1 – 10)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$100 (T3 – T5)	\$150 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$45 / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / \$45 / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Bernardino	San Bernardino

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Chronic Care (HMO-POS C-SNP)

H0544-010

Anthem | CareMore Lung Care (HMO-POS C-SNP)

H0544-019

ESSENTIAL EXTRAS	(Pick 1) Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year	(Pick 1) Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and \$0 for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and \$0 for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$89 per quarter	\$80 per quarter
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 10 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year	\$0 copay - 10 one-way trips to PAL per year \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition	14 post discharge / 2 meals per day for 90 days chronic condition



Southern California 2026 Plan Highlights (CareMore Health Network)

	Anthem CareMore Kidney Care (HMO-POS C-SNP) H0544-015	Anthem CareMore Kidney Care (HMO-POS C-SNP) H0544-020
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$7
MAX OUT-OF-POCKET	\$800	\$1,900
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 31) \$25 copay (days 32 – 100)	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)	\$150 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / 20% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange	San Bernardino

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Kidney Care (HMO-POS C-SNP) H0544-015

Anthem | CareMore Kidney Care (HMO-POS C-SNP) H0544-020

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$100 per month OTC, Assistive Devices, Healthy Foods and Utilities	\$100 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A	N/A
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 150 one-way trips to PAL per year	\$0 copay for unlimited trips for the LCB per year
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition	14 post discharge / 2 meals per day for 90 days chronic condition



Southern California 2026 Plan Highlights

Anthem Prime
(HMO-POS)
H4161-005

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,200
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$110 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 31% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Alameda, Kern, Marin, San Joaquin, San Mateo, Stanislaus



Southern California 2026 Plan Highlights

Anthem Prime
(HMO-POS)
H4161-005

ESSENTIAL EXTRAS	N/A
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay / Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$38 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Southern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-062

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,800
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Kern



H0544-062

ESSENTIAL EXTRAS	(Pick 1) Healthy Meals - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$56 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year

Southern California 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H0544-063

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$6,751
PCP	\$5 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$330 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$210 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Ventura



Southern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-063

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$0 Copay; 1 exam, 1 cleaning every year in network; Out of Network: 20% copay
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$750 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$64 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year



Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Medicare Advantage 2 **(HMO-POS)** H0544-002 (Transitioned H0544-007, 008)

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,500
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$25 copay (days 21 - 100)
RX DEDUCTIBLE	\$85 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 32% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange, San Bernardino

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Medicare Advantage 2 **(HMO-POS) H0544-002** (Transitioned H0544-007, 008)

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; Comprehensive In Network: 25% copay Comprehensive Out of Network: 50% copay
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$48 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 22 one-way trips to PAL per year / unlimited one-way trips to CCC per year
HEALTHY MEALS	12 post discharge
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year

Southern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-061

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$7,550
PCP	\$20 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$403 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$255 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$3 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange



Southern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS)

H0544-061

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$0 copay – 1 oral exam, 1 cleanings every year; Preventive Dental Out of Network – 20% coinsurance
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year

Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore
Premium Savings (HMO-POS)
H4161-012

PREMIUM	\$0
PART B GIVEBACK	\$62.10
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$20 copay \$0 copay at CCC
INPATIENT HOSPITAL	\$125 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 - 100)
RX DEDUCTIBLE	\$115 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange, San Bernardino



Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore **Premium Savings (HMO-POS)** H4161-012

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,200 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services In Network: \$0 copay / Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$100 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 10 one-way trips to PAL per year
PERS	N/A
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition
CHIROPRACTIC	\$20 copay – 12 visits per year

Southern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-066

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,800
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$100 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 31% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Riverside, San Bernardino



Southern California 2026 Plan Highlights

Anthem Select (HMO-POS) H0544-066

ESSENTIAL EXTRAS	N/A
DENTAL	\$500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 20% for comprehensive services Out of Network: 25% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$20 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 20 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A

Southern California 2026 Plan Highlights

**Anthem Select
(HMO-POS)**
H0544-091

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,500
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 30% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Diego



Southern California 2026 Plan Highlights

Anthem Select (HMO-POS) H0544-091

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$15 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 2 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A

Southern California 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H0544-065

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,400
PCP	\$10 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$42 / 30% / 33% / \$0 \$0 copay – T1, T2, and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	San Diego



Southern California 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H0544-065

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$15 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year



Southern California 2026 Plan Highlights

Anthem Prime
(HMO-POS)
H4161-009

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$499
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 - 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / \$42 / 25% / 33% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange



Southern California 2026 Plan Highlights

Anthem Prime (HMO-POS) H4161-009

ESSENTIAL EXTRAS	N/A
DENTAL	\$200 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$75 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per quarter
FITNESS	N/A
ACTIVE FITNESS	N/A
TRANSPORTATION	\$0 copay – 2 one-way trips per year to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A



Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Home Care
(HMO I-SNP)
H0544-005

PREMIUM	\$0
PART B GIVEBACK	\$30
MAX OUT-OF-POCKET	\$700
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$0 copay (days 21 - 100)
RX DEDUCTIBLE	\$100 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Los Angeles, Orange



Southern California 2026 Plan Highlights (CareMore Health Network)

Anthem | CareMore Home Care **(HMO I-SNP)** H0544-005

ESSENTIAL EXTRAS	N/A
DENTAL	Unlimited allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$130 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 22 one way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A

Colorado - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- D-SNP plan option for Partial and Full Dual-Eligibles
- D-SNP plan with increased Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- HMO service area reduction in Arapahoe, Douglas, Pueblo, El Paso
- Network includes key provider partners including UC Health, CU Medicine, Saint Joseph, Intermountain Health St. Mary's, AdventHealth, HCA HealthONE Presbyterian St. Luke's, Denver Health

SERVICE AREA

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Fremont, Jefferson, Larimer, Mesa, Pueblo, Routt, Teller, Weld

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	4	All
Anthem Kidney Care (HMO-POS C-SNP) H4346-029		

Colorado 2026 Plan Highlights



MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$28.90
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / \$0 / 25% / 25% / 25% / \$0 Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Fremont, Jefferson, Larimer, Mesa, Pueblo, Routt, Teller, Weld	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Colorado 2026 Plan Highlights



MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$525 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$120 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$ copay – 24 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year

Colorado 2026 Plan Highlights

Anthem Medicare Advantage (HMO) H4346-012

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$325 copay (days 1 –6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$325 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Boulder, Broomfield, Denver, Fremont, Jefferson, Larimer, Mesa, Routt, Teller, Weld



Colorado 2026 Plan Highlights

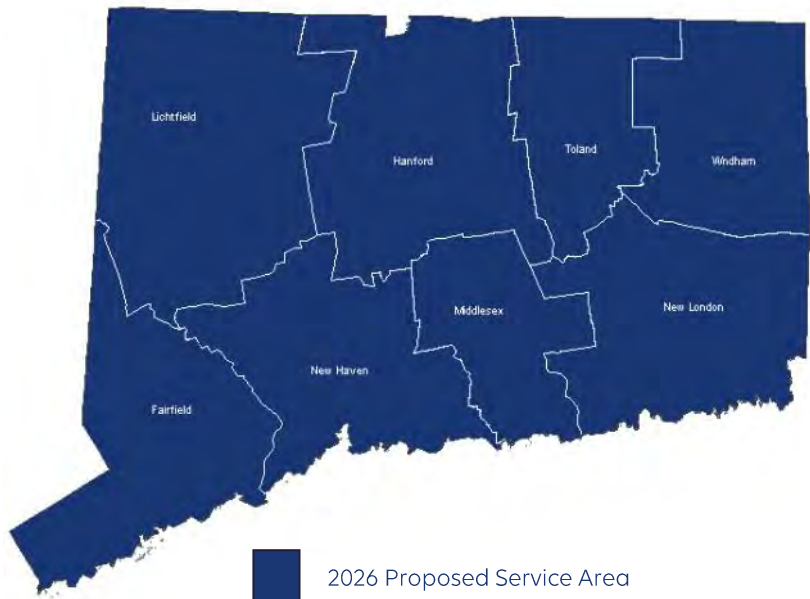
Anthem Medicare Advantage
(HMO)
H4346-012

ESSENTIAL EXTRAS	N/A
DENTAL	N/A
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$35 per quarter
EVERYDAY OPTIONS ALLOWANCE	N/A
FITNESS	N/A



Connecticut - Medicare Advantage 2026

MARKET HIGHLIGHTS



- #2 D-SNP player in Connecticut
- Lead HMO D-SNP plan with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- New HMO D-SNP and PPO D-SNP plans for QMB only (Partial Dual Eligible)
- HMO in 6 counties with Vision and Hearing benefits

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	2	All
Anthem Medicare Advantage (PPO) H2836-005		
Anthem Extra Help (HMO-POS) H5854-011		

Connecticut 2026 Plan Highlights

	NEW Anthem Medicare Dual Advantage (HMO D-SNP) H5854-020		Anthem Medicare Full Dual Advantage (HMO D-SNP) H5854-013	
MEDICAID STATUS	Partial Dual	QMB	Full Dual	QMB+, SLMB+, FBDE
PREMIUM		\$0		\$0
PART B GIVEBACK		\$0		\$0
MEDICAL DEDUCTIBLE		\$0		\$0
MAX OUT-OF-POCKET		\$9,250		\$9,250
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay for a one-month supply of select insulin		\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.

Connecticut 2026 Plan Highlights

	NEW Anthem Medicare Dual Advantage (HMO D-SNP) H5854-020		Anthem Medicare Full Dual Advantage (HMO D-SNP) H5854-013	
MEDICAID STATUS	Partial Dual	QMB	Full Dual	QMB+, SLMB+, FBDE
ESSENTIAL EXTRAS	N/A		N/A	
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year		\$1,200 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year	
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year		\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year	
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	
EVERYDAY OPTIONS ALLOWANCE	\$50 per month OTC, Assistive Devices, Healthy Foods and Utilities		\$120 per month OTC, Assistive Devices, Healthy Foods and Utilities	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – 60 one-way trips per year		\$0 copay – 60 one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	14 post discharge		14 post discharge	

Connecticut 2026 Plan Highlights

	NEW Anthem Medicare Dual Advantage (PPO D-SNP) H2836-007		Anthem Medicare Full Dual Advantage (PPO D-SNP) H2836-006	
MEDICAID STATUS	Partial Dual	QMB	Full Dual	QMB+, SLMB+, FBDE
PREMIUM		\$		\$0
PART B GIVEBACK		\$0		\$0
MEDICAL DEDUCTIBLE		\$0		\$0
MAX OUT-OF-POCKET		\$9,250 (IN) / \$13,900 (OON)		\$9,250 (IN) / \$13,900 (OON)
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay for a one-month supply of select insulin		\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.

Connecticut 2026 Plan Highlights

	NEW	Anthem Medicare Dual Advantage (PPO D-SNP) H2836-007	Anthem Medicare Full Dual Advantage (PPO D-SNP) H2836-006
MEDICAID STATUS	Partial Dual	QMB	Full Dual
ESSENTIAL EXTRAS		N/A	QMB+, SLMB+, FBDE
DENTAL		\$1,200 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year	\$1,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		N/A	N/A
OVER THE COUNTER		\$72 per quarter	\$150 per quarter
FITNESS		\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips per year	\$0 copay – 60 one-way trips per year
PERS		\$0 copay	\$0 copay
PODIATRY		N/A	\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge	42 post discharge



Connecticut 2026 Plan Highlights

**Anthem Kidney Care HMO-POS
(C-SNP)
H5854-012**

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (OON)
PCP	\$0 copay
SPECIALIST	\$0 copay nephrologists 20% coinsurance all others
INPATIENT HOSPITAL	Medicare Fee For Service
SKILLED NURSING FACILITY	Medicare Fee For Service
RX DEDUCTIBLE	\$350 (T3 - T6)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$2 / 25% / 25% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fairfield, Hartford, Litchfield, Middlesex, New Haven, Tolland



Connecticut 2026 Plan Highlights

Anthem Kidney Care HMO-POS (C-SNP) H5854-012

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay - \$2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year; Out of Network: 20% for preventive, 50% for comprehensive per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
OVER THE COUNTER + HEALTHY FOODS	\$50 per month
FITNESS	N/A
TRANSPORTATION	\$0 copay – 36 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge



Connecticut 2026 Plan Highlights

Consolidation & Segmentation

Anthem Medicare Advantage (HMO) H5854-019-001			Anthem Medicare Advantage (HMO) H5854-019-002		
PREMIUM	\$36		\$63		
PART B GIVEBACK	\$0		\$0		
MEDICAL DEDUCTIBLE	\$0		\$0		
MAX OUT-OF-POCKET	\$9,250		\$9,250		
PCP	\$5 copay		\$0 copay		
SPECIALIST	\$50 copay		\$50 copay		
INPATIENT HOSPITAL	\$425 copay (days 1 – 5)		\$450 copay (days 1 – 5)		
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)		\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)		
RX DEDUCTIBLE	\$215 (T3 – T5)		\$215 (T3 – T5)		
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply		\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply		
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin		\$0 - \$35 copay for a one-month supply of select insulin		
MARKET SERVICE AREA	Hartford, Litchfield, Middlesex, Windham		Fairfield, New Haven		



Connecticut 2026 Plan Highlights

Consolidation & Segmentation

Anthem Medicare Advantage (HMO) H5854-019-001		Anthem Medicare Advantage (HMO) H5854-019-002
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	N/A	N/A
VISION	\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	N/A	N/A
FITNESS	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	N/A	N/A



Connecticut 2026 Plan Highlights

**Anthem Veteran
(HMO-POS)**
H5854-018

PREMIUM	\$0
PART B GIVEBACK	\$80
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Fairfield, Hartford, Litchfield, Middlesex, New Haven, Windham



Connecticut 2026 Plan Highlights

Anthem Veteran **(HMO-POS)** H5854-018

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive dental services per year; Out of Network: 20% for preventive, 50% for comprehensive per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge
ACUPUNCTURE	\$15 copay – 24 visits per year



Florida - Medicare Advantage 2026

MARKET HIGHLIGHTS



- 5-Star Excellence: HealthSun (8 years) and Optimum (4 years) lead the way in Florida
- All plans rated 4+ Stars - paired with stable benefits, reliable service, and a partner agents and members' trust
- #1 C-SNP Market Share and #3 D-SNP & HMO Market Share in Florida
- #2 Medicaid leader with 20% Market Share
- 7.2% growth - ELV FL grew 6x AEP '25 market average at 1.2%
- Robust portfolio including D-SNP, C-SNP and HMO
- Simply D-SNP HMO expansion in 13 counties
- Designation as a Highly Integrated Dual Eligible Plan (HIDE)
- Maximum HMO Part B Giveback plans available
- Competitive Everyday Options Allowance for Assistive Devices, Healthy Foods and Utilities
- All plans offer OTC, Vision, Hearing and enhanced Dental
- Active Fitness available on select Optimum & Freedom plans

SERVICE AREA

Brevard, Broward, Charlotte, Citrus, Clay, Collier, Duval, Hernando, **Highlands**, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Simply Comfort (HMO I-SNP) H5471-068	11
Simply Freedom (PPO) H9469 (all plans)	All

Florida – Optimum Medicare Advantage 2026

MARKET HIGHLIGHTS



- Optimum = 5-Stars Excellence 4 years in a row
- #1 C-SNP leader in Florida
- Broad portfolio of products include D-SNP, C-SNP and HMO
- Easy C-SNP enrollment process with 98% acceptance
- Everyday Options Allowance – Assistive Devices, Healthy Foods and Utilities on D-SNP and C-SNP plans
- Maximum HMO Part B Giveback plans available
- Monthly OTC on all plans
- Rich Dental with no maximum allowance
- MOOP as low as \$1,000
- All Part D covered drugs at \$0 copay for Tiers 1 and 5 on D-SNP

SERVICE AREA

Brevard, Broward, Charlotte, Citrus, Collier, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, Volusia

Florida – Freedom Medicare Advantage 2026

MARKET HIGHLIGHTS



- Freedom = 4-Stars rating
- #1 C-SNP leader in Florida
- Broad portfolio of products include D-SNP, C-SNP and HMO
- POS plans with OON benefits in Puerto Rico using plan approved provider network
- Easy C-SNP enrollment process with 98% acceptance
- Everyday Options Allowance – Assistive Devices, Healthy Foods and Utilities on D-SNP and C-SNP plans
- Maximum HMO Part B Giveback plans available
- Monthly OTC on all plans
- Rich Dental with no maximum allowance
- MOOP as low as \$1,000
- All Part D covered drugs at \$0 copay for Tiers 1 and 5 on D-SNP

SERVICE AREA

Brevard, Broward, Charlotte, Citrus, Collier, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, Volusia

Florida – Simply Medicare Advantage 2026

MARKET HIGHLIGHTS



- Simply = 4.5-Stars rating
- #1 C-SNP leader in Florida
- Broad portfolio of products include D-SNP, C-SNP and HMO
- Benefit rich provider specific plans
- Everyday Options Allowance – Assistive Devices, Healthy Foods and Utilities on D-SNP and C-SNP
- Monthly OTC on all plans
- Competitive Part B Giveback plans
- All Part D covered drugs at \$0 copay for Tiers 1 and 6
- Comprehensive Dental coverage
- Dental, Vision and Hearing on all plans
- Flexible Dental Benefit—One Allowance, Member's Choice

SERVICE AREA

Broward, Charlotte, Citrus, Clay, Duval, Hernando, [Highlands](#), Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Simply Comfort (HMO I-SNP) H5471-068	11
Simply Freedom (PPO) H9469 (all plans)	All

Florida – HealthSun Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- Health Sun = 5-Stars Excellence 8 years in a row
- #1 C-SNP leader in Florida
- Robust portfolio including D-SNP, C-SNP and HMO plans in Miami-Dade, Broward and Palm Beach
- Monthly OTC benefit and competitive Everyday Options Allowance – Assistive Devices, Healthy Foods and Utilities on all D-SNPs and C-SNP
- All plans offer generous OTC, Vision, Hearing and enhanced Dental
- Maximum HMO Part B Giveback plans offered in all counties
- Offering a cutting-edge primary and multispecialty medical center model through our exclusive provider network
- Rich comprehensive Dental coverage, including implants
- All Part D covered drugs at \$0 copay for Tiers 1 and 6

SERVICE AREA

Broward, Miami-Dade, Palm Beach

Central

Freedom
Optimum
Simply

Treasure Coast

Freedom
Optimum
Simply

Jacksonville

Simply



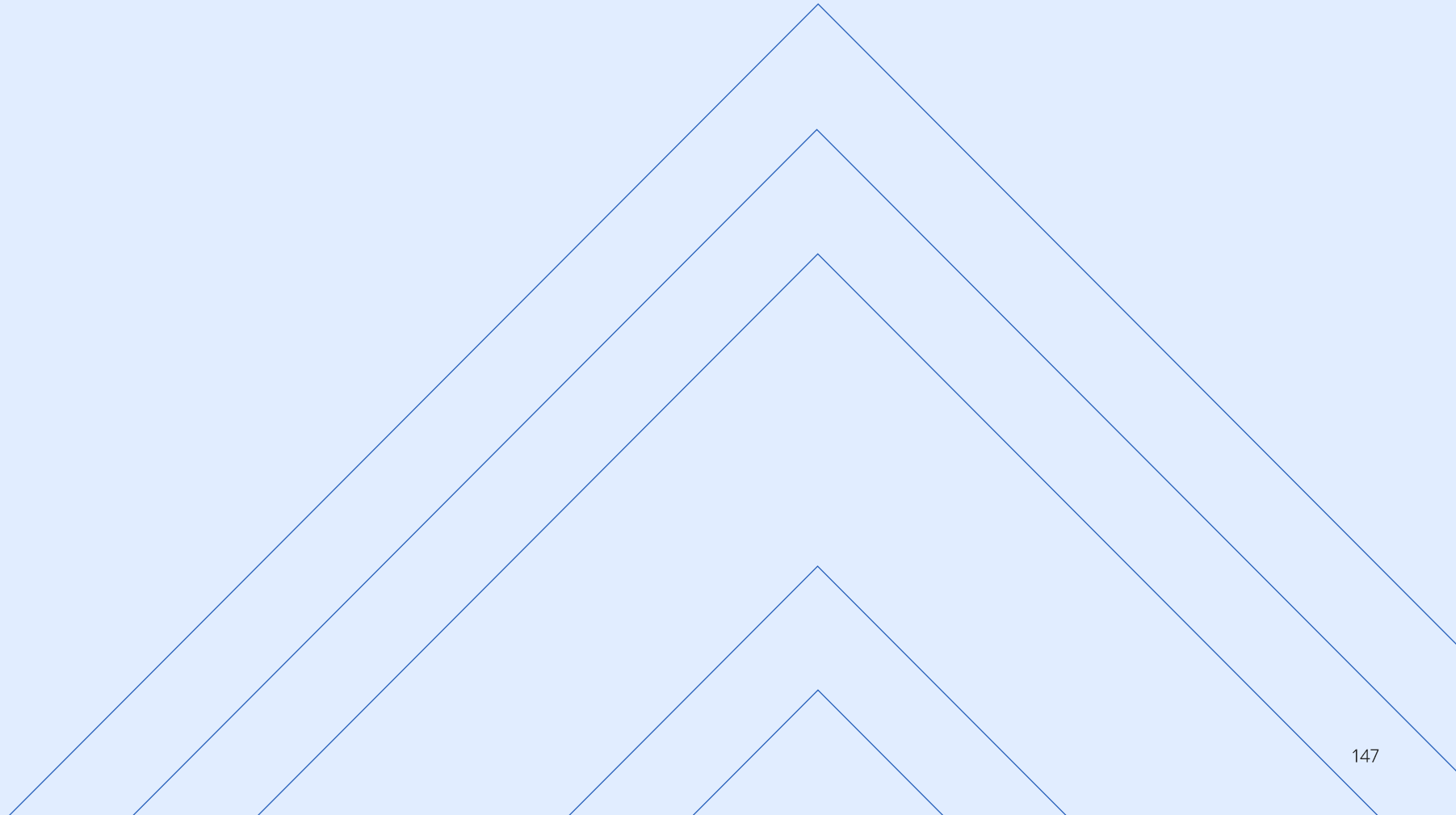
Florida - East

Central

Freedom
Optimum
Simply

FREEDOM

Central



Freedom - Central Florida 2026 Plan Highlights

	 Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	 Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia	Orange, Osceola, Seminole, Volusia

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - Central Florida 2026 Plan Highlights

	 Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	 Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$130 per month	\$130 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights

	 Freedom VIP Care (HMO C-SNP) H5427-070	 Freedom VIP Savings (HMO C-SNP) H5427-072
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$185
MAX OUT-OF-POCKET	\$1,000	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$10 copay
INPATIENT HOSPITAL	\$0 copay	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$10 / \$60 / 33% / \$0 \$0 copay – T1 and T5 mail order 30 - 100 day supply	\$0 / \$20 / \$65 / 33% / \$10 \$0 copay – T1 and T5 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia	Orange, Osceola, Seminole, Volusia



Freedom - Central Florida 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights



**Freedom VIP Savings COPD
(HMO C-SNP)**
H5427-077

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$175 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$20 / \$65 / 33% / N/A \$0 copay – T1 and T5 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia



Freedom - Central Florida 2026 Plan Highlights



DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights



Freedom Máximo

(HMO-POS)

H5427-112

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole



Freedom - Central Florida 2026 Plan Highlights

★
Freedom Máximo
(HMO-POS)
H5427-112

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx

(HMO)

H5427-102

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia



Freedom - Central Florida 2026 Plan Highlights

★

Freedom Platinum Rewards Plan Rx
(HMO)
H5427-102

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$65 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights

Freedom Platinum Plan Rx (HMO)

H5427-089

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$25 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$75 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia



Freedom - Central Florida 2026 Plan Highlights

Freedom Platinum Plan Rx (HMO)

H5427-089

Option 2

DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Central Florida 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$4,200
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia



Freedom - Central Florida 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

Option 1

DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



OPTIMUM

Central

Optimum - Central Florida 2026 Plan Highlights

	★ Optimum Emerald Partial (HMO D-SNP) H5594-016	★ Optimum Emerald Full (HMO D-SNP) H5594-017
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia	Orange, Osceola, Seminole, Volusia

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - Central Florida 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge in 7 days		10 post discharge in 7 days	



Optimum - Central Florida 2026 Plan Highlights

	Optimum Diamond Savings (HMO C-SNP) H5594-030	Optimum Diamond Savings COPD (HMO C-SNP) H5594-031
PREMIUM	\$0	\$0
PART B GIVEBACK	\$65	\$50
MAX OUT-OF-POCKET	\$5,000	\$5,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$30 copay	\$30 copay
INPATIENT HOSPITAL	\$195 copay (days 1 - 7)	\$195 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$35 / \$85 / 33% / \$10 \$0 copay – T1 mail order 30 - 100 day supply	\$0 / \$35 / \$85 / 33% / N/A \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia	Orange, Osceola, Seminole



Optimum - Central Florida 2026 Plan Highlights

	Optimum Diamond Savings (HMO C-SNP) H5594-030	Optimum Diamond Savings COPD (HMO C-SNP) H5594-031
	Option 2	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$35 per month	\$35 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 4 one-way trips per year	\$0 copay – 4 one-way trips per year
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



SIMPLY

Central

Simply - Central Florida 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-129	NEW ★ Simply Integrated Platinum (HMO D-SNP) H5471-136
MEDICAID STATUS	Full Dual FBDE, QMB+, SLMB+	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)	\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole, Volusia	Orange, Osceola, Seminole, Volusia

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Central Florida 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-129	NEW ★ Simply Integrated Platinum (HMO D-SNP) H5471-136
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$350 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$125 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$125 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - Central Florida 2026 Plan Highlights



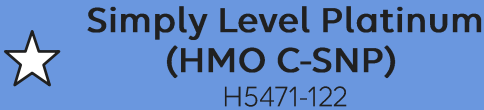
Simply Level Platinum (HMO C-SNP)

H5471-122

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,200
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$200 copay (days 1-5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$20 / \$65 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole



Simply - Central Florida 2026 Plan Highlights



DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$225 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$20 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Central Florida 2026 Plan Highlights



Simply Extra Platinum (HMO) H5471-120 (Transitioned H5471-107)

PREMIUM	\$0
PART B GIVEBACK	\$170
MAX OUT-OF-POCKET	\$3,200
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$200 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$10 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole



Simply - Central Florida 2026 Plan Highlights



Simply Extra Platinum
(HMO) H5471-120
(Transitioned H5471-107)

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$225 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 3 visits per year
HEALTHY MEALS	10 post discharge



Simply - Central Florida 2026 Plan Highlights

Simply Complete Platinum (HMO D-SNP) H5471-121			Simply Complete (HMO D-SNP) H5471-072	
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Partial Dual	QMB, SLMB, QDWI, QI
PREMIUM		\$0 - \$4.80		\$0 - \$4.80
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Orange, Osceola, Seminole, Volusia		Orange, Osceola, Seminole, Volusia

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Central Florida 2026 Plan Highlights

Simply Complete Platinum (HMO D-SNP) H5471-121		Simply Complete (HMO D-SNP) H5471-072	
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$350 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$350 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$125 per month Assistive Devices, Healthy Foods and Utilities	\$125 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$122 per month	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge / 36 chronic condition	10 post discharge	10 post discharge



Simply - Central Florida 2026 Plan Highlights

Simply Level
(HMO C-SNP)
H5471-073

PREMIUM	\$0
PART B GIVEBACK	\$55
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$50 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$20 / \$65 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole



Simply - Central Florida 2026 Plan Highlights

Simply Level
(HMO C-SNP)
H5471-073

Value Dental Plan

DENTAL	\$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Central Florida 2026 Plan Highlights

**Simply More
(HMO)**
H5471-074

PREMIUM	\$0
PART B GIVEBACK	\$40
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$50 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$30 / \$85 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Orange, Osceola, Seminole



Simply - Central Florida 2026 Plan Highlights

Simply More (HMO)

H5471-074

Value Dental Plan

DENTAL	\$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Florida East

Treasure Coast

Freedom
Optimum
Simply

FREEDOM

Treasure Coast

Freedom - Treasure Coast 2026 Plan Highlights

	 Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	 Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie	Brevard, Indian River, Martin, St Lucie

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - Treasure Coast 2026 Plan Highlights

★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078

★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year		\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge within 7 days		10 post discharge within 7 days	



Freedom - Treasure Coast 2026 Plan Highlights

★ **Freedom VIP Rewards**
(HMO C-SNP)
H5427-108

★ **Freedom VIP Savings**
(HMO C-SNP)
H5427-082

PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$120
MAX OUT-OF-POCKET	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$25 copay	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 - 7)	\$195 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$30 / \$80 / 33% / \$10 \$0 copay – T1 mail order 30 - 100 day supply	\$0 / \$30 / \$80 / 33% / \$10 \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie	Brevard, Indian River, Martin, St Lucie



Freedom - Treasure Coast 2026 Plan Highlights

★ **Freedom VIP Rewards
(HMO C-SNP)**
H5427-108

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-082

	Option 2	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	N/A
OVER THE COUNTER	\$60 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Treasure Coast 2026 Plan Highlights

 **Freedom VIP Savings COPD
(HMO C-SNP)**
H5427-083

PREMIUM	\$0
PART B GIVEBACK	\$120
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$195 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$80 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Indian River, Martin, St Lucie



Freedom - Treasure Coast 2026 Plan Highlights



DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$55 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Treasure Coast 2026 Plan Highlights



Freedom Platinum Rewards Plan Rx (HMO)

H5427-106

PREMIUM	\$0
PART B GIVEBACK	\$150
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$250 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$80 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie



Freedom - Treasure Coast 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx
(HMO)
H5427-106

Option 2

DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$55 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Treasure Coast 2026 Plan Highlights

**Freedom Platinum Plan Rx
(HMO)**
H5427-088

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,750
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$85 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$75 / 33% \$0 copay – T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie



Freedom - Treasure Coast 2026 Plan Highlights

Freedom Platinum Plan Rx (HMO)

H5427-088

Option 2

DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Treasure Coast 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$4,200
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie



Freedom - Treasure Coast 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

Option 1

DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



OPTIMUM

Treasure Coast

Optimum - Treasure Coast 2026 Plan Highlights

	 Optimum Emerald Partial (HMO D-SNP) H5594-016	 Optimum Emerald Full (HMO D-SNP) H5594-017
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brevard, Indian River, Martin, St Lucie	Brevard, Indian River, Martin, St Lucie

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - Treasure Coast 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge in 7 days		10 post discharge in 7 days	



SIMPLY

Treasure Coast

Simply - Treasure Coast 2026 Plan Highlights

	NEW Simply Complete Platinum (HMO D-SNP) H5471-142	NEW Simply Integrated Platinum (HMO D-SNP) H5471-143
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)	\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3, T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Highlands, Indian River, Martin, St Lucie	Highlands, Indian River, Martin, St Lucie

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Treasure Coast 2026 Plan Highlights

	NEW Simply Complete Platinum (HMO D-SNP) H5471-142	NEW Simply Integrated Platinum (HMO D-SNP) H5471-143
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$100 per month Assistive Devices, Healthy Foods and Utilities	\$100 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$129 per month	\$125 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Florida - East

Jacksonville
Simply

SIMPLY

Jacksonville

Simply - Jacksonville 2026 Plan Highlights

★ Simply Complete (HMO D-SNP) H5471-111		NEW	★ Simply Integrated (HMO D-SNP) H5471-133	
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
PREMIUM	\$0 - \$4.80		\$0	
PART B GIVEBACK	\$0		\$0	
MAX OUT-OF-POCKET	\$500		\$500	
PCP	\$0 copay		\$0 copay	
SPECIALIST	\$0 copay		\$0 copay	
INPATIENT HOSPITAL	\$0 copay		\$0 copay	
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)	
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)	
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin	
MARKET SERVICE AREA	Clay, Duval, St Johns		Clay, Duval, St Johns	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Jacksonville 2026 Plan Highlights

★ **Simply Complete
(HMO D-SNP)**
H5471-111

NEW

★ **Simply Integrated
(HMO D-SNP)**
H5471-133

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year		Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year	
EVERYDAY OPTIONS ALLOWANCE	\$125 per month Assistive Devices, Healthy Foods and Utilities		\$125 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$100 per month		\$107 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year		\$0 copay – unlimited one-way trips to PAL per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	\$0 copay – 12 visits per year		\$0 copay – 12 visits per year	
HEALTHY MEALS	14 post discharge		14 post discharge	



Simply - Jacksonville 2026 Plan Highlights

	Simply More (HMO) H5471-110	Simply Extra (HMO) H5471-112
PREMIUM	\$0	\$0
PART B GIVEBACK	\$33	\$125
MAX OUT-OF-POCKET	\$3,450	\$3,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$10 copay	\$35 copay
INPATIENT HOSPITAL	\$125 copay (days 1 - 5)	\$325 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply	\$0 / \$10 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clay, Duval, St Johns	Clay, Duval, St Johns



Simply - Jacksonville 2026 Plan Highlights

	Simply More (HMO) H5471-110	Simply Extra (HMO) H5471-112
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$200 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$35 per month	\$40 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 trips one-way trips to PAL per year	\$0 copay – 12 one-way trips per year
PERS	\$0 copay	N/A
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 3 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Florida - West

Tampa Bay

Freedom
Optimum
Simply

The Villages

Freedom
Optimum
Simply

Gulf Coast

Freedom
Optimum
Simply



Florida - West

Tampa Bay

Optimum
Freedom
Simply

OPTIMUM

Tampa Bay

Optimum - Tampa Bay 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0		\$0
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T4)		\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5		\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0		\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk		Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - Tampa Bay 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge in 7 days		10 post discharge in 7 days	



Optimum - Tampa Bay 2026 Plan Highlights

	★ Optimum Diamond Rewards (HMO C-SNP) H5594-028	★ Optimum Diamond Rewards COPD (HMO C-SNP) H5594-029
PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$185
MAX OUT-OF-POCKET	\$1,750	\$1,750
PCP	\$0 copay	\$0 copay
SPECIALIST	\$10 copay	\$10 copay
INPATIENT HOSPITAL	\$65 copay (days 1 - 5)	\$65 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$15 / \$55 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$10 / \$45 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas	Citrus, Hernando, Hillsborough, Pasco, Pinellas



Optimum - Tampa Bay 2026 Plan Highlights

★ **Optimum Diamond Rewards
(HMO C-SNP)**
H5594-028

★ **Optimum Diamond Rewards
(HMO C-SNP)**
H5594-029

	Option 2	Option 4
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 monthly allowance Assistive Devices, Healthy Foods and Utilities	\$70 monthly allowance Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$75 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Optimum - Tampa Bay 2026 Plan Highlights

★ **Optimum Diamond**
(HMO C-SNP)
H5594-036

PREMIUM	\$0
PART B GIVEBACK	\$10
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (days 1 - 90)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$95 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$5/ \$40 / 33% / \$0 \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas



Optimum - Tampa Bay 2026 Plan Highlights



	Option 3
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 monthly allowance Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$75 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Optimum - Tampa Bay 2026 Plan Highlights

	★ Optimum Gold Rewards Plan (HMO) H5594-001	★ Optimum Platinum Plan (HMO) H5594-002
PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$0
MAX OUT-OF-POCKET	\$1,900	\$1,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$10 copay	\$0 copay
INPATIENT HOSPITAL	\$95 copay (days 1 - 5)	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 - 100)	\$0 copay (days 1 – 20) \$95 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$70 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$5 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hernando, Hillsborough, Pasco, Pinellas	Hernando, Hillsborough, Pasco, Pinellas



Optimum - Tampa Bay 2026 Plan Highlights

	 Optimum Gold Rewards Plan (HMO) H5594-001	 Optimum Platinum Plan (HMO) H5594-002
	Option 2	Option 4
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$60 per month	\$85 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Optimum - Tampa Bay 2026 Plan Highlights

**Optimum Gold Plus Plan
(HMO)**
H5594-032

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$1,900
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$75 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus and Hernando



Optimum - Tampa Bay 2026 Plan Highlights

★**Optimum Gold Plus Plan**
(HMO)
H5594-032

	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Optimum - Tampa Bay 2026 Plan Highlights

	Optimum Diamond Savings (HMO C-SNP) H5594-030	Optimum Diamond Savings COPD (HMO C-SNP) H5594-031
PREMIUM	\$0	\$0
PART B GIVEBACK	\$65	\$50
MAX OUT-OF-POCKET	\$5,000	\$5,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$30 copay	\$30 copay
INPATIENT HOSPITAL	\$195 copay (days 1 - 7)	\$195 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$35 / \$85 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$35 / \$85 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Polk	Citrus, Polk



Optimum - Tampa Bay 2026 Plan Highlights

Optimum Diamond Savings (HMO C-SNP) H5594-030		Optimum Diamond Savings COPD (HMO C-SNP) H5594-031	
	Option 2		Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year		\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A		N/A
OVER THE COUNTER	\$35 per month		\$35 per month
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 4 one-way trips per year		\$0 copay – 4 one-way trips per year
PERS	N/A		N/A
PODIATRY	N/A		N/A
HEALTHY MEALS	10 post discharge within 7 days		10 post discharge within 7 days



FREEDOM

Tampa Bay

Freedom - Tampa Bay 2026 Plan Highlights

	★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - Tampa Bay 2026 Plan Highlights

★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078

★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year		\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge within 7 days		10 post discharge within 7 days	



Freedom - Tampa Bay 2026 Plan Highlights

★ **Freedom VIP Rewards**
(HMO C-SNP)
H5427-099

★ **Freedom VIP Savings COPD**
(HMO C-SNP)
H5427-077

PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$185
MAX OUT-OF-POCKET	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$10 copay	\$10 copay
INPATIENT HOSPITAL	\$75 copay (days 1 - 5)	\$175 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$30 / \$65 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$20 / \$65 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Polk	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk



Freedom - Tampa Bay 2026 Plan Highlights

★ **Freedom VIP Rewards
(HMO C-SNP)**
H5427-099

★ **Freedom VIP Savings COPD
(HMO C-SNP)**
H5427-077

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Tampa Bay 2026 Plan Highlights

★ **Freedom VIP Care**
(HMO C-SNP)
H5427-070

★ **Freedom VIP Savings**
(HMO C-SNP)
H5427-072

PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$185
MAX OUT-OF-POCKET	\$1,000	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$10 copay
INPATIENT HOSPITAL	\$0 copay	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$10 / \$60 / 33% / \$0 \$0 copay – Part D on T1 and T5 mail order 30 - 90 day supply	\$0 / \$20 / \$65 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk



Freedom - Tampa Bay 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Tampa Bay 2026 Plan Highlights



Freedom Máximo

(HMO-POS)

H5427-113

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$1,900
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$95 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hillsborough and Polk



Freedom - Tampa Bay 2026 Plan Highlights



Freedom Máximo

(HMO-POS)

H5427-113

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Tampa Bay 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx
(HMO) H5427-107
(Transitioned H5427-092)

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$95 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$35 / \$65 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Polk



Freedom - Tampa Bay 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx
(HMO) H5427-107
(Transitioned H5427-092)

DENTAL	Option 4 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$55 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Tampa Bay 2026 Plan Highlights

	Freedom Savings (HMO) H5427-052	Freedom Platinum Plan Rx (HMO) H5427-093
PREMIUM	\$0	\$0
PART B GIVEBACK	\$75	\$0
MAX OUT-OF-POCKET	\$4,200	\$2,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$40 copay	\$10 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)	\$60 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A	\$0
RX COST SHARE T1/T2/T3/T4	N/A	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk	Citrus



Freedom - Tampa Bay 2026 Plan Highlights

	Freedom Savings (HMO) H5427-052	Freedom Platinum Plan Rx (HMO) H5427-093
	Option 1	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$35 per month	\$110 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year	\$0 copay – 12 one-way trips per year
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



SIMPLY

Tampa Bay

Simply - Tampa Bay 2026 Plan Highlights

★ Simply Complete Platinum (HMO D-SNP) H5471-118

NEW

★ Simply Integrated Platinum (HMO D-SNP) H5471-135

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0 - \$4.80		\$0
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* on (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk		Citrus, Hernando, Hillsborough, Pasco, Pinellas, Polk

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Tampa Bay 2026 Plan Highlights

★ Simply Complete Platinum (HMO D-SNP) H5471-118

NEW

★ Simply Integrated Platinum (HMO D-SNP) H5471-135

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year		Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$122 per month		\$125 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year		\$0 copay – unlimited one-way trips to PAL per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	\$0 copay – 12 visits per year		\$0 copay – 12 visits per year	
HEALTHY MEALS	10 post discharge / 30 chronic condition		10 post discharge / 30 chronic condition	



Simply - Tampa Bay 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-131	NEW ★ Simply Integrated (HMO D-SNP) H5471-128
MEDICAID STATUS	Full Dual FBDE, QMB+, SLMB+	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)	\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* on T2 – T5 T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Citrus, Hernando, Hillsborough, Pasco, Pinellas	Polk

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Tampa Bay 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-131	NEW ★ Simply Integrated (HMO D-SNP) H5471-128
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$100 per month Assistive Devices, Healthy Foods and Utilities	\$125 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$55 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge / 30 chronic condition



Simply - Tampa Bay 2026 Plan Highlights



Simply Level Platinum (HMO C-SNP)

H5471-119

PREMIUM	\$0
PART B GIVEBACK	\$164.90
MAX OUT-OF-POCKET	\$2,450
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$100 copay (days 1-5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hernando, Hillsborough, Pasco, Pinellas, Polk



Simply - Tampa Bay 2026 Plan Highlights



DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$150 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$50 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$50 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

 **Simply Extra Platinum**
(HMO) H5471-117
(Transitioned H5471-106, 108)

PREMIUM	\$0
PART B GIVEBACK	\$164.90
MAX OUT-OF-POCKET	\$3,200
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$40 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hernando, Hillsborough, Pasco, Pinellas, Polk



Simply - Tampa Bay 2026 Plan Highlights

★ **Simply Extra Platinum**
(HMO) H5471-117
(Transitioned H5471-106, 108)

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$100 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$20 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 3 visits per year
HEALTHY MEALS	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

	Simply Complete (HMO D-SNP) H5471-066		Simply Complete (HMO D-SNP) H5471-082	
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Partial Dual	QMB, SLMB, QDWI, QI
PREMIUM		\$0		\$0 - \$4.80
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* on T2 – T5 T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Polk		Citrus, Hernando, Hillsborough, Pasco, Pinellas

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - Tampa Bay 2026 Plan Highlights

Simply Complete (HMO D-SNP) H5471-066		Simply Complete (HMO D-SNP) H5471-082	
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$125 per month Assistive Devices, Healthy Foods and Utilities	\$100 per month Assistive Devices, Healthy Foods and Utilities	\$100 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$55 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge / 30 chronic condition	10 post discharge	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

Simply Level
(HMO C-SNP)
H5471-070

PREMIUM	\$0
PART B GIVEBACK	\$65
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$40 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$10 / \$55 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Polk



Simply - Tampa Bay 2026 Plan Highlights

**Simply Level
(HMO C-SNP)**
H5471-070

Value Dental Plan

DENTAL	\$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 maximum plan benefit per year hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$40 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$45 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

Simply Level
(HMO C-SNP)
H5471-075

PREMIUM	\$0
PART B GIVEBACK	\$10
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$50 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$30 / \$75 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hernando, Hillsborough, Pasco, Pinellas



Simply - Tampa Bay 2026 Plan Highlights

Simply Level
(HMO C-SNP)
H5471-075

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$40 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$30 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

Simply More (HMO) H5471-071

PREMIUM	\$0
PART B GIVEBACK	\$20
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$40 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$10 / \$55 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Polk



Simply - Tampa Bay 2026 Plan Highlights

Simply More (HMO)

H5471-071

Value Dental Plan

DENTAL	\$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - Tampa Bay 2026 Plan Highlights

**Simply More
(HMO)**
H5471-078

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$50 copay (days 1 - 8)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$35 / \$85 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Hernando, Hillsborough, Pasco, Pinellas



Simply - Tampa Bay 2026 Plan Highlights

Simply More (HMO) H5471-078

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



West Florida

The Villages

Freedom
Optimum
Simply

FREEDOM

The Villages

Freedom - The Villages 2026 Plan Highlights

	 Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	 Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* on T2 – T4 Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* on T2 – T4 Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter	Lake, Marion, Sumter

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - The Villages 2026 Plan Highlights

	 Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	 Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$130 per month	\$130 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - The Villages 2026 Plan Highlights

★ **Freedom VIP Care**
(HMO C-SNP)
H5427-070

★ **Freedom VIP Savings**
(HMO C-SNP)
H5427-072

PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$185
MAX OUT-OF-POCKET	\$1,000	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$10 copay
INPATIENT HOSPITAL	\$0 copay	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$10 / \$60 / 33% / \$0 \$0 copay – Part D on T1 and T5 mail order 30 - 90 day supply	\$0 / \$20 / \$65 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter	Lake, Marion, Sumter



Freedom - The Villages 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - The Villages 2026 Plan Highlights

**Freedom VIP Savings COPD
(HMO C-SNP)**
H5427-077

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$175 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$20 / \$65 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter



Freedom - The Villages 2026 Plan Highlights



DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - The Villages 2026 Plan Highlights



Freedom Platinum Rewards Plan Rx (HMO)

H5427-096

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter



Freedom - The Villages 2026 Plan Highlights

**Freedom Platinum Rewards Plan Rx
(HMO)**
H5427-096

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$57 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - The Villages 2026 Plan Highlights

**Freedom Platinum Plan Rx
(HMO)**
H5427-094

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,000
PCP	\$0 copay
SPECIALIST	\$5 copay
INPATIENT HOSPITAL	\$40 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$75 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter



Freedom - The Villages 2026 Plan Highlights

**Freedom Platinum Plan Rx
(HMO)**
H5427-094

	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$300 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - The Villages 2026 Plan Highlights

**Freedom Savings
(HMO)**
H5427-052

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$4,200
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 10) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5	N/A
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter



Freedom - The Villages 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

	Option 1
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



OPTIMUM

The Villages

Optimum - The Villages 2026 Plan Highlights

	★ Optimum Emerald Partial (HMO D-SNP) H5594-016	★ Optimum Emerald Full (HMO D-SNP) H5594-017
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* on T2 – T4 Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* on T2 – T4 Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter	Lake, Marion, Sumter

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - The Villages 2026 Plan Highlights

	 Optimum Emerald Partial (HMO D-SNP) H5594-016	 Optimum Emerald Full (HMO D-SNP) H5594-017
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$130 per month	\$130 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge in 7 days	10 post discharge in 7 days



Optimum - The Villages 2026 Plan Highlights

	Optimum Diamond Savings (HMO C-SNP) H5594-030	Optimum Diamond Savings COPD (HMO C-SNP) H5594-031
PREMIUM	\$0	\$0
PART B GIVEBACK	\$65	\$50
MAX OUT-OF-POCKET	\$5,000	\$5,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$30 copay	\$30 copay
INPATIENT HOSPITAL	\$195 copay (days 1 - 7)	\$195 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$35 / \$85 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$35 / \$85 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter	Lake, Marion, Sumter



Optimum - The Villages 2026 Plan Highlights

Optimum Diamond Savings (HMO C-SNP) H5594-030		Optimum Diamond Savings COPD (HMO C-SNP) H5594-031	
	Option 2		Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A	
OVER THE COUNTER	\$35 per month	\$35 per month	
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – 4 one-way trips per year	\$0 copay – 4 one-way trips per year	
PERS	N/A	N/A	
PODIATRY	N/A	N/A	
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days	



SIMPLY

The Villages

Simply - The Villages 2026 Plan Highlights

	NEW Simply Complete Platinum (HMO D-SNP) H5471-138	NEW Simply Integrated Platinum (HMO D-SNP) H5471-139
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$490 (T2 – T5)	\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Lake, Marion, Sumter	Lake, Marion, Sumter

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - The Villages 2026 Plan Highlights

	NEW Simply Complete Platinum (HMO D-SNP) H5471-138	NEW Simply Integrated Platinum (HMO D-SNP) H5471-139
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$100 per month Assistive Devices, Healthy Foods and Utilities	\$100 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$125 per month	\$128 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



West Florida

Gulf Coast
Freedom
Optimum
Simply

FREEDOM

Gulf Coast

Freedom - Gulf Coast 2026 Plan Highlights

	★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Charlotte, Collier, Lee, Manatee, Sarasota	Charlotte, Collier, Lee, Manatee, Sarasota

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - Gulf Coast 2026 Plan Highlights

★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078

★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year		\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge within 7 days		10 post discharge within 7 days	



Freedom - Gulf Coast 2026 Plan Highlights

	★ Freedom VIP Care (HMO C-SNP) H5427-070	★ Freedom VIP Savings (HMO C-SNP) H5427-072
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$185
MAX OUT-OF-POCKET	\$1,000	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$10 copay
INPATIENT HOSPITAL	\$0 copay	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$10 / \$60 / 33% / \$0 \$0 copay – Part D on T1 and T5 mail order 30 - 90 day supply	\$0 / \$20 / \$65 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Manatee, Sarasota	Manatee, Sarasota



Freedom - Gulf Coast 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

	★ Freedom VIP Savings (HMO C-SNP) H5427-082	★ Freedom VIP Savings COPD (HMO C-SNP) H5427-083
PREMIUM	\$0	\$0
PART B GIVEBACK	\$120	\$120
MAX OUT-OF-POCKET	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$25 copay	\$25 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)	\$195 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$30 / \$80 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$30 / \$80 / 33% / NA \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Charlotte, Collier, Lee	Charlotte, Collier, Lee



Freedom - Gulf Coast 2026 Plan Highlights



Freedom VIP Savings (HMO C-SNP)

H5427-082



Freedom VIP Savings COPD (HMO C-SNP)

H5427-083

	Option 2	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$55 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

★ **Freedom VIP Savings COPD**
(HMO C-SNP)
H5427-077

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$175 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$20 / \$65 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Manatee, Sarasota



Freedom - Gulf Coast 2026 Plan Highlights



DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx

(HMO)

H5427-105

PREMIUM	\$0
PART B GIVEBACK	\$105
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Charlotte, Collier, Lee



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx

(HMO)

H5427-105

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Platinum Rewards Plan Rx
(HMO)
H5427-103

PREMIUM	\$0
PART B GIVEBACK	\$150
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$35 / \$85 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Manatee, Sarasota



Freedom - Gulf Coast 2026 Plan Highlights

★

Freedom Platinum Rewards Plan Rx
(HMO)
H5427-103

	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$55 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Platinum Plan Rx
(HMO) H5427-091
(Transitioned H5427-098)

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,750
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$75 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$10 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Charlotte, Collier, Lee, Manatee, Sarasota



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Platinum Plan Rx
(HMO) H5427-091
(Transitioned H5427-098)

DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - Gulf Coast 2026 Plan Highlights

**Freedom Savings
(HMO)**
H5427-052

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$4,200
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Lee, Manatee, Sarasota



Freedom - Gulf Coast 2026 Plan Highlights

Freedom Savings (HMO)

H5427-052

	Option 1
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



OPTIMUM

Gulf Coast

Optimum - Gulf Coast 2026 Plan Highlights

	★ Optimum Emerald Partial (HMO D-SNP) H5594-016	★ Optimum Emerald Full (HMO D-SNP) H5594-017
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward, Palm Beach	Broward, Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - Gulf Coast 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips		\$0 copay – unlimited one-way trips	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge in 7 days		10 post discharge in 7 days	



Optimum - Gulf Coast 2026 Plan Highlights

Optimum Diamond Savings (HMO C-SNP) H5594-030

PREMIUM	\$0
PART B GIVEBACK	\$65
MAX OUT-OF-POCKET	\$5,000
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$195 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$35 / \$85 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Manatee, Sarasota



Optimum - Gulf Coast 2026 Plan Highlights

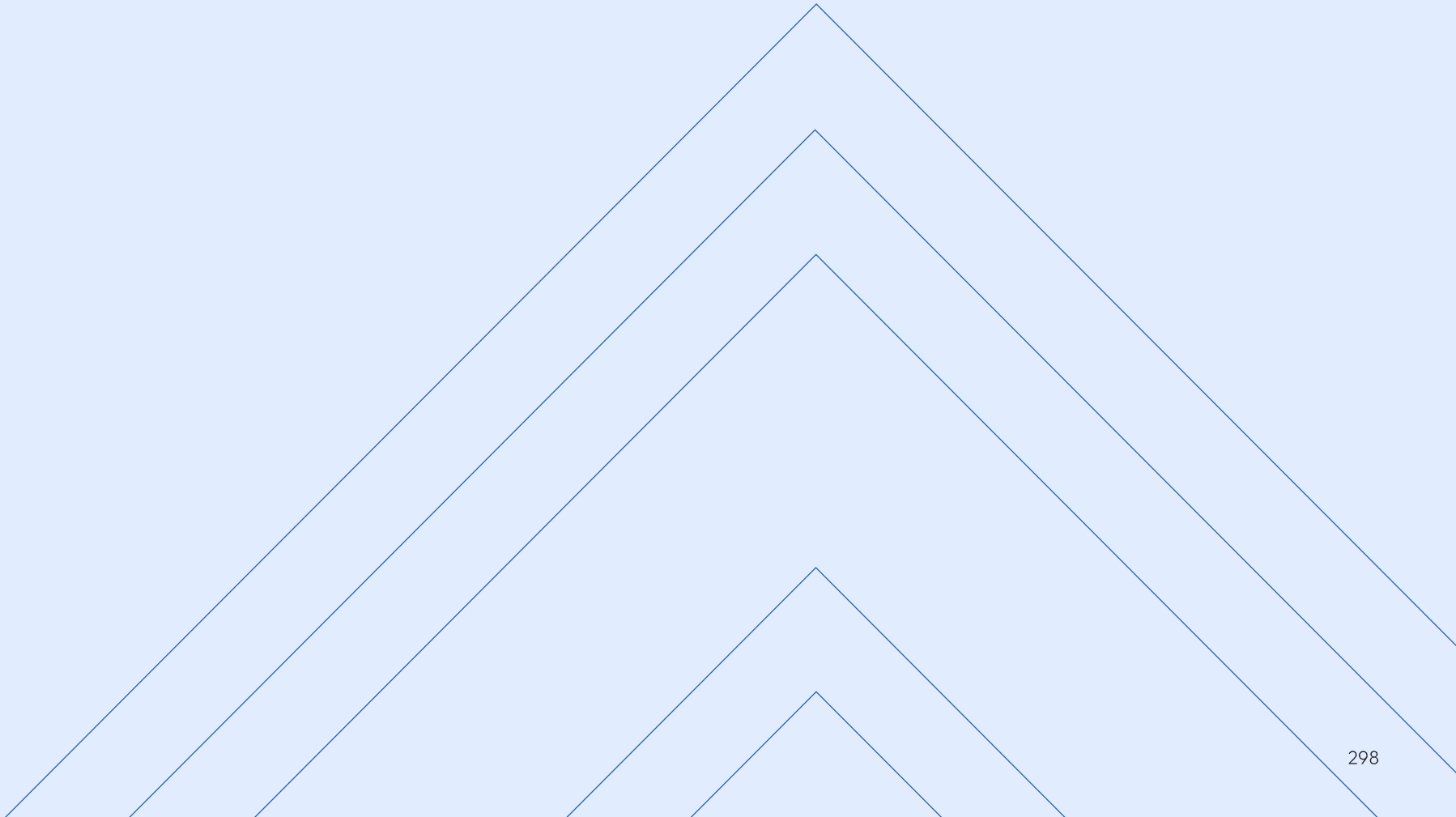
Optimum Diamond Savings (HMO C-SNP) H5594-030

	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 4 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



SIMPLY

Gulf Coast



Simply – Gulf Coast 2026 Plan Highlights

	NEW	Simply Complete Platinum (HMO D-SNP) H5471-140	NEW	Simply Integrated Platinum (HMO D-SNP) H5471-141
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0		\$0
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Charlotte, Lee, Manatee, Sarasota		Charlotte, Lee, Manatee, Sarasota

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply – Gulf Coast 2026 Plan Highlights

	NEW Simply Complete Platinum (HMO D-SNP) H5471-140	NEW Simply Integrated Platinum (HMO D-SNP) H5471-141
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$100 per month Assistive Devices, Healthy Foods and Utilities	\$100 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$128 per month	\$128 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



South Florida
HealthSun
Simply
Freedom
Optimum



Florida – South

South Florida

HealthSun
Simply
Freedom
Optimum

HEALTHSUN

Florida - South

HealthSun - South Florida 2026 Plan Highlights

	★ HealthSun MediSun Extra (HMO D-SNP) H5431-019	NEW ★ HealthSun MediSun Full Dual Extra (HMO D-SNP) H5431-026
MEDICAID STATUS	Partial Dual	Full Dual
	QMB, SLMB, QDWI, QI	FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$3,450	\$3,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 - 100)	\$0 copay (days 1 - 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1 and T2 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1 and T2 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade, Broward	Miami-Dade, Broward

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



HealthSun - South Florida 2026 Plan Highlights

	 HealthSun MediSun Extra (HMO D-SNP) H5431-019	NEW  HealthSun MediSun Full Dual Extra (HMO D-SNP) H5431-026
MEDICAID STATUS	Partial Dual	Full Dual
	QMB, SLMB, QDWI, QI	FBDE, QMB+, SLMB+
DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam per year \$0 copay - 1 fitting/evaluation per year \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam per year \$0 copay - 1 fitting/evaluation per year \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$225 per month Assistive Devices, Healthy Foods and Utilities	\$225 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$128 per month	\$125 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 4 visits per year	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge / 20 chronic condition meals per month	42 post discharge / 20 chronic condition meals per month



HealthSun - South Florida 2026 Plan Highlights

	 HealthSun MediSun Plus (HMO D-SNP) H5431-016	NEW  HealthSun MediSun Full Duals Plus (HMO D-SNP) H5431-025
MEDICAID STATUS	Partial Dual	Full Dual
	QMB, SLMB, QDWI, QI	FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$3,450	\$3,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 - 100)	\$0 copay (days 1 - 100)
RX DEDUCTIBLE	\$0 - \$615 (T3-T5)	\$0 - \$615 (T3-T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1 and T2 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1, T2 and T6 Members pay LIS copay* (T3 – T5) T1 – T2 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Palm Beach	Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



HealthSun - South Florida 2026 Plan Highlights

	 HealthSun MediSun Plus (HMO D-SNP) H5431-016	NEW  HealthSun MediSun Full Duals Plus (HMO D-SNP) H5431-025
MEDICAID STATUS	Partial Dual	Full Dual
	QMB, SLMB, QDWI, QI	FBDE, QMB+, SLMB+
DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam per year; \$0 copay - 1 fitting/evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam per year; \$0 copay - 1 fitting/evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$225 per month Assistive Devices, Healthy Foods and Utilities	\$225 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$155 per month	\$155 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 4 visits per year	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge / 20 chronic condition meals per month	42 post discharge / 20 chronic condition meals per month



HealthSun - South Florida 2026 Plan Highlights

	 HealthSun VitalCare (HMO C-SNP) H5431-021	 HealthSun VitalCare (HMO C-SNP) H5431-022
PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$185
MAX OUT-OF-POCKET	\$1,900	\$2,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$15 copay
INPATIENT HOSPITAL	\$0 copay	\$150 (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$5 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply	\$0 / \$0 / \$5 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade, Broward	Palm Beach



HealthSun - South Florida 2026 Plan Highlights

★ **HealthSun VitalCare
(HMO C-SNP)**
H5431-021

★ **HealthSun VitalCare
(HMO C-SNP)**
H5431-022

	HS 8	HS 8
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year	\$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$40 per month Assistive Devices, Healthy Foods and Utilities	\$40 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$70 per month	\$65 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 4 visits per year	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge / 20 chronic condition meals per month	42 post discharge / 20 chronic condition meals per month



HealthSun - South Florida 202 Plan Highlights

HealthSun HealthAdvantage Plus

(HMO)

H5431-017

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$5 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade



HealthSun - South Florida 2026 Plan Highlights



HealthSun HealthAdvantage Plus (HMO) H5431-017

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$200 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$95 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plus

(HMO)

H5431-018

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$150 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$5 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward



HealthSun - South Florida 2026 Plan Highlights

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HealthSun HealthAdvantage Plus
(HMO)
H5431-018

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$200 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam per year \$0 copay - 1 fitting/evaluation per year \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$103 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plus

(HMO)

H5431-020

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$15 copay
INPATIENT HOSPITAL	\$150 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$60 copay (days 21 - 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$10 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Palm Beach



HealthSun - South Florida 2026 Plan Highlights

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HealthSun HealthAdvantage Plus
(HMO)
H5431-020

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$200 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$85 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	N/A
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan
(HMO)
H5431-001

PREMIUM	\$0
PART B GIVEBACK	\$50
MAX OUT-OF-POCKET	\$1,500
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$0 / \$30 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan
(HMO)
H5431-001

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$90 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge / 20 chronic condition meals per month



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan
(HMO)
H5431-012

PREMIUM	\$0
PART B GIVEBACK	\$50
MAX OUT-OF-POCKET	\$2,500
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$5 / \$30 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan (HMO)

H5431-012

	HS 8
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam per year \$0 copay - 1 fitting/evaluation per year \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$82 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



HealthSun - South Florida 2026 Plan Highlights

**HealthSun MediMax
(HMO)**
H5431-006

PREMIUM	\$0
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 - 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$10 / \$50 / 33% / \$0 \$0 copay – T1, T2 and T6 T1 – T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade, Broward



HealthSun - South Florida 2026 Plan Highlights

**HealthSun MediMax
(HMO)**
H5431-006

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam; \$0 copay – 1 fitting/evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$90 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan
(HMO)
H5431-013

PREMIUM	\$0
PART B GIVEBACK	\$50
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$20 copay (days 1 - 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 - 20) \$60 copay (days 21 - 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$10 / \$50 / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Palm Beach



HealthSun - South Florida 2026 Plan Highlights

HealthSun HealthAdvantage Plan (HMO)

H5431-013

DENTAL	HS 8 \$0 copay – 2 oral exams, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$5,000 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	N/A
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 4 visits per year
HEALTHY MEALS	42 post discharge



SIMPLY

Florida - South

Simply - South Florida 2026 Plan Highlights

	 Simply Complete Platinum (HMO D-SNP) H5471-115	NEW  Simply Integrated Platinum (HMO D-SNP) H5471-134
MEDICAID STATUS	Partial Dual	Full Dual
	QMB, SLMB, QDWI, QI	FBDE, QMB+, SLMB+
PREMIUM	\$0 - \$4.80	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)	\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade	Miami-Dade

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - South Florida 2026 Plan Highlights

★ Simply Complete Platinum (HMO D-SNP) H5471-115

NEW

★ Simply Integrated Platinum (HMO D-SNP) H5471-134

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year		Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	
EVERYDAY OPTIONS ALLOWANCE	\$225 per month Assistive Devices, Healthy Foods and Utilities		\$225 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$132 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year		\$0 copay – unlimited one-way trips to PAL per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	\$0 copay – 12 visits per year		\$0 copay – 12 visits per year	
HEALTHY MEALS	10 post discharge / 36 chronic condition		10 post discharge / 36 chronic condition	



Simply - South Florida 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-127	NEW ★ Simply Integrated Platinum (HMO D-SNP) H5471-137
MEDICAID STATUS	Full Dual FBDE, QMB+, SLMB+	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T5)	\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade	Broward, Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - South Florida 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-127	NEW ★ Simply Integrated Platinum (HMO D-SNP) H5471-137
MEDICAID STATUS	Full Dual FBDE, QMB+, SLMB+	Full Dual FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$150 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$115 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge / 36 chronic condition	10 post discharge



Simply - South Florida 2026 Plan Highlights

	NEW	★ Simply Integrated (HMO D-SNP) H5471-130	NEW	★ Simply Integrated (HMO D-SNP) H5471-132
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0		\$0
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Broward		Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - South Florida 2026 Plan Highlights

	NEW ★ Simply Integrated (HMO D-SNP) H5471-130	NEW ★ Simply Integrated (HMO D-SNP) H5471-132
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$125 per month Assistive Devices, Healthy Foods and Utilities	\$125 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$55 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - South Florida 2026 Plan Highlights

★ Simply Level Platinum (HMO C-SNP) H5471-126 (Transitioned H5471-085)

★ Simply Level Platinum (HMO C-SNP) H5471-116

PREMIUM	\$0	\$0
PART B GIVEBACK	\$164.90	\$175
MAX OUT-OF-POCKET	\$3,450	\$2,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$20 copay	\$0 copay
INPATIENT HOSPITAL	\$150 copay (days 1-5)	\$50 copay (days 1-5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$60 coFpay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply	\$0 / \$0 / \$30 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward, Palm Beach	Miami-Dade



Simply - South Florida 2026 Plan Highlights

★ **Simply Level Platinum**
(HMO C-SNP) H5471-126
(Transitioned H5471-085)

★ **Simply Level Platinum**
(HMO C-SNP)
H5471-116

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$225 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$30 per month Assistive Devices, Healthy Foods and Utilities	\$40 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$50 per month	\$30 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year	\$0 copay – 24 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - South Florida 2026 Plan Highlights

	 Simply More Platinum (HMO) H5471-114	 Simply Extra Platinum (HMO) H5471-113 (Transitioned H5471-103)
PREMIUM	\$0	\$0
PART B GIVEBACK	\$50	\$164.90
MAX OUT-OF-POCKET	\$3,400	\$2,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$75 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$60 copay (days 1 – 100)	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$0 / \$30 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply	\$0 / \$0 / \$10 / \$50 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade	Miami-Dade



Simply - South Florida 2026 Plan Highlights

	 Simply More Platinum (HMO) H5471-114	 Simply Extra Platinum (HMO) H5471-113 (Transitioned H5471-103)
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$200 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$45 per month	\$20 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – 12 one-way trips per year
PERS	\$0 copay	N/A
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - South Florida 2026 Plan Highlights

★ **Simply More Platinum** (HMO) H5471-124 (Transitioned H5471-083)

★ **Simply Extra Platinum** (HMO) H5471-123 (Transitioned H5471-104, 105)

PREMIUM	\$0	\$0
PART B GIVEBACK	\$30	\$164.90
MAX OUT-OF-POCKET	\$3,850	\$3,200
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$20 copay
INPATIENT HOSPITAL	\$0 copay	\$200 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$20 / \$75 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply	\$0 / \$10 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward, Palm Beach	Broward, Palm Beach



Simply - South Florida 2026 Plan Highlights

★ **Simply More Platinum** (HMO) H5471-124 (Transitioned H5471-083)

★ **Simply Extra Platinum** (HMO) H5471-123 (Transitioned H5471-104, 105)

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$45 per month	\$45 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – 12 one-way trips per year
PERS	\$0 copay	N/A
PODIATRY	\$0 copay – 12 visits per year	N/A
HEALTHY MEALS	10 post discharge	10 post discharge



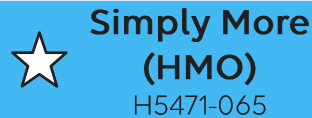
Simply - South Florida 2026 Plan Highlights

★ **Simply More
(HMO)**
H5471-065

PREMIUM	\$0
PART B GIVEBACK	\$35
MAX OUT-OF-POCKET	\$3,850
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 - 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$0 / \$30 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade



Simply - South Florida 2026 Plan Highlights



Value Dental Plan

DENTAL	\$0 copay unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$350 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$37 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



Simply - South Florida 2026 Plan Highlights

Simply Complete Platinum (HMO D-SNP) H5471-125			Simply Complete (HMO D-SNP) H5471-064		
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Partial Dual	QMB, SLMB, QDWI, QI	
PREMIUM		\$0 - \$4.80		\$0	
PART B GIVEBACK		\$0		\$0	
MAX OUT-OF-POCKET		\$500		\$500	
PCP		\$0 copay		\$0 copay	
SPECIALIST		\$0 copay		\$0 copay	
INPATIENT HOSPITAL		\$0 copay		\$0 copay	
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)	
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)	
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0	
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin	
MARKET SERVICE AREA		Broward, Palm Beach		Miami-Dade	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - South Florida 2026 Plan Highlights

Simply Complete Platinum (HMO D-SNP) H5471-125		Simply Complete (HMO D-SNP) H5471-064	
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$150 per month Assistive Devices, Healthy Foods and Utilities	\$150 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$115 per month	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge / 36 chronic condition	10 post discharge / 36 chronic condition



Simply - South Florida 2026 Plan Highlights

	Simply Complete (HMO D-SNP) H5471-084		Simply Complete (HMO D-SNP) H5471-076	
MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Partial Dual	QMB, SLMB, QDWI, QI
PREMIUM		\$0 - \$4.80		\$0 - \$4.80
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0		\$0 copay – T1 and T6 Members pay LIS copay* (T2 – T5) T1, T2, T3 and T6 mail order 30 - 90 day supply Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Palm Beach		Broward

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Simply - South Florida 2026 Plan Highlights

	Simply Complete (HMO D-SNP) H5471-084	Simply Complete (HMO D-SNP) H5471-076
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Partial Dual QMB, SLMB, QDWI, QI
DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,500 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$125 per month Assistive Devices, Healthy Foods and Utilities	\$125 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$50 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips to PAL per year	\$0 copay – unlimited one-way trips to PAL per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - South Florida 2026 Plan Highlights

	Simply Level (HMO C-SNP) H5471-069	Simply Level (HMO C-SNP) H5471-080
PREMIUM	\$0	\$0
PART B GIVEBACK	\$42	\$0
MAX OUT-OF-POCKET	\$3,450	\$3,450
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)	\$0 copay (days 1 – 21) \$60 copay (days 21 - 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$0 / \$25 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply	\$0 / \$0 / \$15 / \$75 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Miami-Dade	Broward



Simply - South Florida 2026 Plan Highlights

**Simply Level
(HMO C-SNP)**
H5471-069

**Simply Level
(HMO C-SNP)**
H5471-080

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$350 allowance - eyeglasses or contact lenses per year	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	\$40 per month Assistive Devices, Healthy Foods and Utilities	\$40 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$45 per month	\$35 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge	10 post discharge



Simply - South Florida 2026 Plan Highlights

Simply More (HMO) H5471-077

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,450
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$60 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / \$47 / \$95 / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward



Simply - South Florida 2026 Plan Highlights

Simply More (HMO) H5471-077

DENTAL	Value Dental Plan \$0 copay – unlimited oral exams, unlimited cleanings, unlimited dental X-rays, unlimited fluoride treatments every year; \$1,200 allowance for preventive and comprehensive services per year
VISION	\$0 copay - 1 routine eye exam per year; \$300 allowance - eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 maximum plan benefit per year for hearing aids
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$72 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	10 post discharge



FREEDOM

Florida – South

Freedom - South Florida 2026 Plan Highlights

	★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$500	\$500
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$0 copay
INPATIENT HOSPITAL	\$0 copay	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 100)	\$0 copay (days 1 – 100)
RX DEDUCTIBLE	\$0 - \$615 (T2 – T4)	\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0	\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward, Palm Beach	Broward, Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Freedom - South Florida 2026 Plan Highlights

	★ Freedom Medi-Medi Partial (HMO D-SNP) H5427-078	★ Freedom Medi-Medi Full (HMO D-SNP) H5427-087
MEDICAID STATUS	Partial Dual QMB, SLMB, QDWI, QI	Full Dual FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities	\$200 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$130 per month	\$130 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - South Florida 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$185
MAX OUT-OF-POCKET	\$1,000	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 copay	\$10 copay
INPATIENT HOSPITAL	\$0 copay	\$175 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$10 / \$60 / 33% / \$0 \$0 copay – Part D on T1 and T5 mail order 30 - 90 day supply	\$0 / \$20 / \$65 / 33% / \$10 \$0 copay – Part D on T1 and T5 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Palm Beach	Palm Beach



Freedom - South Florida 2026 Plan Highlights

★ **Freedom VIP Care
(HMO C-SNP)**
H5427-070

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-072

	Option 4	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month	\$80 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - South Florida 2026 Plan Highlights

	★ Freedom VIP Savings (HMO C-SNP) H5427-082	★ Freedom VIP Savings COPD (HMO C-SNP) H5427-083
PREMIUM	\$0	\$0
PART B GIVEBACK	\$120	\$120
MAX OUT-OF-POCKET	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$25 copay	\$25 copay
INPATIENT HOSPITAL	\$195 copay (days 1 – 5)	\$195 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$30 / \$80 / 33% / \$10 \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$30 / \$80 / 33% / NA \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Charlotte, Collier, Lee	Charlotte, Collier, Lee



Freedom - South Florida 2026 Plan Highlights

★ **Freedom VIP Savings
(HMO C-SNP)**
H5427-082

★ **Freedom VIP Savings COPD
(HMO C-SNP)**
H5427-083

	Option 2	Option 2
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$150 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$55 per month	\$55 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – 20 one-way trips per year
PERS	\$0 copay	\$0 copay
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Freedom - South Florida 2026 Plan Highlights



Freedom VIP Savings COPD

(HMO C-SNP)

H5427-077

PREMIUM	\$0
PART B GIVEBACK	\$185
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$175 copay (days 1 - 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5	\$0 / \$20 / \$65 / 33% / N/A \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Palm Beach



Freedom - South Florida 2026 Plan Highlights



DENTAL	Option 2 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	\$70 per month Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	\$80 per month
FITNESS	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



Freedom - South Florida 2026 Plan Highlights

**Freedom Savings
(HMO)**
H5427-052

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$4,200
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Palm Beach



Freedom - South Florida 2026 Plan Highlights

Freedom Savings (HMO) H5427-052

	Option 1
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$10 copay for eyeglasses or contact lenses \$100 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,000 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per month
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	10 post discharge within 7 days



OPTIMUM

Florida - South

Optimum - South Florida 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0		\$0
PART B GIVEBACK		\$0		\$0
MAX OUT-OF-POCKET		\$500		\$500
PCP		\$0 copay		\$0 copay
SPECIALIST		\$0 copay		\$0 copay
INPATIENT HOSPITAL		\$0 copay		\$0 copay
SKILLED NURSING FACILITY		\$0 copay (days 1 – 100)		\$0 copay (days 1 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 – T4)		\$0 - \$615 (T2 – T4)
RX COST SHARE T1/T2/T3/T4/T5		\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0		\$0 copay – T1 and T5 mail order 30 - 90 day supply Member pay LIS copay* (T2 – T4) Note: Part D excluded drugs are \$0
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Broward, Palm Beach		Broward, Palm Beach

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Optimum - South Florida 2026 Plan Highlights

★ Optimum Emerald Partial (HMO D-SNP) H5594-016

★ Optimum Emerald Full (HMO D-SNP) H5594-017

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI	Full Dual	FBDE, QMB+, SLMB+
DENTAL	Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services		Option 3 \$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	
VISION	\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year		\$0 copay - 1 routine eye exam per year; \$400 allowance - eyeglasses or contact lenses per year	
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 hearing aid maximum per year	
EVERYDAY OPTIONS ALLOWANCE	\$200 per month Assistive Devices, Healthy Foods and Utilities		\$200 per month Assistive Devices, Healthy Foods and Utilities	
OVER THE COUNTER	\$130 per month		\$130 per month	
FITNESS	\$0 copay - SilverSneakers®		\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – unlimited one-way trips per year		\$0 copay – unlimited one-way trips per year	
PERS	\$0 copay		\$0 copay	
PODIATRY	N/A		N/A	
HEALTHY MEALS	10 post discharge in 7 days		10 post discharge in 7 days	



Optimum - South Florida 2026 Plan Highlights

	 Optimum Gold Rewards Plan (HMO) H5594-001	 Optimum Platinum Plan (HMO) H5594-002
PREMIUM	\$0	\$0
PART B GIVEBACK	\$185	\$0
MAX OUT-OF-POCKET	\$1,900	\$1,000
PCP	\$0 copay	\$0 copay
SPECIALIST	\$10 copay	\$0 copay
INPATIENT HOSPITAL	\$95 copay (days 1 - 5)	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$95 copay (days 21 – 100)
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4	\$0 / \$30 / \$70 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply	\$0 / \$5 / \$50 / 33% \$0 copay – Part D on T1 mail order 30 - 100 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Broward	Broward



Optimum - South Florida 2025 Plan Highlights

	 Optimum Gold Rewards Plan (HMO) H5594-001	 Optimum Platinum Plan (HMO) H5594-002
	Option 2	Option 4
DENTAL	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services	\$0 copay – 2 oral exams, 2 problem focused visits, 2 cleanings, 2 fluoride treatments every year and dental X-rays; \$0 copay for preventive and comprehensive services per year Refer to plan benefits for specific comprehensive services
VISION	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year	\$0 copay - 1 routine eye exam per year; \$0 copay for eyeglasses or contact lenses \$400 per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$1,500 hearing aid maximum per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$60 per month	\$85 per month
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
ACTIVE FITNESS	\$500 per year	\$500 per year
TRANSPORTATION	\$0 copay – 20 one-way trips per year	\$0 copay – unlimited one-way trips per year
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	10 post discharge within 7 days	10 post discharge within 7 days



Georgia - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- Full and Partial D-SNP HMO plans with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- \$0 HMO-POS available with preventive Dental, Vision and Hearing
- Competitive Medicare Supplement plans

SERVICE AREA

All Counties EXCEPT:
Calhoun, Camden, Clay, Dougherty, Early, Glynn,
Gordon, Lee, Seminole, Sumter, Terrell, Walker,
Whitfield

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
PPO	26	
Anthem Full Dual Advantage (PPO D-SNP) (H4036-032)		All
Anthem Grocery (PPO) (H4036-033)		All
Anthem Dual Advantage (PPO D-SNP) (H4036-039)		All
Anthem Premium Savings (PPO) (H4036-041)		All
Anthem Medicare Advantage 3 (PPO) (H4036-042)		All



Georgia 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H5422-019

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$520 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Georgia 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H5422-019

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips per year
PERS		N/A
PODIATRY		\$0 copay – 6 visits per year
HEALTHY MEALS		42 post discharge



Georgia 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H5422-018

MEDICAID STATUS	Partial Dual	QMB, SLMB, QI, QDWI
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$40 copay
INPATIENT HOSPITAL		\$300 copay (days 1 – 6)
SKILLED NURSING FACILITY		\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE		\$0 - \$355 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Georgia 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H5422-018

MEDICAID STATUS	Partial Dual	SLMB, QI, QDWI
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,600 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$50 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips per year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		N/A



Georgia 2026 Plan Highlights

Anthem Kidney Care
(HMO POS C-SNP)
H5422-015

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900
PCP	\$0 copay
SPECIALIST	\$0 copay Nephrologist \$40 copay
DIALYSIS	\$0
INPATIENT HOSPITAL	\$325 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 30% / 33% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield



Georgia 2026 Plan Highlights

Anthem Kidney Care
(HMO POS C-SNP)
H5422-015

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$50 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A



Georgia 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H5422-011

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$450 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield



Georgia 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H5422-011

ESSENTIAL EXTRAS	N/A
DENTAL	In Network: \$0 copay for 2 exams, 2 cleanings, 1 X-ray and 1 fluoride treatment every year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	28 post discharge



Georgia 2026 Plan Highlights

Anthem Extra Help (HMO-POS) H5422-013

LIS ELIGIBILITY	No LIS	25% Subsidy	50% Subsidy	75% Subsidy	100% Subsidy
PREMIUM	\$25.40	\$0	\$0	\$0	\$0
PART B GIVEBACK	\$0				
MEDICAL DEDUCTIBLE	\$0				
MAX OUT-OF-POCKET	\$5,900				
PCP	\$0 copay				
SPECIALIST	\$20 copay				
INPATIENT HOSPITAL	\$440 copay (day 1 – 5)				
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)				
	Part D				
EXTRA HELP LEVEL	No Extra Help		Level 1	Level 2	Level 3
RX DEDUCTIBLE	\$390 (T2 – T5)		\$0	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / 25% / 25% / 25% / 28% / \$0		\$0 copay (T1 and T6) \$5.10 - \$12.65	\$0 copay (T1 and T6) \$1.60 - \$4.90	\$0
INSULIN COST SHARE	\$35 or LIS copay for a one-month supply of select insulin				
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield				



Georgia 2026 Plan Highlights

**Anthem Extra Help
(HMO-POS)**
H5422-013

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$95 per quarter
TRANSPORTATION	\$0 copay – 12 one-way trips per year
FITNESS	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	\$0 copay – 42 post discharge



Georgia 2026 Plan Highlights

**Anthem Veteran
(HMO-POS)**
H5422-014

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$400 copay (days 1 - 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Calhoun, Camden, Catoosa, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Sumter, Terrell, Walker, Whitfield



Georgia 2026 Plan Highlights

**Anthem Veteran
(HMO-POS)**
H5422-014

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$1,600 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$75 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	8 post discharge



Georgia 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4036-040

PREMIUM	\$0
PART B GIVEBACK	\$155
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,350 (IN) / \$13,900 (IN & OON)
PCP	\$20 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$375 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Calhoun, Camden, Clay, Dougherty, Early, Glynn, Gordon, Lee, Seminole, Terrell, Walker, Whitfield



Georgia 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4036-040

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	1 hearing exam, fitting & evaluation per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Georgia 2026 Plan Highlights

**Anthem Medicare Advantage 2
(PPO)**
H4036-030

PREMIUM	\$82
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$750 (applies only to OON)
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (IN & OON)
PCP	\$10 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Bacon, Calhoun, Camden, Campbell, Clayton, Clinch, Dade, Early, Echols, Glynn, Grady, Green, Harrelson, Lanier, McIntosh, Meriwether, Mitchell, Morgan, Oglethorpe, Randolph, Seminole, Sumter, Thomas, Toombs, Towns, Walker, White, Whitfield, Worth



Georgia 2026 Plan Highlights

Anthem Medicare Advantage 2 **(PPO)** H4036-030

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Indiana - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- Over 170K MA members with 29% Market Share in Indiana
- #3 D-SNP player in Indiana
- D-SNP transition to PathWays FIDE. Full and Partial Dual plans with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- \$0 Premium HMO plans include Dental, Vision, and Hearing
- Former IUHP plans rebranded Anthem Blue Cross Blue Shield
- Access to hospitals in 5 state HMO network including Cleveland Clinic

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	31	
PPO	32	
Anthem Chronic Care (HMO-POS C-SNP) H3447-043		1
IU Health Plans Medicare Select - Medical Only (HMO) H7220-002		22
IU Health Plans Medicare Kidney Care (HMO) H7220-012		9

Indiana 2026 Plan Highlights

Anthem | PathWays Dual Care Advantage
(HMO D-SNP) H0629-003
(Transitioned H3447-048)

MEDICAID STATUS	Full Dual	PathWays Eligible: FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Indiana 2026 Plan Highlights

★ **Anthem | PathWays Dual Care Advantage**
(HMO D-SNP) H0629-003
(Transitioned H3447-048)

MEDICAID STATUS	Full Dual	PathWays Eligible: FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$289 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Indiana 2026 Plan Highlights

Anthem | PathWays Dual Care Advantage NFLOC (HMO D-SNP) H0629-004 (Transitioned H3447-055)

MEDICAID STATUS	Full Dual	PathWays Eligible, Nursing Facility Level of Care (NFLOC): FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Indiana 2026 Plan Highlights

Anthem | PathWays Dual Care Advantage NFLOC (HMO D-SNP) H0629-004 (Transitioned H3447-055)

MEDICAID STATUS	Full Dual	PathWays Eligible, Nursing Facility Level of Care (NFLOC): FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$364 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 150 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Indiana 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H0629-001 (Transitioned H3447-020)

MEDICAID STATUS	Full Dual	Not Eligible for PathWays: FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 - \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Indiana 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H0629-001 (Transitioned H3447-020)

MEDICAID STATUS	Full Dual	Not Eligible for PathWays: FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 or prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 36 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year



Indiana 2026 Plan Highlights

Anthem Dual Advantage (HMO D–SNP) H0629-002 (Transitioned H3447–046)

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI
	QMB pays	SLMB, QDWI, QI pays
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$257
MAX OUT-OF-POCKET	N/A	\$9,250
PCP	\$0 copay	20% copay
SPECIALIST	\$0 copay	20% copay
INPATIENT HOSPITAL	\$0 copay	Medicare Fee For Service
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$0 copay (days 21 – 100)	Medicare Fee For Service
RX DEDUCTIBLE	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – (T1 and T6) Members pay LIS copay* (T2 – T5)	\$0 copay – (T1 and T6) Members pay LIS copay* (T2 – T5)
INSULIN COST SHARE	\$0 - \$35 copay* for a one-month supply of select insulin	\$0 - \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties	All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
 If you do not qualify for Extra Help, you pay the coinsurance.



Indiana 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H0629-002 (Transitioned H3447-046)

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$97 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 38 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Indiana 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO – POS)**
H3447-042-001

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,150
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$440 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Elkhart, Jasper, Kosciusko, Lagrange, Lake, La Porte, Porter, St Joseph



Indiana 2026 Plan Highlights

Anthem Medicare Advantage (HMO – POS) H3447-042-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$38 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H3447-042-004	Anthem Medicare Advantage (HMO-POS) H3447-042-002
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$4,150	\$4,150
PCP	\$0 copay	\$0 copay
SPECIALIST	\$35 copay	\$35 copay
INPATIENT HOSPITAL	\$440 copay (days 1 – 5)	\$440 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Blackford, Carroll, Cass, Clark, Crawford, Daviess, Delaware, Dubois, Fayette, Floyd, Harrison, Henry, Howard, Huntington , Jackson, Knox, Lawrence, Martin, Miami, Monroe, Noble , Ohio, Orange, Owen, Parke, Pike, Posey, Pulaski , Randolph, Scott, Steuben , Switzerland, Tippecanoe, Tipton, Vanderburgh, Wabash , Warrick, Washington, Wayne, Wells , White	Allen, DeKalb, Whitley



Indiana 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H3447-042-004	Anthem Medicare Advantage (HMO-POS) H3447-042-002
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	N/A	\$38 per quarter
FITNESS	N/A	N/A
PERS	N/A	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge	20 post discharge



Indiana 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H3447-042-003

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,000
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Boone, Brown, Grant, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Montgomery, Morgan, Putnam, Shelby



Indiana 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H3447-042-003

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO - POS)
H7220-004

PREMIUM	\$100
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,850
PCP	\$0 copay (IN) / 50% (OON)
SPECIALIST	\$35 copay (IN) / 50% (OON)
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 35% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Benton, Boone, Carroll, Cass, Clinton, Delaware, Hamilton, Hancock, Hendricks, Henry, Johnson, Lawrence, Marion, Monroe, Morgan, Putnam, Shelby, Tippecanoe, Tipton, White



Indiana 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO - POS)
H7220-004

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$40 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-009-001

PREMIUM	\$54
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,150
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 35% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Benton, Brown, Carroll, Cass, Delaware, Fountain, Greene, Howard, Jay, Lawrence, Montgomery, Orange, Owen, Randolph, Tipton, Warren, White



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-009-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$1500 preventive and comprehensive allowance per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$40 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-009-002

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$440 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 35% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Boone, Clinton, Hamilton, Hancock, Hendricks, Huntington, Johnson, Madison, Marion, Martin, Monroe, Morgan, Tippecanoe, Wells, Whitley



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-009-002

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 preventive and comprehensive allowance per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	\$0 copay – 14 one-way trips to PAL per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-010

PREMIUM	\$0
PART B GIVEBACK	\$20
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,500
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 35% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Benton, Blackford, Boone, Brown, Carroll, Cass, Clinton, Delaware, Fountain, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Jay, Johnson, Lawrence, Madison, Marion, Martin, Monroe, Montgomery, Morgan, Orange, Owen, Putnam, Randolph, Shelby, Tippecanoe, Tipton, Warren, Wells, White, Whitley



Indiana 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO)**
H7220-010

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 preventive and comprehensive allowance per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year;
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	20 post discharge



Indiana 2026 Plan Highlights

Anthem Extra Help (HMO-POS) H3447-024

LIS ELIGIBILITY	No LIS	25% Subsidy	50% Subsidy	75% Subsidy	100% Subsidy
PREMIUM	\$22.80	\$0	\$0	\$0	\$0
PART B GIVEBACK	\$0				
MEDICAL DEDUCTIBLE	\$0				
MAX OUT-OF-POCKET	\$4,900				
PCP	\$0 copay				
SPECIALIST	\$25 copay				
INPATIENT HOSPITAL	\$290 copay (day 1 – 6)				
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)				
EXTRA HELP LEVEL	No Extra Help		Level 1	Level 2	Level 3
RX DEDUCTIBLE	\$390 (T2 – T5)		\$0	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / 25% / 25% / 25% / 28% / \$0		\$0 copay (T1 and T6) \$5.10 - \$12.65	\$0 copay (T1 and T6) \$1.60 - \$4.90	\$0
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin				
MARKET SERVICE AREA	All Counties				



Indiana 2026 Plan Highlights

Anthem Extra Help (HMO-POS) H3447-024

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	\$0 copay – 20 post discharge



Indiana 2026 Plan Highlights

**Anthem Medicare Advantage 3
(PPO)**
H1607-012

PREMIUM	\$55
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$500 (applies only to OON)
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,100 (IN & OON)
PCP	\$10 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$7 / 25% / 30% / 31% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clinton, Daviess, De Kalb, Dearborn, Decatur, Delaware, Elkhart, Fayette, Floyd, Franklin, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Howard, Huntington, Jackson, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, Lagrange, Lake, Madison, Marion, Monroe, Morgan, Newton, Ohio, Parke, Pike, Porter, Posey, Putnam, Randolph, Scott, Shelby, Spencer, St Joseph, Tippecanoe, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, Whitley



Indiana 2026 Plan Highlights

Anthem Medicare Advantage 3 (PPO) H1607-012

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,800 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Indiana 2026 Plan Highlights

Anthem Medicare Advantage 2 (PPO) H1607-015

PREMIUM	\$26
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,100 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$370 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (per days 21 – 100)
RX DEDUCTIBLE	\$250 (T3-T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$3 / 25% / 30% / 30% / \$0
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bartholomew, Benton, Boone, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, De Kalb, Dearborn, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jefferson, Johnson, Kosciusko, La Porte, Lake, Lawrence, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Ripley, Rush, Scott, Shelby, Spencer, St Joseph, Starke, Steuben, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Vigo, Wabash, Washington, Wayne, Wells, White



Indiana 2026 Plan Highlights

Anthem Medicare Advantage 2 (PPO) H1607-015

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Indiana 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H7093-001

PREMIUM	\$0
PART B GIVEBACK	\$90
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$445 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties



Indiana 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H7093-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge



Indiana 2026 Plan Highlights

**Anthem Medicare Advantage
(PPO)**
H7093-002

PREMIUM	\$9
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,000 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$345 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$95 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$9 / 20% / 35% / 31% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Daviess, Decatur, Fulton, Jasper, Perry



Indiana 2026 Plan Highlights

**Anthem Medicare Advantage
(PPO)**
H7093-002

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,750 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Indiana 2026 Plan Highlights

Anthem Medicare Advantage (RPPO) R5941-016

PREMIUM	\$97
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$500 (applies only to OON)
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$345 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$45 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$8 / 25% / 30% / 32% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties in Indiana and Kentucky



Indiana 2026 Plan Highlights

Anthem Medicare Advantage (RPPO)

R5941-016

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam and 1 cleaning every year Out-of-Network – 20%
VISION	\$0 copay – 1 routine eye exam per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A

Iowa - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #2 D-SNP player in Iowa
- Full Dual D-SNP plan with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- D-SNP HMO-POS plans include OON Dental coverage for improved access to dental providers
- Network includes key provider partners Unity Point Health System, Mercy One, Genesis/Trinity Health Systems, University of Iowa, McFarland Clinic, Medical Associates

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Wellpoint Dual Advantage (HMO-POS D-SNP) H0907-002	All

Iowa 2026 Plan Highlights

Wellpoint Full Dual Advantage 2

HMO-POS D-SNP

H0907-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare FFS
SKILLED NURSING FACILITY		Medicare FFS
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Iowa 2026 Plan Highlights

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Wellpoint Full Dual Advantage 2
HMO-POS D-SNP
H0907-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$425 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$105 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 24 one-way trips per year to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Iowa 2026 Plan Highlights



Wellpoint Full Dual Advantage HMO-POS D-SNP H0907-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare FFS
SKILLED NURSING FACILITY		Medicare FFS
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Iowa 2026 Plan Highlights

Wellpoint Full Dual Advantage
HMO-POS D-SNP
H0907-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$105 per month OTC and Healthy Foods
FITNESS		\$0 copay - SilverSneakers®
FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 24 one-way trips per year to PAL per year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Kansas - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #3 D-SNP player in Kansas
- D-SNP plan service area expansion in 46 counties
- Full Dual D-SNP plan with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- Strong Dental, Vision, Hearing and Transportation benefits
- Network includes key provider partners including University of Kansas, University of Kansas - St. Francis, Ascension Via Christi St. Francis, Advent Health - Ottawa & Wellsville, Lawrence Memorial, Salina Regional, Hays Medical Center, Providence medical Center and St. Catherine Hospital

SERVICE AREA

All Counties EXCEPT:
Barton, Cheyenne, Cloud, Edwards, Ellis, Ford, Grant, Hodgeman, Kearny, Morton, Riley, Seward

Kansas 2026 Plan Highlights

**Healthy Blue Full Dual Advantage
(HMO D-SNP)**
H6316-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare FFS
SKILLED NURSING FACILITY		Medicare FFS
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 to \$615 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Allen, Anderson, Atchison, Barber, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Clark, Clay, Coffey, Comanche, Cowley, Crawford, Decatur, Dickinson, Doniphan, Douglas, Elk, Ellsworth, Finney, Franklin, Geary, Greenwood, Gove, Graham, Gray, Greeley, Hamilton, Harper, Harvey, Haskell, Jackson, Jefferson, Jewell, Johnson, Kingman, Kiowa, Labette, Lane, Leavenworth, Lincoln, Linn, Logan, Lyon, Marion, Marshall, McPherson, Meade, Miami, Mitchell, Montgomery, Morris, Nemaha, Neosho, Ness, Norton, Osage, Osborne, Ottawa, Pawnee, Phillips, Pottawatomie, Pratt, Rawlins, Reno, Republic, Rice, Rooks, Rush, Russell, Saline, Scott, Sedgwick, Shawnee, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wabaunsee, Wallace, Washington, Wichita, Wilson, Woodson, Wyandotte	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Kansas 2026 Plan Highlights

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Healthy Blue Full Dual Advantage
(HMO D-SNP)
H6316-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
DENTAL	\$3,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year;	
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	
EVERYDAY OPTIONS ALLOWANCE	\$180 per month OTC, Assistive Devices, Healthy Foods and Utilities	
FITNESS	\$0 copay - SilverSneakers®	
TRANSPORTATION	\$0 copay – 48 one-way trips per year to PAL per year	
PERS	N/A	
PODIATRY	\$0 copay – unlimited visits per year	
HEALTHY MEALS	3 meals per day for 14 days chronic condition	



Kentucky - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #2 MA plan with over 115K MA members and 30% Market Share in Kentucky
- \$0 Premium HMO plans include Dental, Vision, and Hearing
- Access to hospitals in 5 state HMO network including Cleveland Clinic
- 15 re-segmented HMO counties including new Bowling Green segmentation
- Competitive Medicare Supplement/ Medicare Select plans

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	4	All
Anthem Medicare Advantage 4 (PPO) H4036-038		
Anthem Chronic Care (HMO-POS C-SNP) H9525-017		1

Kentucky 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H9525-013-001	Anthem Medicare Advantage (HMO-POS) H9525-013-002
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$6,300	\$6,750
PCP	\$0 copay	\$0 copay
SPECIALIST	\$45 copay	\$45 copay
INPATIENT HOSPITAL	\$450 copay (days 1 – 5)	\$450 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$230 (T3 – T5)	\$230 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adair, Anderson, Ballard, Barren, Bath, Bell, Boyd, Boyle, Bracken , Breathitt, Breckinridge, Caldwell, Calloway, Carlisle, Carroll, Carter, Casey, Christian, Clay, Clinton, Cumberland, Daviess , Elliott, Estill, Fleming, Floyd, Franklin, Fulton, Garrard, Graves, Grayson, Green, Greenup, Hancock, Hardin, Harlan, Harrison, Hart, Henderson , Hickman, Hopkins, Jackson, Jesamine , Johnson, Knott, Knox, Larue, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, Livingston, Logan, Lyon, Magoffin, Marion, Marshall, Martin, Mason, McCracken , McCreary, McLean, Menifee, Mercer, Metcalfe, Monroe, Montgomery, Morgan, Muhlenberg, Nelson , Nicholas, Ohio, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Scott , Shelby , Simpson, Spencer , Taylor, Trimble , Todd, Trigg, Union, Wayne, Webster, Whitley, Wolfe, Woodford	Bullitt, Henry, Jefferson, Meade, Oldham



Kentucky 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H9525-013-001	Anthem Medicare Advantage (HMO-POS) H9525-013-002
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	N/A	\$35 per quarter
FITNESS	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	N/A	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge	20 post discharge



Kentucky 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H9525-013-003	Anthem Medicare Advantage (HMO-POS) H9525-013-004
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$6,750	\$6,700
PCP	\$0 copay	\$0 copay
SPECIALIST	\$45 copay	\$45 copay
INPATIENT HOSPITAL	\$450 copay (days 1 – 5)	\$450 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$230 (T3 – T5)	\$230 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bourbon, Clark, Fayette, Madison	Boone, Campbell, Gallatin, Grant, Kenton, Pendleton

Kentucky 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H9525-013-003

**Anthem Medicare Advantage
(HMO-POS)**
H9525-013-004

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$30 per quarter	\$30 per quarter
FITNESS	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	N/A	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge	20 post discharge



Kentucky 2026 Plan Highlights

Anthem Kidney Care
(HMO-POS C-SNP)
H9525-011

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900
PCP	\$0 copay
SPECIALIST	\$0 – \$40 copay
INPATIENT HOSPITAL	\$325 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$50 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 32% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties



Kentucky 2026 Plan Highlights

Anthem Kidney Care **(HMO-POS C-SNP)**

H9525-011

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 or prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$55 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – unlimited one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A

Kentucky 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO POS)**
H9525-013-005

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,700
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$450 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$230 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Allen, Butler, Edmonson, Warren



Kentucky 2026 Plan Highlights

NEW

**Anthem Medicare Advantage
(HMO POS)**
H9525-013-005

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$32 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Kentucky 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4909-023

PREMIUM	\$0
PART B GIVEBACK	\$75
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$445 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties



Kentucky 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4909-023

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage (PPO) H4036-036

PREMIUM	\$15
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$8,000 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$550 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage (PPO) H4036-036

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments ever year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage 3 (PPO) H4036-034

PREMIUM	\$44
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900 (IN) / \$6,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$5 / 20% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adair, Allen, Anderson, Ballard, Barren, Bath, Bell, Boone, Bourbon, Boyd, Boyle, Bracken, Breathitt, Breckinridge, Bullitt, Butler, Caldwell, Calloway, Campbell, Carlisle, Carroll, Carter, Casey, Christian, Clark, Clay, Clinton, Crittenden, Cumberland, Daviess, Edmonson, Elliott, Estill, Fayette, Fleming, Floyd, Franklin, Fulton, Gallatin, Garrard, Grant, Graves, Grayson, Green, Greenup, Hancock, Hardin, Harlan, Harrison, Hart, Henderson, Henry, Hickman, Hopkins, Jackson, Jefferson, Jessamine, Johnson, Kenton, Knott, Knox, Larue, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, Livingston, Logan, Lyon, Madison, Magoffin, Marion, Marshall, Martin, Mason, Mc Cracken, Mc Creary, McLean, Meade, Menifee, Mercer, Metcalfe, Monroe, Montgomery, Morgan, Muhlenberg, Nelson, Nicholas, Ohio, Oldham, Owen, Owsley, Pendleton, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Scott, Shelby, Simpson, Spencer, Taylor, Todd, Trigg, Trimble, Union, Warren, Washington, Wayne, Webster, Whitley, Wolfe, Woodford



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage 3 (PPO) H4036-034

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage (RPPO)

R5941-016 (formerly R4487-001)

PREMIUM	\$97
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$500 (applies only to OON)
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$345 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$45 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$8 / 25% / 30% / 32% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties in Kentucky and Indiana



Kentucky 2026 Plan Highlights

Anthem Medicare Advantage (RPPO) R5941-016

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam and 1 cleaning per year; Out-of-Network – 20% per year
VISION	\$0 copay – 1 routine eye exam per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Louisiana - Medicare Advantage 2026

MARKET HIGHLIGHTS



- Full Dual D-SNP plan with Everyday Options Allowance (EOA) for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- Full Dual D-SNP plan with EOA for OTC and Healthy Foods and Essential Extras and Tiers 1 and 6 at \$0
- Partial Dual D-SNP plan available
- Simple and consistent Essential Extras offering
- Network includes key provider partners including Ochsner Health, LCMC Health, CenterWell, JenCare, and Oak Street Health

SERVICE AREA

All Parishes

Louisiana 2026 Plan Highlights

Healthy Blue Dual Advantage 2
(HMO D-SNP)
H1947-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee for Service
SKILLED NURSING FACILITY		Medicare Fee for Service
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Louisiana 2026 Plan Highlights

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Healthy Blue Dual Advantage 2
(HMO D-SNP)
H1947-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$375 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$195 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 96 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge
CHIROPRACTIC		\$0 copay – 12 visits per year



Louisiana 2026 Plan Highlights

**Healthy Blue Dual Advantage
(HMO D-SNP)**
H1947-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee for Service
SKILLED NURSING FACILITY		Medicare Fee for Service
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Louisiana 2026 Plan Highlights

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Healthy Blue Dual Advantage
(HMO D-SNP)
H1947-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		(Pick 1) Utilities – \$150 per quarter, Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year to PAL, Assistive Devices – \$500 per year
DENTAL		\$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$4,000 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$500 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$140 per month OTC and Healthy Foods
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 65 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge
CHIROPRACTIC		\$0 copay – 12 visits per year



Louisiana 2026 Plan Highlights

Healthy Blue Enhanced Care (HMO D-SNP) H1947-003

MEDICAID STATUS	Partial Dual	SLMB, QDWI, QI
PREMIUM		\$0 - \$3.70
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$6,750
PCP		\$0 copay
SPECIALIST		\$30 copay
INPATIENT HOSPITAL		\$295 copay (days 1 – 7)
SKILLED NURSING FACILITY		\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Louisiana 2026 Plan Highlights

Healthy Blue Enhanced Care (HMO D-SNP) H1947-003

MEDICAID STATUS	Partial Dual	SLMB, QDWI, QI
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$25 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 36 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge

Maine - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- Partnership with MaineHealth
- Lead D-SNP plan has embedded Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- HMO plans with OTC, Vision and Hearing benefits

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Anthem I MaineHealth Advantage Extra (HMO-POS) H9065-006	11
Anthem I MaineHealth Advantage Extra (HMO-POS) H9065-007	5
Anthem I MaineHealth Advantage Access (PPO) H9219-001	All

Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Dual Plus
(HMO D-SNP)
H9065-001

MEDICAID STATUS	Full Dual	FBDE, SLMB+, QMB+, QMB
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, York

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Dual Plus
(HMO D-SNP)
H9065-001

MEDICAID STATUS	Full Dual	FBDE, SLMB+, QMB+, QMB
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$80 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 40 one-way trips per year
PERS		\$0 copay
PODIATRY		N/A
HEALTHY MEALS		14 post discharge 30 chronic



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Choice
(HMO-POS)
H9065-002

PREMIUM	\$28
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$8,900 (IN) / \$13,900 (OON)
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 – T3 mail order 30 - 60 day supply, T4 – T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Cumberland, York



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Choice
(HMO-POS)
H9065-002

ESSENTIAL EXTRAS	N/A
DENTAL	N/A
VISION	\$0 copay – 1 routine eye exam every year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	N/A
HEALTHY MEALS	N/A



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Choice
(HMO-POS)
H9065-003

PREMIUM	\$55
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$7,550 (IN) / \$13,900 (OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Choice
(HMO-POS)
H9065-003

ESSENTIAL EXTRAS	N/A
DENTAL	N/A
VISION	\$0 copay – 1 routine eye exam every year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Plus
(HMO-POS)
H9065-008

PREMIUM	\$25
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,800
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$425 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$235 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Penobscot, Sagadahoc, Somerset, Waldo



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Plus
(HMO-POS)
H9065-008

ESSENTIAL EXTRAS	N/A
DENTAL	N/A
VISION	\$0 copay – 1 routine eye exam every year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	28 post discharge



Maine 2026 Plan Highlights

**Anthem | MaineHealth Advantage Veteran
(PPO)**
H9219-004

PREMIUM	\$0
PART B GIVEBACK	\$64
MEDICAL DEDUCTIBLE	\$750 (applies only to OON)
MAX OUT-OF-POCKET	\$7,200 (IN) / \$11,500 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, York



Maine 2026 Plan Highlights

Anthem | MaineHealth Advantage Veteran (PPO) H9219-004

ESSENTIAL EXTRAS	N/A
DENTAL	\$750 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PODIATRY	N/A
HEALTHY MEALS	N/A



Missouri - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #3 D-SNP player in Missouri
- Full Dual D-SNP plan with Everyday Options Allowance (EOA) for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- Full Dual D-SNP plan with Essential Extras and EOA for OTC and Healthy Foods plus Rx Tiers 1 and 6 at \$0
- HMO-POS plans have reduced service area and leaner benefits

SERVICE AREA

All Counties in
Anthem BCBS license area

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	67	All
Anthem Dual Advantage (HMO D-SNP) H3447-047		
Anthem Medicare Advantage 2 (HMO-POS) H3447-054		

Missouri 2026 Plan Highlights

Anthem Full Dual Advantage 2
(HMO D-SNP)
H3447-053

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee For Service
RX DEDUCTIBLE		\$0 to \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adair, Audrain, Barry, Barton, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Christian, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Hickory, Howard, Howell, Iron, Jasper, Jefferson, Knox, Laclede, Lawrence, Lewis, Lincoln, Linn, Macon, Madison, Maries, Marion, Mc Donald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St Charles, St Francois, St Louis, St Louis City, Ste Genevieve, Stoddard, Stone, Sullivan, Taney, Texas, Warren, Washington, Wayne, Webster, Wright	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Missouri 2026 Plan Highlights

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Anthem Full Dual Advantage 2
(HMO D-SNP)
H3447-053

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – \$3,500 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$475 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS		N/A
EVERYDAY OPTIONS ALLOWANCE		\$200 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Missouri 2026 Plan Highlights

Anthem Full Dual Advantage
(HMO D-SNP)
H3447-018

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee For Service
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adair, Audrain, Barry, Barton, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Christian, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Hickory, Howard, Howell, Iron, Jasper, Jefferson, Knox, Laclede, Lawrence, Lewis, Lincoln, Linn, Macon, Madison, Maries, Marion, Mc Donald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St Charles, St Francois, St Louis, St Louis City, Ste Genevieve, Stoddard, Stone, Sullivan, Taney, Texas, Warren, Washington, Wayne, Webster, Wright	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Missouri 2026 Plan Highlights

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Anthem Full Dual Advantage
(HMO D-SNP)
H3447-018

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		(Pick 1) Utilities – \$150 per quarter, Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL		\$0 copay – \$3,500 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$425 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$160 per month OTC and Healthy Foods
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 36 one-way trips per year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Missouri 2026 Plan Highlights

NEW

**Anthem Chronic Care
(HMO-POS C-SNP)**
H3447-056

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$3,500
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$25 copay for a one-month supply of select insulin
MARKET SERVICE AREA	St Louis, St Louis City



Missouri 2026 Plan Highlights

NEW

**Anthem Chronic Care
(HMO-POS C-SNP)**
H3447-056

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$400 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$40 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 26 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	10 post discharge / 30 meals chronic condition



Missouri 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3447-038-001

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$3,900
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$325 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$210 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Christian, Dallas, Douglas, Greene, Hickory, Laclede, Polk, Pulaski, Webster, Wright



Missouri 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3447-038-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$90 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	20 post discharge



Missouri 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3447-038-002

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$3,500
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$325 copay (days 1 – 8)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$210 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Franklin, Jefferson, Lincoln, St Charles, St Louis, St Louis City, Warren, Washington



Missouri 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3447-038-002

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$375 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$130 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	20 post discharge



Missouri 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4909-021

PREMIUM	\$0
PART B GIVEBACK	\$70
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,751 (IN) / \$10,000 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$360 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Adair, Audrain, Barry, Barton, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Christian, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Hickory, Howard, Howell, Iron, Jasper, Jefferson, Knox, Laclede, Lawrence, Lewis, Lincoln, Linn, Macon, Madison, Maries, Marion, Mc Donald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St Charles, St Francois, St Louis, St Louis City, Ste Genevieve, Stoddard, Stone, Sullivan, Taney, Texas, Warren, Washington, Wayne, Webster, Wright



Missouri 2026 Plan Highlights

Anthem Veteran (PPO) H4909-021

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$65 per quarter
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	14 post discharge



Nevada - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- New lead D-SNP plan with Everyday Options Allowance (EOA) for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 2 at \$0 available in Clark, Carson City, Nye and Washoe
- Anthem CareMore HMO-POS, Chronic C-SNP and Lung C-SNP plans with EOA for OTC, Assistive Devices, Healthy Foods and Utilities and enhanced Dental
- Anthem and CareMore legacy D-SNPs consolidating
- CareMore Health will replace the Carelon Health brand
- CareMore Health's clinical model continues to provide the gold standard for care
- Network includes key provider partners including CareMore Health, Astrana Health, Saint Mary's, and West Henderson

SERVICE AREA

Clark, Carson City, Nye, Washoe

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Anthem Medicare Advantage (HMO-POS) H4346-019	1

Nevada 2026 Plan Highlights

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Anthem Full Dual Advantage 2
(HMO D-SNP)
H4346-031

MEDICAID STATUS	Full Dual	FBDE, QMB, QMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$257
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee for Service
RX DEDUCTIBLE		\$0 - \$615 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5		Members pay LIS copay* (T3 - T5) \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Carson City, Clark, Nye, Washoe Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Nevada 2026 Plan Highlights

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Anthem Full Dual Advantage 2
(HMO D-SNP)
H4346-031

MEDICAID STATUS	Full Dual	FBDE, QMB, QMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$2,500 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 96 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – 12 visits per year
HEALTHY MEALS		14 post discharge
ACUPUNCTURE		\$0 copay – 24 visits per year
CHIROPRACTIC		\$0 copay – 20 visits per year



Nevada 2026 Plan Highlights



Anthem | Caremore Chronic Care (HMO-POS C-SNP)

H4346-006

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



Nevada 2026 Plan Highlights



ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$250 allowance for preventive and comprehensive services per year In Network: \$0 copay Out of Network: 20% preventive - 50% comprehensive
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 40 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay for CCC / \$10 copay for PAL; 24 visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition



Nevada 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H4346-025 (Transitioned H4346-026)

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee for Service
RX DEDUCTIBLE		\$0 to \$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5		\$0 / \$0 / 25% / 25% / 30% Members pay LIS copay* (T3 - T5) \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Clark, Washoe

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Nevada 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H4346-025 (Transitioned H4346-026)

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – \$2,250 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$65 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 52 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – 12 visits per year
HEALTHY MEALS		14 post discharge
ACUPUNCTURE		\$0 copay – 24 visits per year
CHIROPRACTIC		\$0 copay – 20 visits per year



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Kidney Care
(HMO-POS C-SNP)
H4346-030

PREMIUM	\$0
MAX OUT-OF-POCKET	\$499
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Kidney Care
(HMO-POS C-SNP)
H4346-030

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$300 per quarter
OVER THE COUNTER + HEALTHY FOODS	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 150 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay unlimited visits per year
HEALTHY MEALS	14 post discharge



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Lung Care
(HMO-POS C-SNP)
H4346-005

PREMIUM	\$0
MAX OUT-OF-POCKET	\$0
MAX OUT-OF-POCKET	\$1,000
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 15% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Lung Care
(HMO-POS C-SNP)
H4346-005

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$0 copay for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 40 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay - 24 visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Home Care
(HMO I-SNP)
H4346-010

PREMIUM	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$1,500
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$50 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$0 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$7.50 / 25% / 30% / 33% / \$0 \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Home Care
(HMO I-SNP)
H4346-010

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – \$1,750 allowance for preventive and comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$205 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 6 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year



Nevada 2026 Plan Highlights (Caremore Health Network)

**Anthem | Caremore Medicare Advantage
(HMO-POS)**
H4346-001

PREMIUM	\$0
MAX OUT-OF-POCKET	\$1,250
PCP	\$0 - \$20 copay
SPECIALIST	\$0 - \$10 copay
INPATIENT HOSPITAL	\$0 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$100 copay (days 21 – 100)
RX DEDUCTIBLE	\$95 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



Nevada 2026 Plan Highlights (Caremore Health Network)

Anthem | Caremore Medicare Advantage
(HMO-POS)
H4346-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,800 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$25 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay - 12 one-way trips to PAL per year / \$0 copay - unlimited one-way trips to CCC per year
PERS	N/A
PODIATRY	\$0 copay CCC / \$10 copay PAL; 4 visits per year
HEALTHY MEALS	14 post discharge / 3 meals per day for 14 days chronic condition
CHIROPRACTIC	\$20 copay – 12 visits per year



Nevada 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H4346-017

PREMIUM	\$0
MAX OUT-OF-POCKET	\$1,250
PCP	\$0 copay
SPECIALIST	\$0 copay
INPATIENT HOSPITAL	\$0 copay (per stay)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	\$50 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5	\$0 / \$0 / 25% / 30% / 32% \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Clark



H4346-017

New Jersey - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #3 D-SNP player in New Jersey
- Lead D-SNP FIDE plan with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus all Rx at \$0

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Wellpoint Extra Help (HMO-POS) H3240-021	7
Wellpoint Medicare Advantage (HMO-POS) H3240-022	8

New Jersey 2026 Plan Highlights



Wellpoint Full Dual Advantage (HMO D-SNP) H3240-013

MEDICAID STATUS	Full Dual	FBDE, QMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 all tiers
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1, T2 and T6) Members pay LIS copay* (T3 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



New Jersey 2026 Plan Highlights

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Wellpoint Full Dual Advantage
(HMO D-SNP)
H3240-013

MEDICAID STATUS	Full Dual	FBDE, QMB+
ESSENTIAL EXTRAS		N/A
EVERYDAY OPTIONS ALLOWANCE		\$250 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		Medicaid provides transportation
PERS		\$0 copay
PODIATRY		N/A
HEALTHY MEALS		2 meals per day chronic condition (90 days total per year)
ACUPUNCTURE		\$0 copay – 24 visits per year



New Jersey 2026 Plan Highlights

Wellpoint Kidney Care (POS C-SNP) H3240-017

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$13,900 (OON)
PCP	\$0 copay
SPECIALIST	\$0 Nephrologist copay 20% coinsurance all other specialists
INPATIENT HOSPITAL	Medicare FFS Cost Share
SKILLED NURSING FACILITY	Medicare FFS Cost Share
RX DEDUCTIBLE	\$340 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$2 / 25% / 25% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Atlantic, Bergen, Burlington, Camden, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Union



New Jersey 2026 Plan Highlights

Wellpoint Kidney Care (POS C-SNP) H3240-017

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,200 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$55 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 90 meals chronic condition

New York - Medicare Advantage 2026

MARKET HIGHLIGHTS



- Lead HIDE D-SNP plan has embedded Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- Portfolio of Non-SNP plans with options that include Dental, OTC, Vision and/or Hearing
- Network includes key provider partners including Mount Sinai, NYC Health and Hospitals

SERVICE AREA

Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, Westchester

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Anthem Medicare Advantage (PPO) H3342-023-001	11
Anthem Medicare Advantage (PPO) H3342-023-002	3
Centers Plan for Medicare Advantage Care (HMO) H6988-001	9
Centers Plan for Dual Coverage Care (HMO D-SNP) H6988-002	7
Centers Plan for Nursing Home Care (HMO I-SNP) H6988-003	9

New York 2026 Plan Highlights

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Anthem HealthPlus Full Dual Advantage
(HMO D-SNP)
H8432-042

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, Westchester

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



New York 2026 Plan Highlights

**Anthem HealthPlus Full Dual Advantage
(HMO D-SNP)**
H8432-042

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – preventive and comprehensive services per year; No maximum allowance; Exclusions and limitations apply
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$155 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 48 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge
ACUPUNCTURE		\$0 copay – 24 visits per year



New York 2026 Plan Highlights

NEW

Anthem Veteran 2
(HMO POS)
H6988-008

PREMIUM	\$0
PART B GIVEBACK	\$80
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,800
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester



New York 2026 Plan Highlights

NEW

Anthem Veteran 2
(HMO POS)
H6988-008

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION	\$0 copay – 1 routine eye exam per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$65 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO POS)
H6988-006

PREMIUM	\$56
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$8,300
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$400 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / N/A \$0 copay – All tiers mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Nassau



New York 2026 Plan Highlights

NEW

**Anthem Medicare Advantage 2
(HMO POS)**
H6988-006

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning every year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	42 post discharge



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 3
(HMO POS)
H6988-007

PREMIUM	\$70
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$410 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / N/A \$0 copay – all tiers mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Suffolk



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 3
(HMO POS)
H6988-007

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning every year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO POS)
H6988-010

PREMIUM	\$30
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$385 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$230 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – all tiers mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Rockland, Westchester



New York 2026 Plan Highlights

NEW

**Anthem Medicare Advantage 2
(HMO POS)**
H6988-010

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 1 dental X-ray every year
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO POS)
H6988-009

PREMIUM	\$34
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$480 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$240 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – all tiers mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bronx, Kings, New York, Queens, Richmond



New York 2026 Plan Highlights

NEW

Anthem Medicare Advantage 2
(HMO POS)
H6988-009

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning, 1 dental X-ray, 1 fluoride treatment every year
VISION	\$0 copay – 1 routine eye exam per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

Anthem Veteran
(HMO-POS) H8432-036
(Transitioned H8432-037-001)

PREMIUM	\$0
PART B GIVEBACK	\$81
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,800
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Bronx, Kings, New York, Orange, Queens, Richmond, Rockland, Westchester



New York 2026 Plan Highlights

Anthem Veteran
(HMO-POS) H8432-036
(Transitioned H8432-037-001)

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$65 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

Anthem Medicare Advantage (HMO) H8432-040

PREMIUM	\$44
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$480 copay (days 1 – 4)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 31% / N/A
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bronx, Kings, New York, Queens, Richmond



New York 2026 Plan Highlights

Anthem Medicare Advantage (HMO) H8432-040

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning, 1 dental X-ray, 1 fluoride treatment every year
VISION	\$0 copay – 1 routine eye exam per year
HEARING	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

Anthem Medicare Advantage 2 (HMO-POS) H8432-016

PREMIUM	\$44
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$5 copay
SPECIALIST	\$55 copay
INPATIENT HOSPITAL	\$415 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$150 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$4 / 25% / 30% / 31% / N/A
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bronx, Kings, New York, Queens, Richmond



New York 2026 Plan Highlights

Anthem Medicare Advantage 2 (HMO-POS) H8432-016

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and \$0 copay for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$175 allowance eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H8432-009

PREMIUM	\$65
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$10 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$385 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Rockland, Westchester



New York 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H8432-009

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 1 oral exam, 1 cleaning, 1 dental X-ray, 1 fluoride treatment every year; In Network: \$0 copay per year; Out of Network: 20% per year
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



New York 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H8432-010	Anthem Medicare Advantage (HMO-POS) H8432-011
PREMIUM	\$80	\$90
PART B REBATE	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$9,250	\$9,250
PCP	\$15 copay	\$15 copay
SPECIALIST	\$55 copay	\$55 copay
INPATIENT HOSPITAL	\$400 copay (days 1 – 6)	\$410 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)	\$100 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A	\$0 / \$0 / 25% / 30% / 31% / N/A
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Nassau	Suffolk



New York 2026 Plan Highlights

	Anthem Medicare Advantage (HMO-POS) H8432-010	Anthem Medicare Advantage (HMO-POS) H8432-011
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	N/A	N/A
VISION	\$0 copay – 1 routine eye exam every year; \$125 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam every year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	N/A	N/A
FITNESS	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	N/A	N/A
PODIATRY	N/A	N/A
HEALTHY MEALS	42 post discharge	N/A

Ohio - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #2 D-SNP player in Ohio
- Largest MA Plan with over 318K MA members and #1 Market Share
- Awarded Next Generation MyCare OH FIDE D-SNP effective 1/1/2026. Initial launch in 29 counties, remainder of state by 10/1/2026
- Full Dual D-SNP plans with embedded Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- \$0 HMO plans with Dental, Vision and Hearing benefits
- 4 county segmentation to outstate plan segment

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	13	
PPO	1	
Anthem Medicare Advantage 3 (HMO-POS) H3655-034		All
Anthem Chronic Care (HMO-POS C-SNP) H3655-047		3

Ohio 2026 Plan Highlights

NEW



Anthem | MyCare Full Dual Advantage
(HMO D-SNP)
H2628-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PART B GIVEBACK		\$0
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0
SKILLED NURSING FACILITY		\$0
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood, Wyandot	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Ohio 2026 Plan Highlights

NEW  Anthem MyCare Full Dual Advantage (HMO D-SNP) H2628-001		
MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – preventive and comprehensive services per year; No maximum allowance; Exclusions and limitations apply
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$240 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – unlimited one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge



Ohio 2026 Plan Highlights

Anthem Full Dual Advantage 2
(HMO D-SNP) H2628-004
(Transitioned H3655-049)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Carrol, Champaign, Coshocton, Crawford, Darke, Defiance, Erie, Fairfield, Fayette, Gallia, Guernsey, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pike, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Tuscarawas, Van Wert, Vinton, Washinton, Williams, Wyandot	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Ohio 2026 Plan Highlights

Anthem Full Dual Advantage 2
(HMO D-SNP) H2628-004
(Transitioned H3655-049)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – preventive and comprehensive services per year; No maximum allowance; Exclusions and limitations apply
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$200 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Ohio 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H2628-005 (Transitioned H3655-048)

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI
PREMIUM		\$0 - \$7.10
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$6,750
PCP		\$0 copay
SPECIALIST		\$0 - \$25 copay
INPATIENT HOSPITAL		\$0 - \$435 (days 1 – 7)
SKILLED NURSING FACILITY		\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Ohio 2026 Plan Highlights

Anthem Dual Advantage (HMO D-SNP) H2628-005 (Transitioned H3655-048)

MEDICAID STATUS	Partial Dual	QMB, SLMB, QDWI, QI
ESSENTIAL EXTRAS		N/A
DENTAL		\$1,800 allowance for preventive and comprehensive services per year; \$0 copay for preventive and comprehensive services per year; Preventive includes 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year
VISION		\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 24 trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Ohio 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H2628-003 (Transitioned H3655-033)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay* for a one-month supply of select insulin
MARKET SERVICE AREA		Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Carrol, Champaign, Coshocton, Crawford, Darke, Defiance, Erie, Fairfield, Fayette, Gallia, Guernsey, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lawrence, Licking, Logan, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pike, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Tuscarawas, Van Wert, Vinton, Washinton, Williams, Wyandot

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Ohio 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H2628-003 (Transitioned H3655-033)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		(Pick 1) Utilities – \$150 per quarter, Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL		\$0 copay – preventive and comprehensive services per year; No maximum allowance; Exclusions and limitations apply
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$125 per month OTC and Healthy Foods
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 48 trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3655-045-001

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$470 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Auglaize, Belmont, Champaign, Clark, Clinton, Coshocton, Darke, Defiance, Erie, Fulton, Gallia, Guernsey, Hardin, Harrison, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Lucas, Marion, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding,, Putnam, Richland, Sandusky, Seneca, Shelby, Vinton, Washington, Wayne, Williams, Wood



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)
H3655-045-001**

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3655-045-002

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$400 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Brown, Butler, Clermont, Greene, Hamilton, Miami, Montgomery, Preble, Warren



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)
H3655-045-002**

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)**
H3655-045-003

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,500
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$437 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Delaware, Fairfield, Franklin, Licking, Knox, Madison, Morrow, Pickaway, Union



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage
(HMO-POS)
H3655-045-003**

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Ohio 2026 Plan Highlights

Anthem Medicare Advantage

(HMO-POS) H3655-045-004

(Transitioned H3655-038, H3655-045-004)

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,000
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$375 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Ashland, Ashtabula, Carroll, Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Tuscarawas



Ohio 2026 Plan Highlights

Anthem Medicare Advantage

(HMO-POS) H3655-045-004

(Transitioned H3655-038, H3655-045-004)

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Ohio 2026 Plan Highlights

Anthem Extra Help (HMO-POS) H3655-041

LIS ELIGIBILITY	No LIS	25% Subsidy	50% Subsidy	75% Subsidy	100% Subsidy
PREMIUM	\$31.40	\$0	\$0	\$0	\$0
PART B GIVEBACK	\$0				
MEDICAL DEDUCTIBLE	\$0				
MAX OUT-OF-POCKET	\$7,350				
PCP	\$0 copay				
SPECIALIST	\$40 copay				
INPATIENT HOSPITAL	\$310 copay (days 1 – 7)				
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)				
Part D					
EXTRA HELP LEVEL	No Extra Help		Level 1	Level 2	Level 3
RX DEDUCTIBLE	\$390 (T2 – T5)		\$0	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / 25% / 25% / 25% / 28% / \$0		\$0 copay (T1 and T6) \$5.10 - \$12.65	\$0 copay (T1 and T6) \$1.60 - \$4.90	\$0
INSULIN COST SHARE	\$35 or LIS copay for a one-month supply of select insulin				
MARKET SERVICE AREA	All Counties				



Ohio 2026 Plan Highlights

**Anthem Extra Help
(HMO-POS)**
H3655-041

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$125 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 12 one-way trips per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Ohio 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4036-022

PREMIUM	\$0
PART B GIVEBACK	\$165
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900 (IN) / \$8,950 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties



Ohio 2026 Plan Highlights

Anthem Veteran (PPO)

H4036-022

ESSENTIAL EXTRAS	(Pick 1) Dental Vision Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$0 copay – \$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay for preventive and comprehensive services per year Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$130 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge



Ohio 2026 Plan Highlights

Anthem Medicare Advantage 3 (PPO) H4036-025

PREMIUM	\$51
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$1,000 (applies only to OON)
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,100 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$3 / \$13 / 20% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Allen, Ashland, Ashtabula, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Highland, Holmes, Huron, Jefferson, Knox, Lake, Lawrence, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Mercer, Miami, Montgomery, Morrow, Muskingum, Ottawa, Pickaway, Portage, Preble, Putnam, Richland, Ross, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Warren, Washington, Wayne, Williams, Wood



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage 3
(PPO)**
H4036-025

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,200 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$75 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A



Ohio 2026 Plan Highlights

Anthem Medicare Advantage (LPPO) H4036-026

PREMIUM	\$10
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,100 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$375 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 (days 21 – 100)
RX DEDUCTIBLE	\$350 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$9 / 20% / 30% / 29% / \$0 \$0 copay T1 and T2 mail order 30-90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Athens, Belmont, Butler, Carroll, Clermont, Columbiana, Defiance, Fulton, Gallia, Greene, Hamilton, Harrison, Jefferson, Lucas, Mahoning, Meigs, Monroe, Montgomery, Ottawa, Trumbull, Warren, Washington, Williams, Wood



Ohio 2026 Plan Highlights

Anthem Medicare Advantage (LPPO) H4036-026

ESSENTIAL EXTRAS	(Pick 1) Dental Vision Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$1,000 allowance for preventive and comprehensive services per year In Network: \$0 copay for preventive and comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$30 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits
HEALTHY MEALS	14 post discharge



Ohio 2026 Plan Highlights

**Anthem Medicare Advantage 4
(PPO)**
H4036-017

PREMIUM	\$56
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,900 (IN) / \$10,200 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 8)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$2 / \$12 / 20% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Belmont, Carroll, Columbiana, Cuyahoga, Delaware, Geauga, Greene, Lake, Lorain, Miami, Montgomery, Muskingum, Preble, Sandusky, Stark, Summit, Trumbull



Ohio 2026 Plan Highlights

Anthem Medicare Advantage 4 (PPO) H4036-017

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$100 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – unlimited visits
HEALTHY MEALS	N/A



Ohio 2026 Plan Highlights

	Anthem Veteran (RPPO) R5941-013	Anthem Medicare Advantage (RPPO) R5941-014
PREMIUM	\$0	\$87
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$1,000 (applies to OON only)
MAX OUT-OF-POCKET	\$4,900 (IN) / \$7,200 (IN & OON)	\$6,750 (IN) / \$10,100 (IN & OON)
PCP	\$0 copay	\$10 copay
SPECIALIST	\$35 copay	\$40 copay
INPATIENT HOSPITAL	\$255 copay (days 1 – 8)	\$295 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A	\$250 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	N/A	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties	All Counties



Ohio 2026 Plan Highlights

	Anthem Veteran (RPPO) R5941-013	Anthem Medicare Advantage (RPPO) R5941-014
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$1,750 allowance for preventive and comprehensive services per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year	1 oral exam and 1 cleaning per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$70 per quarter	N/A
FITNESS	\$0 copay – SilverSneakers®	N/A
TRANSPORTATION	N/A	N/A
PERS	\$0 copay	N/A
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	N/A	N/A



South Carolina - Medicare Advantage 2026

MARKET HIGHLIGHTS

- NEW WellPoint Market
- HMO plan with \$0 PCP copay, Vision and Hearing coverage



2026 Proposed Service Area

SERVICE AREA

Greenville, Pickens

South Carolina 2026 Plan Highlights

NEW

Wellpoint Medicare Advantage
(HMO)
H2687-001

PREMIUM	\$14
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$50 copay
INPATIENT HOSPITAL	\$450 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / N/A \$0 copay – T1 and T2 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Greenville, Pickens



South Carolina 2026 Plan Highlights

NEW

Wellpoint Medicare Advantage (HMO) H2687-001

ESSENTIAL EXTRAS	N/A
VISION	\$0 copay – 1 routine eye exam every year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	14 post discharge



Tennessee - Medicare Advantage 2026

MARKET HIGHLIGHTS

- #3 D-SNP player in Tennessee
- Two FIDE D-SNPs:
 - Full Duals enrolled in Choices
 - New FIDE for Aligned Full Duals not enrolled in Choices
- D-SNP plans include embedded Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- Lead \$0 HMO-POS plans in all counties with OTC, Dental, Vision and Hearing



2026 Proposed Service Area

SERVICE AREA

All Counties

Tennessee 2026 Plan Highlights

NEW



Wellpoint Full Dual Advantage 2
(HMO D-SNP) H5828-018
(Transitioned H5828-002)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, De Kalb, Decatur, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, Mc Minn, Mc Nairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Pery, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Tennessee 2026 Plan Highlights

NEW



Wellpoint Full Dual Advantage 2
(HMO D-SNP) H5828-018
 (Transitioned H5828-002)

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$6,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$650 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$203 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – unlimited one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge
CHIROPRACTIC		\$0 copay – unlimited visits per year



Tennessee 2026 Plan Highlights

Wellpoint Full Dual Advantage Support (HMO D-SNP) H5828-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Tennessee 2026 Plan Highlights

Wellpoint Full Dual Advantage Support (HMO D-SNP)

H5828-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$6,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$650 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$288 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – unlimited one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge
CHIROPRACTIC		\$0 copay – unlimited visits per year



Tennessee 2026 Plan Highlights

Wellpoint Full Dual Advantage (HMO D-SNP)

H5828-002

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 or LIS copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Tennessee 2026 Plan Highlights

Wellpoint Full Dual Advantage (HMO D-SNP) H5828-002

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$5,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$600 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$175 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – unlimited trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge
CHIROPRACTIC		\$0 copay – 48 visits per year

Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS)

H5828-014

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,200
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 - 5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fayette, Shelby, Tipton



Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H5828-014

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$55 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	42 post discharge



Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H5828-015

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,200
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$235 (T3 - 5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Cannon, Cheatham, Davidson, Dickson, Maury, Macon, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson, Wilson

Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H5828-015

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$25 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	42 post discharge

Tennessee 2026 Plan Highlights

	Wellpoint Medicare Advantage 2 (HMO-POS) H5828-016	Wellpoint Medicare Advantage 2 (HMO-POS) H5828-017
PREMIUM	\$0	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$6,460	\$6,445
PCP	\$0 copay	\$0 copay
SPECIALIST	\$45 copay	\$35 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 6)	\$350 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 - T5)	\$200 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 – 90 day supply	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bedford, Benton, Bledsoe, Bradley, Carroll, Carter, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, De Kalb, Decatur, Dyer, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Madison, Marshall, Mc Minn, Mc Nairy, Meigs, Monroe, Montgomery, Moore, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Scott, Sevier, Stewart, Sullivan, Unicoi, Van Buren, Warren, Washington, Wayne, Weakley, White	Anderson, Blount, Campbell, Hamilton, Knox, Loudon, Marion, Morgan, Roane, Sequatchie, Union



Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage 2 (HMO-POS) H5828-016

Wellpoint Medicare Advantage 2 (HMO-POS) H5828-017

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A	N/A
OVER THE COUNTER	\$25 per quarter	\$30 per quarter
FITNESS	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	\$0 copay	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	28 post discharge	28 post discharge



Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage (HMO-POS)

H5828-013

PREMIUM	\$19
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,100 (OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$350 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$200 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties



Tennessee 2026 Plan Highlights

Wellpoint Medicare Advantage (HMO-POS)

H5828-013

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips to PAL per year, Assistive Devices – \$500 per year
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$40 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	28 post discharge



Tennessee 2026 Plan Highlights

Anthem Extra Help (HMO-POS) H5828-008

LIS ELIGIBILITY	No LIS	25% Subsidy	50% Subsidy	75% Subsidy	100% Subsidy
PREMIUM	\$0	\$0	\$0	\$0	\$0
PART B GIVEBACK	\$0				
MEDICAL DEDUCTIBLE	\$0				
MAX OUT-OF-POCKET	\$9,000				
PCP	\$0 copay				
SPECIALIST	\$25 copay				
INPATIENT HOSPITAL	\$345 copay (days 1 – 6)				
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)				
	Part D				
EXTRA HELP LEVEL	No Extra Help		Level 1	Level 2	Level 3
RX DEDUCTIBLE	\$390 (T2 – T5)		\$0	\$0	\$0
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / 25% / 25% / 25% / 28% / \$0		\$0 copay (T1 and T6) \$5.10 - \$12.65	\$0 copay (T1 and T6) \$1.60 - \$4.90	\$0
INSULIN COST SHARE	\$35 or LIS copay for a one-month supply of select insulin				
MARKET SERVICE AREA	All Counties				



Tennessee 2026 Plan Highlights

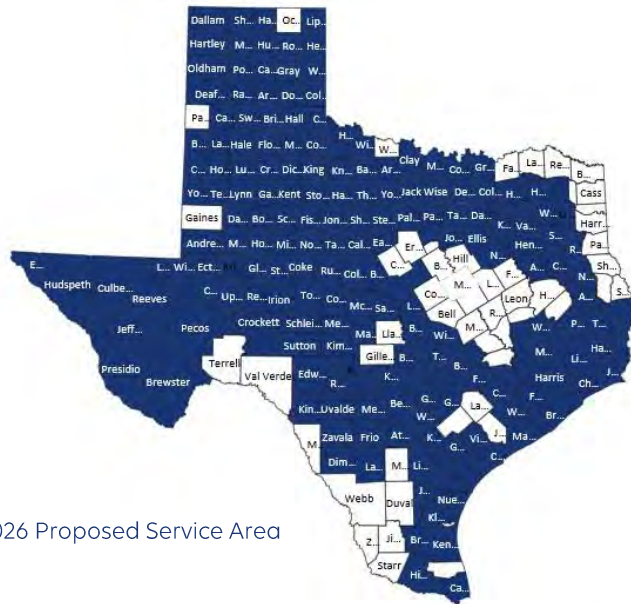
Wellpoint Extra Help (HMO-POS) H5828-008

ESSENTIAL EXTRAS	N/A
DENTAL	\$3,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$60 per quarter
OVER THE COUNTER + HEALTHY FOODS	N/A
FITNESS	N/A
TRANSPORTATION	\$0 copay – 96 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge



Texas - Medicare Advantage 2026

MARKET HIGHLIGHTS



- #4 D-SNP player in Texas
- Lead Full Dual D-SNP plans with Everyday Options Allowance (EOA) for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- Partial Dual D-SNP plans with EOA for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- Enhanced EOA on HIDE D-SNPs in Jefferson, Lubbock, Nueces and West Texas and Coordination D-SNPs in Dallas, Hidalgo and Houston
- D-SNP plan expansion into Hemphill in West Texas plan
- Chronic C-SNPs available with EOA for OTC and Healthy Foods
- Network includes key provider partners including Oak Street Health, CenterWell, Astrana Health and Dedicated

SERVICE AREA

Anderson, Andrews, Angelina, Aransas, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bexar, Borden, Brazoria, Brewster, Briscoe, Brooks, Brown, Burnet, Caldwell, Calhoun, Callahan, Cameron, Camp, Carson, Castro, Chambers, Cherokee, Childress, Clay, Cochran, Collin, Colorado, Coke, Coleman, Collingsworth, Comal, Concho, Cooke, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dickens, Gray, Dimmit, Donley, Eastland, Ector, Edwards, Ellis, El Paso, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Frio, Galveston, Garza, Glasscock, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hale, Hall, Hansford, Hardeman, Hardin, Harris, Hartley, Haskell, Hays, Hemphill, Henderson, Hidalgo, Hockley, Hood, Hopkins, Howard, Hudspeth, Hunt, Hutchinson, Irion, Jack, Jasper, Jeff Davis, Jefferson, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kenedy, Kent, Kerr, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamb, Lee, Liberty, Lipscomb, Live Oak, Loving, Lubbock, Lynn, Martin, Mason, Matagorda, McCulloch, Medina, Menard, Midland, Mills, Mitchell, Montague, Montgomery, Moore, Motley, Nacogdoches, Navarro, Newton, Nolan, Nueces, Oldham, Orange, Palo Pinto, Parker, Pecos, Polk, Potter, Presidio, Rains, Randall, Reagan, Real, Reeves, Roberts, Rockwall, Refugio, Runnels, Rusk, San Jacinto, San Patricio, Schleicher, Scurry, Shackelford, Sherman, Smith, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terry, Throckmorton, Titus, Tom Green, Travis, Tyler, Upshur, Upton, Uvalde, Van Zandt, Victoria, Walker, Waller, Ward, Wharton, Wheeler, Wilbarger, Williamson, Wilson, Winkler, Wise, Wood, Yoakum, Young, Zavala

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Wellpoint Full Dual Advantage 2 (HMO D-SNP) H2593-049	2
Wellpoint Full Dual Advantage 2 (HMO D-SNP) H2593-054	6
Wellpoint Full Dual Advantage 2 (HMO D-SNP) H2593-056	7
Wellpoint Lung Care (HMO-POS C-SNP) H8849-013	11

Austin MSA

Texas 2026 Plan Highlights – Austin MSA

Wellpoint Chronic Care (HMO-POS C-SNP)

H8849-001

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Collin, Comal, Dallas, Denton, Guadalupe, Parker, Rockwall, Tarrant, Travis, Wise

Texas 2026 Plan Highlights – Austin MSA

Wellpoint Chronic Care (HMO-POS C-SNP)

H8849-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS	N/A
EVERYDAY OPTIONS ALLOWANCE	\$40 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Austin MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$12,450 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$0 copay - 20% coinsurance
INPATIENT HOSPITAL	Medicare FFS
SKILLED NURSING FACILITY	N/A
RX DEDUCTIBLE	\$100 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 10% / 20% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Comal, El Paso, Hays, Travis, Williamson

Texas 2026 Plan Highlights – Austin MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS	N/A
EVERYDAY OPTIONS ALLOWANCE	\$80 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 26 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Dallas – Fort Worth MSA

Texas 2026 Plan Highlights – Dallas Fort Worth MSA



Wellpoint Full Dual Advantage

(HMO D-SNP)

H8849-010-002

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		Medicare FFS
RX DEDUCTIBLE		\$0 - \$615 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Anderson, Archer, Camp, Cherokee, Clay, Collin, Cooke, Dallas, Delta, Denton, Ellis, Franklin, Grayson, Gregg, Henderson, Hood, Hopkins, Hunt, Jack, Johnson, Kaufman, Montague, Navarro, Palo Pinto, Parker, Rains, Rockwall, Rusk, Smith, Tarrant, Throckmorton, Titus, Upshur, Van Zandt, Wise, Wood	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA



MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$5,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$500 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$180 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-002

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Anderson, Archer, Camp, Cherokee, Clay, Collin, Cooke, Dallas, Delta, Denton, Ellis, Franklin, Grayson, Gregg, Henderson, Hood, Hopkins, Hunt, Jack, Johnson, Kaufman, Montague, Navarro, Palo Pinto, Parker, Rains, Rockwall, Rusk, Smith, Tarrant, Throckmorton, Titus, Upshur, Van Zandt, Wise, Wood

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-002

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$ copay – 38 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Chronic Care (HMO-POS C-SNP)

H8849-001

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$75 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 32% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Collin, Comal, Dallas, Denton, Guadalupe, Parker, Rockwall, Tarrant, Travis, Wise

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Chronic Care (HMO-POS C-SNP)

H8849-001

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$40 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-043

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,900
PCP	\$0 copay
SPECIALIST	\$0 - \$25 copay
INPATIENT HOSPITAL	\$125 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	\$275 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 25% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Archer, Austin, Bailey, Briscoe, Castro, Chambers, Clay, Cochran, Collin, Colorado, Cooke, Crosby, Dallas, Delta, Denton, Dickens, Floyd, Fort Bend, Galveston, Garza, Grayson, Grimes, Hale, Hardin, Harris, Henderson, Hockley, Hunt, Jack, Jasper, Jefferson, Johnson, Lamb, Liberty, Lubbock, Lynn, Matagorda, Montague, Montgomery, Motley, Navarro, Orange, Palo Pinto, Parker, Rains, Rockwall, San Jacinto, Swisher, Tarrant, Terry, Throckmorton, Van Zandt, Walker, Waller, Wharton, Wise



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-043

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$750 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$115 per quarter
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 60 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition



El Paso MSA

Texas 2026 Plan Highlights – El Paso MSA



Wellpoint Full Dual Advantage

(HMO D-SNP)

H8849-010-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		El Paso, Hudspeth

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – El Paso MSA



Wellpoint Full Dual Advantage (HMO D-SNP) H8849-010-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$105 per month Healthy Foods, OTC, Utilities and Assistive Devices
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		42 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – El Paso MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-004

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		El Paso Hudspeth

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – El Paso MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-004

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,250 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$80 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – El Paso MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031 Only sold internally

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$12,450 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$0 copay - 20% coinsurance
INPATIENT HOSPITAL	Medicare FFS
SKILLED NURSING FACILITY	N/A
RX DEDUCTIBLE	\$100 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 10% / 20% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Comal, El Paso, Hays, Travis, Williamson

Texas 2026 Plan Highlights – El Paso MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031 Only sold internally

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$80 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 26 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Hidalgo MSA

Texas 2026 Plan Highlights – Hidalgo MSA



MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$20 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Cameron, Hidalgo

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Hidalgo MSA

Wellpoint Full Dual Advantage **(HMO D-SNP)** H2593-053

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$175 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Houston MSA

Texas 2026 Plan Highlights – Houston MSA



Wellpoint Full Dual Advantage

(HMO D-SNP)

H8849-010-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Angelina, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Walker, Waller, Wharton	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Houston MSA



MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$190 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – Houston MSA

Wellpoint Lung Care (HMO-POS C-SNP)

H8849-005



Wellpoint Chronic Care (HMO-POS C-SNP)

H8849-003

PREMIUM	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
SPECIALIST	\$0 - \$20 copay	\$0 - \$20 copay
INPATIENT HOSPITAL	\$120 copay (days 1 – 3)	\$120 copay (days 1 – 3)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$75 (T3 - T5)	\$75 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 32% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply	\$0 / \$0 / 20% / 30% / 32% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Harris	Harris, Fort Bend

Texas 2026 Plan Highlights – Houston MSA

Wellpoint Lung Care (HMO-POS C-SNP) H8849-005

★ Wellpoint Chronic Care (HMO-POS C-SNP) H8849-003

ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; 300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$40 per month OTC and Healthy Foods	\$40 per month OTC and Healthy Foods
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips to PAL per year	\$0 copay – 24 one-way trips to PAL per year
PERS	N/A	N/A
PODIATRY	\$0 copay – 24 visits per year	\$0 copay – 24 visits per year
HEALTHY MEALS	10 post discharge / 30 chronic condition meals per year	10 post discharge / 30 chronic condition per year

Texas 2026 Plan Highlights – Houston MSA



PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$120 copay (days 1 – 3)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$140 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Fort Bend, Harris, Montgomery



Texas 2026 Plan Highlights – Houston MSA



ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$3,250 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$62 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	3 meals per day for 14 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP)

H8849-011-001

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Angelina, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Orange, Polk, San Jacinto, Walker, Waller, Wharton

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-001

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$80 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Houston MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-043

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$2,900
PCP	\$0 copay
SPECIALIST	\$0 - \$25 copay
INPATIENT HOSPITAL	\$125 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	N/A
RX DEDUCTIBLE	\$350 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 25% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Archer, Austin, Bailey, Briscoe, Castro, Chambers, Clay, Cochran, Collin, Colorado, Cooke, Crosby, Dallas, Delta, Denton, Dickens, Floyd, Fort Bend, Galveston, Garza, Grayson, Grimes, Hale, Hardin, Harris, Henderson, Hockley, Hunt, Jack, Jasper, Jefferson, Johnson, Lamb, Liberty, Lubbock, Lynn, Matagorda, Montague, Montgomery, Motley, Navarro, Orange, Palo Pinto, Parker, Rains, Rockwall, San Jacinto, Swisher, Tarrant, Terry, Throckmorton, Van Zandt, Walker, Waller, Wharton, Wise

Texas 2026 Plan Highlights – Houston MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-043

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$750 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$115 per quarter
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 60 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition



Jefferson SDA

Texas 2026 Plan Highlights – Jefferson SDA

**Wellpoint Full Dual Advantage Aligned
(HMO D-SNP)**
H2593-044

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, San Jacinto, Walker, Polk, Tyler

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Jefferson SDA

★ Wellpoint Full Dual Advantage Aligned (HMO D-SNP) H2593-044

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,500 allowance for preventive and comprehensive services per year \$0 copay - 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$215 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Lubbock MSA

Texas 2026 Plan Highlights – Lubbock SDA

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Wellpoint Full Dual Advantage Aligned
(HMO D-SNP)
H2593-047

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$520 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Swisher, Terry, Carson, Deaf Smith, Hutchinson, Potter, Randall	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Lubbock SDA

★ Wellpoint Full Dual Advantage Aligned (HMO D-SNP) H2593-047

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$160 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 65 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		28 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – Lubbock MSA

Wellpoint Kidney Care
(HMO-POS C-SNP)
H2593-043

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$2,900
PCP	\$0 copay
SPECIALIST	\$0 - \$25 copay
INPATIENT HOSPITAL	\$125 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$350 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 25% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Archer, Austin, Bailey, Briscoe, Castro, Chambers, Clay, Cochran, Collin, Colorado, Cooke, Crosby, Dallas, Delta, Denton, Dickens, Floyd, Fort Bend, Galveston, Garza, Grayson, Grimes, Hale, Hardin, Harris, Henderson, Hockley, Hunt, Jack, Jasper, Jefferson, Johnson, Lamb, Liberty, Lubbock, Lynn, Matagorda, Montague, Montgomery, Motley, Navarro, Orange, Palo Pinto, Parker, Rains, Rockwall, San Jacinto, Swisher, Tarrant, Terry, Throckmorton, Van Zandt, Walker, Waller, Wharton, Wise



Texas 2026 Plan Highlights – Lubbock MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-043

ESSENTIAL EXTRAS	(Pick 1) Healthy Foods - \$50 per month, Utilities - \$150 per quarter, Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$750 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$115 per quarter
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 60 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition



Nueces MSA

Texas 2026 Plan Highlights – Nueces SDA

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Wellpoint Full Dual Advantage Aligned
(HMO D-SNP)
H2593-045

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$550 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Nueces SDA

Wellpoint Full Dual Advantage Aligned (HMO D-SNP) H2593-045

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$200 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 65 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		28 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

San Antonio MSA

Texas 2026 Plan Highlights – San Antonio SDA

Wellpoint Full Dual Advantage 2
(HMO D-SNP)
H2593-051

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 - T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Atascosa, Banderita, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – San Antonio SDA



MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,250 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$400 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$125 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – San Antonio MSA



PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$3,400
PCP	\$0 copay
SPECIALIST	\$10 copay
INPATIENT HOSPITAL	\$225 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$75 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 20% / 30% / 32% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Collin, Comal, Dallas, Denton, Guadalupe, Parker, Rockwall, Tarrant, Travis, Wise



Texas 2026 Plan Highlights – San Antonio MSA



ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$45 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 12 one-way trips to PAL per year
PERS	N/A
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – San Antonio MSA



Wellpoint Select (HMO-POS)

H8849-006

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$3,500
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$100 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$90 copay (days 21 – 100)
RX DEDUCTIBLE	\$0
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 33% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar

Texas 2026 Plan Highlights – San Antonio MSA



ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing - \$500 per year, Transportation - 60 one-way trips per year, Assistive Devices - \$500 per year
DENTAL	\$1,500 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$62 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	3 meals per day for 14 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-002

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Anderson, Archer, Camp, Cherokee, Clay, Collin, Cooke, Dallas, Delta, Denton, Ellis, Franklin, Grayson, Gregg, Henderson, Hood, Hopkins, Hunt, Jack, Johnson, Kaufman, Montague, Navarro, Palo Pinto, Parker, Rains, Rockwall, Rusk, Smith, Tarrant, Throckmorton, Titus, Upshur, Van Zandt, Wise, Wood

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-002

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$250 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 38 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge / 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – San Antonio MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031 Only sold internally

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$9,250 (IN) / \$12,450 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$0 copay - 20% coinsurance
INPATIENT HOSPITAL	Medicare FFS
SKILLED NURSING FACILITY	Medicare FFS
RX DEDUCTIBLE	\$100 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 10% / 20% / 31% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bexar, Comal, El Paso, Hays, Travis, Williamson

Texas 2026 Plan Highlights – San Antonio MSA

Wellpoint Kidney Care (HMO-POS C-SNP) H2593-031 Only sold internally

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive services Out of Network: 20% preventive - 50% comprehensive
VISION	\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay - 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$80 per month OTC and Healthy Foods
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	\$0 copay – 26 one-way trips to PAL per year
PERS	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year
HEALTHY MEALS	14 post discharge / 2 meals per day for 90 days chronic condition

West Texas SDA

Texas 2026 Plan Highlights – West Texas SDA

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Wellpoint Full Dual Advantage Aligned
(HMO D-SNP)
H2593-046

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$205 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill , Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Oldham, Palo Pinto, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Throckmorton, Tom Green, Upton, Uvalde, Ward, Wheeler, Wilbarger, Winkler, Yoakum, Young, Zavala

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – West Texas SDA



MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$4,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$375 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$175 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – Harris SDA

Wellpoint Full Dual Advantage 2 (HMO D-SNP) H2593-048

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 – T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Harris SDA

Wellpoint Full Dual Advantage 2 (HMO D-SNP) H2593-048

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$165 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year

Texas 2026 Plan Highlights – Lubbock SDA

Wellpoint Full Dual Advantage (HMO D-SNP) H8849-010-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bailey, Briscoe, Castro, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Motley, Swisher, Terry	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Lubbock SDA

Wellpoint Full Dual Advantage (HMO D-SNP) H8849-010-005

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$5,000 unlimited allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$700 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$220 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-005

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Bailey, Briscoe, Castro, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Motley, Polk, San Jacinto, Swisher, Terry, Walker, Waller, Wharton

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-005

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		Unlimited allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$650 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$145 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage 2 (HMO D-SNP) H2593-032

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$230 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 30% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Archer, Atascosa, Austin, Bailey, Bandera, Bastrop, Bexar, Blanco, Briscoe, Burnet, Caldwell, Castro, Chambers, Clay, Cochran, Collin, Colorado, Comal, Cooke, Crosby, Dallas, Delta, Denton, Dickens, El Paso, Fayette, Floyd, Fort Bend, Galveston, Garza, Gonzales, Grayson, Grimes, Guadalupe, Hale, Hamilton, Hardin, Harris, Hays, Henderson, Hockley, Hudspeth, Hunt, Jack, Jasper, Jefferson, Johnson, Kendall, La Salle, Lamb, Lampasas, Lee, Liberty, Lubbock, Lynn, Mason, Matagorda, Medina, Mills, Montague, Montgomery, Motley, Navarro, Orange, Palo Pinto, Parker, Rains, Real, Rockwall, San Jacinto, San Saba, Swisher, Tarrant, Terry, Throckmorton, Travis, Van Zandt, Walker, Waller, Wharton, Williamson, Wilson, Wise, Zavala	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage 2 (HMO D-SNP) H2593-032

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,000 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$175 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$50 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 32 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		21 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Legacy

Wellpoint Medicare Advantage 2 (HMO-POS) H2593-029

PREMIUM	\$0
MEDICAL DEDUCTIBLE	\$0
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$9,250
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$335 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 - T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$2 / 20% / 30% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Archer, Atascosa, Austin, Bailey, Bandera, Bastrop, Bexar, Blanco, Briscoe, Burnet, Caldwell, Castro, Chambers, Clay, Cochran, Collin, Colorado, Comal, Cooke, Crosby, Dallas, Delta, Denton, Dickens, El Paso, Floyd, Fort Bend, Galveston, Garza, Gonzales, Grayson, Grimes, Guadalupe, Hale, Hamilton, Hardin, Harris, Hays, Henderson, Hockley, Hudspeth, Hunt, Jack, Jasper, Jefferson, Johnson, Kendall, La Salle, Lamb, Lampasas, Lee, Liberty, Lubbock, Lynn, Mason, Matagorda, Medina, Mills, Montague, Montgomery, Motley, Navarro, Orange, Palo Pinto, Parker, Rains, Real, Rockwall, San Jacinto, San Saba, Swisher, Tarrant, Terry, Throckmorton, Travis, Van Zandt, Walker, Waller, Wharton, Williamson, Wilson, Wise, Zavala



Texas 2026 Plan Highlights – Legacy

Wellpoint Medicare Advantage 2 (HMO-POS) H2593-029

ESSENTIAL EXTRAS	N/A
DENTAL	In Network: \$0 copay – 1 oral exams, 1 cleaning every year Out of Network: 20% preventive
VISION	\$0 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
OVER THE COUNTER	\$44 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-003

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Atascosa, Bandera, Bexar, Comal, Gonzales, Guadalupe, Kendall, La Salle, Medina, Real, Wilson, Zavala

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-003

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,750 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$65 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge - 2 meals per day for 90 days chronic condition

Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-004

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0 - \$4.80
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Partial Dual – Medicare FFS / Full Dual \$0 copay
SKILLED NURSING FACILITY		Partial Dual – Medicare FFS / Full Dual \$0 copay
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 / 25% / 25% / 25% / 25% / \$0 Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		Bailey, Briscoe, Castro, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Motley, Polk, San Jacinto, Swisher, Terry, Walker, Waller, Wharton

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Texas 2026 Plan Highlights – Dallas Fort Worth MSA

Wellpoint Dual Advantage (HMO D-SNP) H8849-011-004

MEDICAID STATUS	All Dual	SLMB, QI, QDWI, FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,250 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year, and comprehensive dental services
VISION		\$0 copay – 1 routine eye exam per year; \$275 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$80 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge - 2 meals per day for 90 days chronic condition

- ## SERVICE AREA

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	15	All
PPO	3	
C-SNP	2	
Anthem Extra Help (HMO-POS) H3447-028		

Virginia 2026 Plan Highlights



Anthem Full Dual Advantage (HMO D-SNP) H4694-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 – \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties (expansion county: Accomack)

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Virginia 2026 Plan Highlights



Anthem Full Dual Advantage (HMO D-SNP)

H4694-004

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$425 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$323 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – 4 visits per year
HEALTHY MEALS		14 post discharge / 3 meals per day for 14 days chronic condition
ACUPUNCTURE		\$0 copay – 12 visits per year

Virginia 2026 Plan Highlights



Anthem Full Dual Advantage 2 (HMO D-SNP) H4694-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 – \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties (expansion county: Accomack)

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Virginia 2026 Plan Highlights



Anthem Full Dual Advantage 2 (HMO D-SNP)

H4694-001

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		(Pick 1) Utilities – \$150 per quarter, Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL		\$3,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS		\$82 per month
EVERYDAY OPTIONS ALLOWANCE		N/A
OVER THE COUNTER		\$400 per quarter
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – 4 visits per year
HEALTHY MEALS		14 post discharge / 3 meals per day for 14 days chronic condition
ACUPUNCTURE		\$0 copay – 12 visits per year



Virginia 2026 Plan Highlights



Anthem Dual Advantage (HMO D-SNP) H4694-002

MEDICAID STATUS	Partial Dual	QMB
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 – \$605 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties (expansion county: Accomack)

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Virginia 2026 Plan Highlights



Anthem Dual Advantage (HMO D-SNP)

H4694-002

MEDICAID STATUS	Partial Dual	QMB
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$110 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 34 one-way trips per year
PERS		\$0 copay
PODIATRY		\$0 copay – 4 visits per year
HEALTHY MEALS		28 post discharge / 42 chronic condition
ACUPUNCTURE		\$0 copay – 12 visits per year

Virginia 2026 Plan Highlights

 Anthem Full Dual Advantage Support
(HMO D-SNP)
H4694-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 – \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties (expansion county: Accomack)

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.

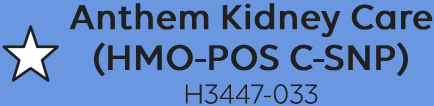


Virginia 2026 Plan Highlights

Anthem Full Dual Advantage Support (HMO D-SNP) H4694-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$362 per month OTC, Assistive Devices, Healthy Foods and Utilities
OVER THE COUNTER		N/A
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – 4 visits per year
HEALTHY MEALS		28 post discharge / 3 meals per day for 14 days chronic condition
ACUPUNCTURE		\$0 copay – 12 visits per year

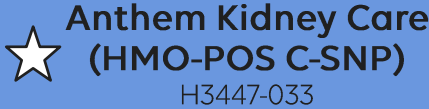
Virginia 2026 Plan Highlights



PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900
PCP	\$0 copay
SPECIALIST	\$0 copay Nephrologist \$0 – \$40 copay
INPATIENT HOSPITAL	\$325 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$325 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 25% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Accomack, Alexandria City, Arlington, Falls Church City



Virginia 2026 Plan Highlights



ESSENTIAL EXTRAS	(Pick 1) Healthy Foods – \$50 per month, Utilities – \$150 per quarter, Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$1,800 allowance for preventive and comprehensive services per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$110 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – 60 one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Dual Advantage (PPO D-SNP) H2441-001

MEDICAID STATUS	Partial Dual	QMB
PREMIUM		\$0
PART B GIVEBACK		\$0
MEDICAL DEDUCTIBLE		\$0
MAX OUT-OF-POCKET		\$9,250 (IN) / \$13,900 (IN & OON)
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay
SKILLED NURSING FACILITY		\$0 copay
RX DEDUCTIBLE		\$0 – \$520 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA		All Counties <u>EXCEPT</u> : Accomack, Alexandria City, Arlington, Fairfax, Fairfax City and Prince William

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.



Virginia 2026 Plan Highlights

Anthem Dual Advantage (PPO D-SNP) H2441-001

MEDICAID STATUS	Partial Dual	QMB
ESSENTIAL EXTRAS		N/A
DENTAL		\$2,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year
VISION		\$0 copay – 1 routine eye exam per year; \$325 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS		\$54 per month
EVERYDAY OPTIONS ALLOWANCE		N/A
OVER THE COUNTER		\$205 per quarter
FITNESS		\$0 copay – SilverSneakers®
TRANSPORTATION		\$0 copay – 24 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – 4 visits per year
HEALTHY MEALS		42 post discharge

Virginia 2026 Plan Highlights

**Anthem Chronic Care
(HMO-POS C-SNP)**
H3447-037

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,400
PCP	\$0 copay
SPECIALIST	\$20 copay
INPATIENT HOSPITAL	\$325 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$295 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Chesapeake City, Chesterfield, Colonial Heights City, Goochland, Hampton City, Hanover, Henrico, Hopewell City, James City, Newport News City, Norfolk City, Petersburg City, Portsmouth City, Powhatan, Prince William, Richmond City, Suffolk City, Virginia Beach City



Virginia 2026 Plan Highlights

Anthem Chronic Care (HMO-POS C-SNP)

H3447-037

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay for preventive and comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$75 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – 48 one-way trips per year
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	28 post discharge

Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-052

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,900
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$220 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bland, Bristol City, Buchanan, Carroll, Danville City, Dickenson, Galax City, Grayson, Henry, Lee, Martinsville City, Norton City, Patrick, Pittsylvania, Russell, Scott, Smyth, Tazewell, Washington, Wise, Wythe



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-052

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,750 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$68 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-050

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,775
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 25% / 29% / N/A \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Albemarle, Alleghany, Amherst, Appomattox, Augusta, Bath, Bedford, Botetourt, Brunswick, Buckingham, Buena Vista City, Campbell, Charlotte, Charlottesville City, Covington City, Craig, Cumberland, Emporia City, Floyd, Fluvanna, Franklin, Frederick, Giles, Greene, Greenville, Halifax, Harrisonburg City, Highland, Lexington City, Louisa, Lunenburg, Lynchburg City, Mecklenburg, Montgomery, Nelson, Nottoway, Orange, Page, Prince Edward, Pulaski, Radford City, Roanoke, Roanoke City, Rockbridge, Rockingham, Salem City, Shenandoah, Staunton City, Waynesboro City, Winchester City



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-050

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$75 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-049

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$4,250
PCP	\$0 copay
SPECIALIST	\$25 copay
INPATIENT HOSPITAL	\$375 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$295 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 25% / 29% / N/A \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Amelia, Caroline, Charles City, Chesapeake City, Chesterfield, Colonial Heights City, Dinwiddie, Essex, Franklin City, Gloucester, Goochland, Hampton City, Hanover, Henrico, Hopewell City, Isle Of Wight, James City, King And Queen, King George, King William, Lancaster, Mathews, Middlesex, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Petersburg City, Poquoson City, Portsmouth City, Powhatan, Prince George, Richmond, Richmond City, Southampton, Suffolk City, Surry, Sussex, Virginia each City, Westmoreland, Williamsburg City, York



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-049

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,500 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$32 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-051

PREMIUM	\$24
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$6,300
PCP	\$0 copay
SPECIALIST	\$30 copay
INPATIENT HOSPITAL	\$389 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / N/A \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Alexandria City, Arlington, Clarke, Culpeper, Fairfax, Fairfax City, Falls Church City, Fauquier, Fredericksburg City, Loudoun, Madison, Manassas City, Manassas Park City, Prince William, Rappahannock, Spotsylvania, Stafford, Warren



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 3 (HMO-POS) H3447-051

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,200 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per quarter
FITNESS	N/A
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 4 (HMO-POS) H3447-039

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$5,900
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$345 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bedford, Botetourt, Chesapeake City, Colonial Heights, Franklin, Goochland, Hampton City, Hanover, Henrico, Hopewell City, Isle Of Wight, Lynchburg City, Montgomery, Petersburg City, Portsmouth City, Powhatan, Richmond City, Roanoke, Roanoke City, Salem City, Suffolk City, Virginia Beach City



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 4 (HMO-POS) H3447-039

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
HEALTHY FOODS	N/A
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$65 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H3447-013

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$8,550
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Chesapeake City, Franklin City, Gloucester, Hampton City, Isle Of Wight, Middlesex, Newport News City, Norfolk City, Northampton, Portsmouth City, Suffolk City, Surry, Virginia Beach City, Williamsburg City, York



Virginia 2026 Plan Highlights

Anthem Medicare Advantage (HMO-POS) H3447-013

ESSENTIAL EXTRAS	N/A
DENTAL	\$0 copay – 2 oral exams, 2 cleanings, 1 dental X-ray, 1 fluoride treatment every year; In Network – \$0 copay per year; Out of Network – 20% per year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$35 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 2 (HMO-POS) H3447-025

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$8,450
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$445 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$214 copay (days 21 – 100)
RX DEDUCTIBLE	\$300 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Albemarle, Alexandria City, Amelia, Amherst, Augusta, Bedford, Botetourt, Bristol City, Buena Vista City, Campbell, Charlottesville City, Danville City, Dinwiddie, Floyd, Fluvanna, Franklin, Frederick, Fredericksburg City, Giles, Greene, Halifax, Harrisonburg City, Henry, King George, Lynchburg City, Manassas City, Manassas Park City, Montgomery, Orange, Pittsylvania, Prince Edward, Prince George, Prince William, Pulaski, Radford City, Roanoke, Roanoke City, Rockbridge, Rockingham, Shenandoah, Stafford, Staunton City, Tazewell, Washington, Waynesboro City, Wise, Wythe



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 2 (HMO-POS) H3447-025

ESSENTIAL EXTRAS	N/A
DENTAL	2 exams, 2 cleanings, 1 x-ray and 1 fluoride; In Network: \$0 copay Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 6 visits per year
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4909-020

PREMIUM	\$0
PART B GIVEBACK	\$80
MEDICAL DEDUCTIBLE	\$750 (applies only to OON)
MAX OUT-OF-POCKET	\$6,800 (IN) / \$10,000 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$290 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	N/A
RX COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Accomack, Arlington, Buckingham, Carroll, Culpeper, Essex, Fairfax, Fluvanna, James City, Loudoun, Mecklenburg, Montgomery, Nelson, Pittsylvania, Prince William, Smyth, Southampton, Sussex, Warren, York



Virginia 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4909-020

ESSENTIAL EXTRAS	N/A
DENTAL	\$2,250 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$50 per quarter
FITNESS	\$0 copay – SilverSneakers®
TRANSPORTATION	\$0 copay – 24 one-way trips per year
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

Anthem Medicare Advantage (PPO) H4909-014

PREMIUM	\$14
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$750 (applies only to OON)
MAX OUT-OF-POCKET	\$8,950 (IN) / \$11,300 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$425 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$250 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	All Counties <u>EXCEPT</u> : Accomack, Alexandria City, Arlington, Bath, Botetourt, Charles City, Colonial Heights City, Craig, Culpeper, Cumberland, Fairfax, Fairfax City, Falls Church City, Fauquier, Fredericksburg City, Gloucester, Hampton City, Hanover, Harrisonburg City, Henrico, Hopewell City, King William, Loudoun, Manassas Park City, Martinsville City, New Kent, Newport News City, Northumberland, Poquoson City, Portsmouth City, Prince George, Prince William, Richmond, Shenandoah, Smyth, Spotsylvania, Tazewell, Waynesboro City



Virginia 2026 Plan Highlights

Anthem Medicare Advantage (PPO)

H4909-014

ESSENTIAL EXTRAS	(Pick 1) Dental, Vision and Hearing – \$500 per year, Transportation – 60 one-way trips per year, Assistive Devices – \$500 per year
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$125 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$1,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Virginia 2026 Plan Highlights

**Anthem Medicare Advantage 2
(PPO)**
H4909-026

PREMIUM	\$16
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$750 (applies only to OON)
MAX OUT-OF-POCKET	\$8,950 (IN) / \$13,900 (IN & OON)
PCP	\$0 copay
SPECIALIST	\$35 copay
INPATIENT HOSPITAL	\$395 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$215 (T3 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 30% / \$0 \$0 copay – T1 and T2 mail order 30 - 60 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Bedford, Chesapeake City, Chesterfield, Franklin, Franklin City, Hampton City, Henrico, Isle Of Wight, Lynchburg City, Poquoson City, Portsmouth City, Richmond City, Roanoke, Salem City, Suffolk City, Virginia Beach City



Virginia 2026 Plan Highlights

Anthem Medicare Advantage 2 **(PPO)** H4909-026

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,750 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$0 copay – 1 routine eye exam per year; \$150 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	\$45 per quarter
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	N/A



Washington - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- Plan options for both Full Dual eligibles and Partial Dual eligibles
- Full and Partial Dual D-SNP plans with Everyday Options Allowance for OTC Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- D-SNP plans expanding into 12 additional counties
- Network includes key provider partners, such as Providence, CHI Franciscan, UW Physicians, Swedish, and Seattle Medical Group

SERVICE AREA

Adams, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Thurston, Wahkiakum, Walla Walla, Whitman, Yakima

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Non-Renewal (# of Counties)
Wellpoint Kidney Care (HMO-POS C-SNP) H1894-008	6

Washington 2026 Plan Highlights

**Wellpoint Full Dual Advantage
(HMO D-SNP)**
H1894-002

MEDICAID STATUS	Full Dual	FBDE, QMB, QMB+, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay - Medicare FFS
SKILLED NURSING FACILITY		\$0 copay - Medicare FFS
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T3 – T5) \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Thurston, Walla Walla, Whitman, Wahkiakum, Yakima	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Washington 2026 Plan Highlights

★
Wellpoint Full Dual Advantage
(HMO D-SNP)
H1894-002

MEDICAID STATUS	Full Dual	FBDE, QMB, QMB+, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,500 allowance for preventive and comprehensive services per year \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year;
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$75 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay - 60 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge meals / 2 meals per day for 90 days chronic condition



Washington 2026 Plan Highlights

Wellpoint Dual Advantage
(HMO D-SNP)
H1894-011

MEDICAID STATUS	Partial Dual	SLMB, QDWI, QI
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		\$0 copay – Medicare FFS
SKILLED NURSING FACILITY		\$0 copay – Medicare FFS
RX DEDUCTIBLE		\$0 - \$615 (T2 – T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Thurston, Walla Walla, Whitman, Wahkiakum, Yakima	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



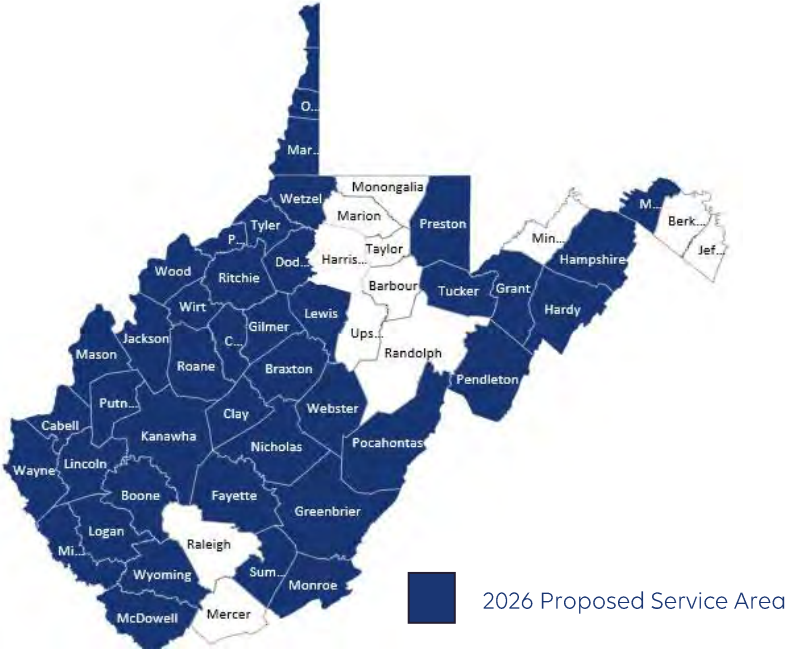
Washington 2026 Plan Highlights

Wellpoint Dual Advantage (HMO D-SNP) H1894-011

MEDICAID STATUS	Partial Dual	SLMB, QDWI, QI
ESSENTIAL EXTRAS		N/A
DENTAL		\$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; \$2,400 allowance for preventive and comprehensive services per year
VISION		\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING		\$0 copay - 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$50 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 34 one-way trips to PAL per year
PERS		\$0 copay
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		14 post discharge meals / 2 meals per day for 90 days chronic condition
ACUPUNCTURE		\$0 copay – unlimited visits per year
CHIROPRACTIC		\$0 copay – 24 visits per year

West Virginia - Medicare Advantage 2026

MARKET HIGHLIGHTS



- NEW Wellpoint Market
- 43 of the 55 counties
- Full and Partial D-SNP plans with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1 and 6 at \$0
- Lead \$0 HMO-POS with \$0 PCP plus Supplemental Dental, Vision and Hearing coverage
- Network includes key provider partners, such as Vandalia Health which includes CAMC Health System, Davis Health System and Mon Health System as well as Marietta Memorial Health System (Ohio) which includes Westbrook Health Services and St. Joseph Recovery Center

SERVICE AREA

Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jackson, Kanawha, Lewis, Lincoln, Logan, Mc Dowell, Marshall, Mason, Mongo, Monroe, Morgan, Nicholas, Ohio, Pendelton, Pheasants, Pocahontas, Preston, Putnam, Ritchie, Roane, Summers, Tucker, Tyler, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming

West Virginia 2026 Plan Highlights

	NEW Wellpoint Dual Advantage (HMO) H1212-002	NEW ★ Wellpoint Full Dual Advantage (HMO) H1212-001
MEDICAID STATUS	Partial Dual SLMB, QDWI, QI	Full Dual FBDE, QMB, QMB+, SLMB+
PREMIUM	\$0 - \$32.70	\$0
PART B GIVEBACK	\$0	\$0
MEDICAL DEDUCTIBLE	\$0	\$0
MAX OUT-OF-POCKET	\$5,400	\$9,250
PCP	\$0 copay	\$0 copay
SPECIALIST	\$25 copay	\$0 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 7)	\$0 copay
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)	\$0 copay
RX DEDUCTIBLE	\$0 - \$615 (T2 - T5)	\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)	\$0 copay – (T1 and T6) Members pay LIS copay* (T2 - T5)
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jackson, Kanawha, Lewis, Lincoln, Logan, Marshall, Mason, Mc Dowell, Mingo, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Ritchie, Roane, Summers, Tucker, Tyler, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming	Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jackson, Kanawha, Lewis, Lincoln, Logan, Marshall, Mason, Mc Dowell, Mingo, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Ritchie, Roane, Summers, Tucker, Tyler, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.

West Virginia 2026 Plan Highlights

	NEW Wellpoint Dual Advantage (HMO) H1212-002	NEW ★ Wellpoint Full Dual Advantage (HMO) H1212-001
MEDICAID STATUS	Partial Dual SLMB, QDWI, QI	Full Dual FBDE, QMB, QMB+, SLMB+
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	\$1,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and comprehensive dental services per year	\$2,500 allowance for preventive and comprehensive services per year; \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year
VISION	\$0 copay – 1 routine eye exam per year; \$225 allowance – eyeglasses or contact lenses per year	\$0 copay – 1 routine eye exam per year; \$300 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,500 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, 1 fitting & 1 evaluation per year; \$3,000 maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	\$55 per month OTC, Assistive Devices, Healthy Foods and Utilities	\$180 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS	\$0 copay - SilverSneakers®	\$0 copay - SilverSneakers®
TRANSPORTATION	\$0 copay – 18 one-way trips per year	\$0 copay – 42 one-way trips per year
PERS	N/A	\$0 copay
PODIATRY	\$0 copay – unlimited visits per year	\$0 copay – unlimited visits per year
HEALTHY MEALS	20 post discharge	42 post discharge
CHIROPRACTIC	N/A	\$0 copay – 48 visits per year

West Virginia 2026 Plan Highlights

NEW

**Wellpoint Medicare Advantage
(HMO-POS)**
H1212-003

PREMIUM	\$0
PART B GIVEBACK	\$0
MEDICAL DEDUCTIBLE	\$0
MAX OUT-OF-POCKET	\$7,500
PCP	\$0 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$415 copay (days 1 – 5)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
RX DEDUCTIBLE	\$275 (T3 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / N/A \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 - \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jackson, Kanawha, Lewis, Lincoln, Logan, Marshall, Mason, Mc Dowell, Mingo, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Ritchie, Roane, Summers, Tucker, Tyler, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming



West Virginia 2026 Plan Highlights

NEW

Wellpoint Medicare Advantage (HMO-POS) H1212-003

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year; In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% comprehensive services per year; Out of Network: 20% for preventive and 50% for comprehensive services per year
VISION	\$45 copay – 1 routine eye exam per year; \$100 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE	N/A
OVER THE COUNTER	N/A
OVER THE COUNTER + HEALTHY FOODS	N/A
FITNESS	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	N/A
HEALTHY MEALS	14 post discharge



Wisconsin - Medicare Advantage 2026

MARKET HIGHLIGHTS



2026 Proposed Service Area

- #2 D-SNP player with largest growth
- Full Dual D-SNP plan with Everyday Options Allowance for OTC, Assistive Devices, Healthy Foods and Utilities plus Rx Tiers 1, 2 and 6 at \$0
- Milwaukee HMO-POS plan now offered in smaller footprint
- Green Bay HMO-POS plan with smaller service area and \$39 premium
- Network includes key provider partners including Froedtert, UW Health, Aurora Health Care, Bellin Health, Marshfield Clinic, Aspirus Health, ThedaCare and Ascension

SERVICE AREA

All Counties

SERVICE AREA REDUCTIONS AND NON-RENEWALS

Plan Type	Service Area Reduction (# of Counties)	Non-Renewal (# of Counties)
HMO	48	
PPO	63	
Anthem Medicare Advantage (PPO) H4036-020		All
Anthem Dual Advantage (HMO D-SNP) H9525-012		All
Anthem Medicare Advantage (HMO-POS) H9525-015		3

Wisconsin 2026 Plan Highlights

**Anthem Full Dual Advantage
(HMO D-SNP)**
H9525-018

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee For Service
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$590 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Ashland, Barron, Bayfield, Brown, Buffalo, Burnett, Calumet, Chippewa, Clark, Columbia, Crawford, Dane, Dodge, Door, Douglas, Dunn, Eau Claire, Florence, Fond Du Lac, Forest, Grant, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kenosha, Kewaunee, La Crosse, Lafayette, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Monroe, Oconto, Oneida, Outagamie, Ozaukee, Pepin, Pierce, Polk, Portage, Price, Racine, Richland, Rock, Rusk, Sauk, Sawyer, Shawano, Sheboygan, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Walworth, Washburn, Washington, Waukesha, Waupaca, Waushara, Winnebago, Wood	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Wisconsin 2026 Plan Highlights

**Anthem Full Dual Advantage
(HMO D-SNP)**
H9525-018

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$450 allowance eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$180 per month OTC, Assistive Devices, Healthy Foods and Utilities
FITNESS		\$0 copay - SilverSneakers®
TRANSPORTATION		\$0 copay – 96 one-way trips to PAL per year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		3 meals per day for 14 days chronic condition



Wisconsin 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H9525-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
PREMIUM		\$0
PART B GIVEBACK		\$0
MAX OUT-OF-POCKET		\$9,250
PCP		\$0 copay
SPECIALIST		\$0 copay
INPATIENT HOSPITAL		Medicare Fee For Service
SKILLED NURSING FACILITY		Medicare Fee For Service
PART B DEDUCTIBLE		\$257
RX DEDUCTIBLE		\$0 - \$615 (T2 - T5)
RX COST SHARE T1/T2/T3/T4/T5/T6		Members pay LIS copay* on (T2 - T5) \$0 copay – T1 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE		\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Ashland, Barron, Bayfield, Brown, Buffalo, Burnett, Calumet, Chippewa, Clark, Columbia, Crawford, Dane, Dodge, Door, Douglas, Dunn, Eau Claire, Florence, Fond Du Lac, Forest, Grant, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kenosha, Kewaunee, La Crosse, Lafayette, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Monroe, Oconto, Oneida, Outagamie, Ozaukee, Pepin, Pierce, Polk, Portage, Price, Racine, Richland, Rock, Rusk, Sauk, Sawyer, Shawano, Sheboygan, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Walworth, Washburn, Washington, Waukesha, Waupaca, Waushara, Winnebago, Wood	

*If you receive Extra Help, the amount you pay is determined by your low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.
If you do not qualify for Extra Help, you pay the coinsurance.



Wisconsin 2026 Plan Highlights

Anthem Full Dual Advantage (HMO D-SNP) H9525-003

MEDICAID STATUS	Full Dual	FBDE, QMB+, QMB, SLMB+
ESSENTIAL EXTRAS		N/A
DENTAL		\$3,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; and \$0 copay for comprehensive services
VISION		\$0 copay – 1 routine eye exam per year; \$350 allowance eyeglasses or contact lenses per year
HEARING		\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
EVERYDAY OPTIONS ALLOWANCE		\$175 per month OTC and Healthy Foods
FITNESS		\$0 copay
HEALTH & FITNESS TRACKER		N/A
TRANSPORTATION		\$0 copay – 48 one-way trips to PAL every year
PERS		N/A
PODIATRY		\$0 copay – unlimited visits per year
HEALTHY MEALS		20 post discharge



Wisconsin 2026 Plan Highlights

	Anthem Medicare Advantage (HMO – POS) H9525-004	Anthem Medicare Advantage (HMO – POS) H9525-006
PREMIUM	\$0	\$39
PART B GIVEBACK	\$0	\$0
MAX OUT-OF-POCKET	\$4,400	\$4,300
PCP	\$0 copay	\$0 copay
SPECIALIST	\$40 copay	\$40 copay
INPATIENT HOSPITAL	\$250 copay (days 1 – 6)	\$325 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 6 - 20) \$218 copay (days 21 - 100)	\$0 copay (days 6 - 20) \$218 copay (days 21 - 100)
RX DEDUCTIBLE	\$315 (T3 – T5)	\$350 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1, T2 and T6 mail order 30 – 90 day supply	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay T1, T2 and T6 mail order 30 – 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Jefferson, Kenosha, Milwaukee, Racine, Walworth, Waukesha	Brown, Calumet, Dodge, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Menominee, Oconto, Outagamie, Ozaukee, Shawano, Sheboygan, Washington, Winnebago

Wisconsin 2026 Plan Highlights

	Anthem Medicare Advantage (HMO – POS) H9525-004	Anthem Medicare Advantage (HMO – POS) H9525-006
ESSENTIAL EXTRAS	N/A	N/A
DENTAL	1 oral exam, 1 cleaning every year In Network: \$0 copay - Out of Network: 20%	1 oral exam, 1 cleaning every year In Network: \$0 copay - Out of Network: 20%
VISION	\$0 copay – 1 routine eye exam per year	\$0 copay – 1 routine eye exam per year \$250 allowance eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$15 per quarter	N/A
FITNESS	N/A	N/A
HEALTH & FITNESS TRACKER	N/A	N/A
TRANSPORTATION	N/A	N/A
PERS	N/A	N/A
PODIATRY	\$0 copay – 12 visits per year	\$0 copay – 12 visits per year
HEALTHY MEALS	20 post discharge	20 post discharge

Wisconsin 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4036-024

PREMIUM	\$0
PART B GIVEBACK	\$75
MAX OUT-OF-POCKET	\$6,750 (IN) / \$10,000 (IN & OON)
PCP	\$15 copay
SPECIALIST	\$45 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 6)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	N/A
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	N/A
INSULIN COST SHARE	N/A
MARKET SERVICE AREA	Brown, Calumet, Dodge, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Menominee, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Shawano, Sheboygan, Walworth, Washington, Waukesha, Winnebago



Wisconsin 2026 Plan Highlights

**Anthem Veteran
(PPO)**
H4036-024

ESSENTIAL EXTRAS	N/A
DENTAL	\$1,000 allowance for preventive and comprehensive services per year In Network: \$0 copay – 2 oral exams, 2 cleanings, 2 dental X-rays, 2 fluoride treatments every year; 25% for comprehensive services Out of Network: 20% for preventive and 50% for comprehensive services
VISION	\$0 copay – 1 routine eye exam per year; \$200 allowance – eyeglasses or contact lenses per year
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$2,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	N/A
FITNESS	\$0 copay - SilverSneakers®
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	14 post discharge



Wisconsin 2026 Plan Highlights

Anthem Medicare Advantage 3 (PPO) H4036-008

PREMIUM	\$68
PART B GIVEBACK	\$0
MAX OUT-OF-POCKET	\$4,500 (IN) / \$8,950 (IN & OON)
PCP	\$5 copay
SPECIALIST	\$40 copay
INPATIENT HOSPITAL	\$295 copay (days 1 – 7)
SKILLED NURSING FACILITY	\$0 copay (days 1 – 20) \$218 copay (days 21 – 100)
PART B DEDUCTIBLE	\$0
RX DEDUCTIBLE	\$275 (T3 – T5)
RX PREFERRED COST SHARE T1/T2/T3/T4/T5/T6	\$0 / \$0 / 25% / 30% / 29% / \$0 \$0 copay – T1, T2 and T6 mail order 30 - 90 day supply
INSULIN COST SHARE	\$0 – \$35 copay for a one-month supply of select insulin
MARKET SERVICE AREA	Adams, Ashland, Brown, Calumet, Dodge, Door, Fond Du Lac, Green, Green Lake, Iron, Jefferson, Juneau, Kenosha, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marquette, Menominee, Milwaukee, Oconto, Oneida, Outagamie, Ozaukee, Racine, Rock, Shawano, Sheboygan, Vilas, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago



Wisconsin 2026 Plan Highlights

Anthem Medicare Advantage 3 **(PPO)** H4036-008

ESSENTIAL EXTRAS	N/A
DENTAL	In Network: \$0 copay – 2 oral exams, 2 cleanings, 1 dental X-ray, 1 fluoride treatment every year; Out of Network: 20% for preventive services
VISION	\$0 copay – 1 routine eye exam per year;
HEARING	\$0 copay – 1 hearing exam, fitting & evaluation per year; \$3,000 for prescribed or \$300 for OTC hearing aid maximum plan benefit per year
OVER THE COUNTER	\$10 per quarter
FITNESS	N/A
HEALTH & FITNESS TRACKER	N/A
TRANSPORTATION	N/A
PERS	N/A
PODIATRY	\$0 copay – 12 visits per year
HEALTHY MEALS	N/A

