# Mid-year supplemental benefit notifications: Considerations for Medicare Advantage bid development and benefit utilization

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## Introduction

In April 2024, the Centers for Medicare and Medicaid Services (CMS) issued the contract year (CY) 2025 final rule,[1] which included a new requirement for Medicare Advantage organizations (MAOs) to issue a "Mid-Year Enrollee Notification of Available Supplemental Benefits" to each enrollee. This notification must include a list of any supplemental benefits the individual has not accessed during the first six months of the year.

Beginning in 2026, MAOs must mail this mid-year personalized notification to enrollees annually between June 30 and July 31 of the plan year. The mailer is intended to remind the beneficiary what supplemental benefits have gone unused year to date, including items such as applicable cost sharing or further eligibility criteria (such as benefits offered under Special Supplemental Benefits for the Chronically Ill (SSBCI)). The mailer must also explain how to access these benefits and include customer support information to assist with questions. MAOs should be aware that the mailer is **not required** to address benefits that have been accessed by the beneficiary but are not yet exhausted. Appendix A covers the background of additional emphasis on supplemental benefits in recent years, as well as key provisions of the final rule regarding mid-year supplemental benefit mailers.

This paper aims to help plan sponsors better understand the financial and strategic implications of this regulatory change in the Medicare Advantage (MA) landscape. In particular, it explores why the final rule on mid-year supplemental benefit mailers matters when it comes to the bid development process, during which plan sponsors may need to build in supplemental benefit adjustment factors to forecast the costs and expected utilization of supplemental benefits.

## Impact analysis of the Medicare final rule

### Questions to ask when considering the impact of the mid-year benefit notification

CMS believes sending personalized and targeted communications about access to supplemental benefits may help ensure that enrollees in MA plans will be aware of and more likely to use covered benefits during the plan year. Greater utilization of these benefits is expected to improve beneficiaries' health outcomes and address certain needs associated with social determinants of health (SDOH), including food insecurity or inadequate access to transportation. Actuaries preparing MA bids should consider how this expected increased utilization may be accounted for in their bid projections.

> CMS stated this opinion in their response to comments on the new mid-year notification requirement in the CY 2025 Final Rule, writing, "We believe that the Mid-Year Notice will generate an increase in the use of supplemental benefits. However, MA organizations should not presume enrollees are overutilizing or will over utilize benefits as we believe most enrollees will use their benefits only when they need them. We expect organizations to establish reasonable safeguards that ensure enrollees are appropriately directed to care."

This paper explores the following key questions:

- Do members read their plan communications?
- Will members utilize a particular benefit more if they are reminded of their non-use of it in the first six months of the year? Does this vary depending on the benefit, or on whether the benefit includes additional cost to the member through cost sharing?
- Does utilization change based on how the benefit is offered, as well as the periodicity of the benefit offering?
- Should plans consider placing stricter guardrails on supplemental benefit services through eligibility qualifications (e.g., Uniformity Flexibility (UF) or SSBCI) and/or through referral/prior authorization requirements to avoid misuse?
- Are benefits utilized differently by different subpopulations of a plan (e.g., low-income vs non-low income, or aged versus age-in)?

All these questions are complex and may be difficult to investigate. Plan sponsors could consider adjusting their supplemental benefit projections to account for these impacts within their bids to CMS.

**Do members read their plan communications?**

Milliman recently published a white paper discussing health literacy with regards to the Medicare Prescription Payment Plan (MPPP).[2] This paper outlines a number of data points on health literacy in the Medicare population that are pertinent to this discussion:

- In 2023, a MedicareAdvantage.com survey of more than 2,000 people identified that almost two-thirds of participants said Medicare was confusing and difficult to understand.[3]
- A 2016 systematic review performed by Chesser and colleagues identified multiple studies highlighting the prevalence of low health literacy among older adults,[4] including a 2007 integrative review from the journal *Orthopedic Nursing* that reported age has one of the highest correlations with low health literacy.[5]
- A 2009 expert panel report from the Centers for Disease Control and Prevention (CDC)[6] identified the following regarding adults older than 60:
  - 71% had difficulty using print materials.
  - 80% had difficulty using documents such as forms or charts.
  - 68% had difficulty with interpreting numbers and doing calculations.

Additional data points to consider with regard to plan communications are as follows:

- In 2023, a study from Deft identified that nearly one-fifth of dual-eligible[7] members surveyed reported confusion with how to use their supplemental benefits, and about 40% had reported not receiving any materials on how to use those benefits.[8]
- According to the Kaiser Family Foundation (KFF), as of the 2022 Annual Enrollment Period (AEP), “among Medicare Advantage enrollees, more than 4 in 10 (43%) did not review their current plan’s coverage to check for potential changes in their plan’s premiums or other out-of-pocket costs, and a similar share (44%) did not review their current plan for potential changes in the kinds of treatments, drugs, and services that would be covered in the following year.”[9]
- KFF also noted that “among Medicare Advantage enrollees, nearly two-thirds of enrollees (65%) did not compare coverage options for 2022, even though year-to-year changes in Medicare Advantage plans, such as changes in provider networks or prior authorization requirements, can affect enrollees’ access to care.”[10] KFF provides a thoughtful overview of this statistic, broken down by age group, income, dual status, and race.

- An eHealth survey in 2024 noted 48% of Medicare beneficiaries carefully read mail communications from their insurer,[11] while 43% "give it a quick glance before throwing it away," and 10% throw away any communications immediately.[12]

The statistics above indicate enrollees have trouble using or simply ignore plan communications. While plans are given leeway in how they publish the information in the mid-year benefit notification, as noted in Appendix A, each benefit shown must be listed consistent with the format of the plan's Evidence of Coverage (EOC). Similar to a point made in the Milliman health literacy article, EOCs, ANOCs, and now mid-year benefit communications still allow for variation across Medicare payers, and such variation in identifying and informing beneficiaries about the unused benefits may create inconsistencies in how effectively beneficiaries are informed of their unused benefits.

One goal of this annually printed material may be to assist Medicare beneficiaries in making decisions about their benefit usage, but given some of the statistics noted above, it may be difficult to influence behavior with this approach. However, we can reasonably anticipate that members who were uncertain how to properly use a benefit (for example, how to schedule their free transportation to a medical appointment, or what items their grocery card benefit can be used on), or who did not read their initial EOC and ANOC materials, will now have the step-by-step information needed to access their benefits, and increased utilization may follow.

**Will utilization increase, and does it change based on the benefit offering?**

It is difficult to provide a benchmark level of utilization for many supplemental benefits, given the wide range of benefits levels offered by MAOs in their plan designs (e.g., does cost sharing apply, what is the periodicity of the offering, what is the level of the offering, etc.). MAOs should analyze their own internal (and/or vendor-provided) data to better understand utilization patterns by population cohort and plan design. One data source that may be of help is a recent study by The Commonwealth Fund, which surveyed enrollees about utilization of three key benefits—dental, vision, and OTC—and provides some context as to benchmarks by various data cuts (perceived importance, income level, function, and race/ethnicity).[13,14]

CMS, in the CY 2025 final rule, goes deeper into this question and notes that the CMS itself lacks complete data to answer some of these questions. CMS provides a qualitative analysis in the final rule, noting how the impact may differ based on several dimensions, including:

> "(1) Which supplemental benefits are not being utilized at all by some enrollees; (2) for each plan offering supplemental benefits, how many enrollees do and do not utilize these benefits; (3) how many more enrollees would utilize these benefits as a result of the notification…[and potential] savings expected from increased utilization; (4) what is the range and distribution of the cost to provide these supplemental benefits."[15]

CMS provides two examples of how it reviews this information in the CY 2025 Final Rule commentary:

| DENTAL BENEFITS | FITNESS BENEFITS |
|---|---|
| Dental supplemental benefits: "Enrollees who use their preventive supplemental dental benefits may uncover problems early, thus preventing unnecessary complications. For example, the filling of cavities may prevent a costlier root canal later. Also note that the filling may happen in one plan while the costlier root canal that was prevented refers to a possible event several years later possibly in another plan (or out of pocket for the enrollee). An interesting subtlety of this example is that enrollees who have preventive dental checkups may do so annually or semi-annually. The effect of the notification might be to increase annual checkups to semi-annual checkups. It is harder to quantify the savings from such a change in frequency." | Gym utilization: "In the case of gym benefits the savings from increased prevention is challenging to analyze since different frequencies of gym attendance have different effects on health. An enrollee, for example, who decides to visit the gym only once because of the notification might not have any significant health benefits generating savings; even enrollees who switch to monthly visits may not experience savings. The savings on enrollees who decide to continue gym visits on a regular basis might arise from varied consequences since increased exercise has the potential to 'reduce risk of chronic conditions like obesity, type 2 diabetes, heart disease, many types of cancer, depression and anxiety, and dementia.' In summary, this is the type of provision that has a savings impact that can be analyzed only after several years of experience with the provision." |

These two examples from the final rule outline the difficulty in measuring the impact and the various layers of analysis and years of plan experience needed to accurately project changes to plan utilization. Ultimately, it may be prudent to review the following:

- Is there a significant proportion of non-utilizers of an offered benefit in the current population? If so, can MAOs work with their vendors to understand this distribution and what additional costs may be incurred if mid-year benefit notifications result in some percentage of non-utilizers becoming utilizers, because they now understand how to access the benefit?
- Did the member use the benefit in a recent prior year? If a beneficiary used a specific supplemental benefit last year or the year prior, it may indicate an ongoing health need that persists over time. Plus, the member already knows how to use and access the benefit, so they may be more inclined to use it again the following year. Or, if you used the benefit in a prior year, your behavior may not be influenced by a mid-year benefit notification. This likely depends on the benefit.
- If a member uses one type of benefit, does it lead to additional use of another benefit? MAOs should consider how certain benefit utilization may affect utilization of related benefits. For example, if a member has not visited their dentist for preventive services, a reminder may result in them seeing their dentist in the latter six months of the year, and if the member has more complex dental needs that would be met with comprehensive services, then comprehensive dental utilization could be impacted as well. In general, MAOs must understand the inter-relationships between benefits, including preventive and comprehensive dental, vision exams and hardware, and hearing exams and hearing hardware; the latter of each of these pairs may see increased utilization as enrollees access the former.
- Does benefit use differ by the following characteristics:
  - New to Medicare status
  - Income status
  - Age
  - Plan design (e.g., $0 premium vs. non-$0 premium)
- If a benefit already requires a qualifying event for eligibility, such as post-acute meals offered after inpatient stays, increases in utilization after a mid-year notification may be muted, as many members may simply not qualify to use the benefit.
  - This may be similar for benefits offered to specific population cohorts, such as SSBCI—or it may not, if members read their benefit notification and understand how their current health status may need to be diagnosed by a provider to gain access to qualifying benefits.
- If a benefit includes cost sharing, as is often the case for a few specific supplemental benefits like comprehensive dental services and hearing aids, MAOs should consider how this may influence member utilization.

**Does utilization change based on the benefit or how the benefit is offered, as well as the periodicity of the benefit offering?**

Plan sponsors may want to consider how they are administering supplemental cash-like benefits, such as OTC benefit cards, food benefits, and utilities benefits. Because they are easier for the member to use for everyday needs, especially if provided in a debit-card like format, cash-like benefits may incur higher utilization after a mid-year notification for those who hadn't accessed it in the first half of the year. Additionally, MAOs should consider how these benefits may be integrated alongside other benefits within combined benefits in their plan design. MAOs are offering "true" combined benefits, sometimes called combo or flex benefits, at an increasing rate—these benefits allow the member to pick from a menu of benefit offerings or allow the member to use a specified set of benefits up to a certain dollar limit established by the plan.[16]

In 2025, about 48% of general enrollment members were enrolled in a plan offering a true combo benefit, and about 91% of dual-eligible special needs plan members were enrolled in a plan offering a true combo benefit. Both of these numbers were up slightly from 2024 at 45% and 87%, respectively.[17] Given the importance of these benefits in competitive Medicare Advantage plan design, it will be critical to understand utilization data underlying combined benefits in order to guide product decisions for 2026 and beyond.

Benefits with a longer periodicity of use, say annually relative to quarterly, or quarterly relative to monthly, are more likely to see increased utilization. For example, if a member has not used their monthly food card benefit in the first six months of the year, the notification will remind them of it, but only for the remaining six months of the benefit, so the average monthly charge will be less given the non-use in the first six months of the year. A food card benefit that is annual, however, would allow a member to utilize the entire limit in the latter half of the year, resulting in an average monthly charge closer to the annual benefit limit.

**Should plans consider adding guardrails on use of supplemental benefits, either by requiring members to qualify through UF (uniformity flexibility) or SSBCI, or by applying referral or prior authorization on supplemental benefits?**

CMS noted they "expect organizations to establish reasonable safeguards that ensure enrollees are appropriately directed to care" in the text of the final rule.

Typical utilization guardrails, such as prior authorizations and referrals, are a permissible approach for managing utilization on certain supplemental benefits. If MAOs are considering this approach to limit unnecessary utilization from the mid-year benefit notification, they must ensure these limitations are not a barrier to members receiving appropriate care. Appendix B outlines the supplemental benefits on which CMS allows referral and prior authorization.[18]

MAOs may also consider adding disease-specific qualifications for members to access certain benefits by utilizing the UF and SSBCI benefit flexibilities. This approach limits the benefit to a specific group of plan members, and often requires documentation from a provider for a qualifying disease. This could in turn influence utilization management, quality, and coding initiatives if members understand they need to be seen by a physician in order to access certain benefits, but it could also result in member grievances for those who do not read their plan communications from year to year if benefits are no longer accessible to them without the documented disease state. Note the CY 2025 final rule language is clear on how communication of benefits falling under SSBCI need to be outlined in the mid-year benefit notification—this is briefly covered in Appendix A.

**Should plans consider transitioning mandatory benefits to optional supplemental benefits?**

One major carrier converted a comprehensive dental benefit in a number of its general enrollment plans from a mandatory supplemental benefit in 2024 to an optional supplemental benefit in 2025. Optional supplemental benefits (OSBs) have historically had low prevalence in the market,[19] and converting existing mandatory benefits to optional benefit status may create some disruption as members realize they now must pay additional premium to access the benefits they once got with the plan. OSBs, however, also need to be included in the mid-year benefit notification to applicable members. Additionally, administration of OSBs has often proved difficult for MAOs, given the need to collect premium and the opportunity for members to drop the OSB mid-year after utilizing their entire benefit.

# Provider organizations should be aware of the mid-year benefit notification implications

Greater utilization of benefits by MA plan enrollees, due to increased awareness from the mid-year notices, may lead to additional costs for providers, particularly those in total cost of care risk arrangements. Providers should be aware of this change in plan communications and work with their payer partners throughout 2025 to ensure risk-sharing contracts adequately contemplate the potential cost impact. Both risk-bearing providers and MAOs should be aware of the potential benefit impact, and both should be tracking and analyzing utilization data. This will help these stakeholders work together to refine supplemental benefit offerings and focus on the highest-impact benefits, alongside sharing cost management and risk.

## A data-driven and member-focused approach will be key to ensuring 2026 benefit designs are aligned with MAO needs, but it remains unclear if a utilization adjustment factor will be necessary to contemplate in bid projections

The mid-year notice on unused supplemental benefits is a new requirement for MA plans, so studies on its downstream impact on utilization have not yet been conducted. However, past research on appointment reminders has highlighted the positive impacts of healthcare providers reminding patients to use their benefits, including increasing the rate of vaccinations, mammograms, and other preventive procedures.[20]

Given the limited data available to measure expected utilization impacts, the available studies supporting Medicare members' lack of understanding and/or use of their plan documents, the guardrails that can be put in place for limiting use (referrals, prior authorizations, UF or SSBCI disease state applicability), and the myriad other changes that occur when changing benefits from year to year (changing limits, periodicity, cost sharing, etc.), it will be difficult for bid actuaries and MAOs to measure the impact of a mid-year benefit notification. However, it is highly likely that some benefits will see an increase in utilization if members realize they have a benefit yet unused as of June 30. As CMS expects MAOs to submit encounter level data on supplemental benefit use, MAOs should make use of this important data source in their own analysis to support data-driven understanding of use of the benefits they are intending to offer in 2026 and beyond.

## Caveats, limitations, and qualifications

The information in this paper is intended to outline considerations Medicare Advantage bid actuaries, providers, and supplemental benefit vendors should make when attempting to measure the impact of a mid-year benefit notification to project utilization changes in the bids submitted to CMS. It may not be appropriate, and should not be used, for other purposes.

Julia Friedman is a member of the American Academy of Actuaries and meets the qualification standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

# Appendix A

## BACKGROUND

### Medicare supplemental benefits spending and CMS actions

According to the contract year (CY) 2025 Medicare Advantage and Part D final rule, issued by CMS in April 2024, the number of MA plans offering supplemental benefits has increased over the past several years,[21] despite the reductions in many 2025 plan benefit offerings.[22]

In addition, supplemental benefits offered are "broader in scope and variety,"[23] and CMS has seen plans direct an increasing amount of MA rebate dollars toward these benefits. In 2025, the Medicare Payment Advisory Commission (MedPAC) reported a slight increase in the projected rebates spent by plan, at an average of $211 per member per month (PMPM).[24] At the same time, however, CMS asserts plans have reported low utilization of such supplemental benefits by their enrollees, and it is not clear to CMS if plans are actively encouraging utilization of these benefits by their enrollees.[25]

With the CY 2025 final rule, CMS will now require MA plans to notify enrollees mid-year of unused supplemental benefits during the first half of the year. This includes both mandatory supplemental benefits and optional supplemental benefits (if the enrollee has elected). This represents a change from the status quo, in which MA plans are not required to send any communication to their enrollees about the enrollees' usage of supplemental benefits—and CMS states in the final rule that it believes this effort could "be an important part of a plan's overall care coordination efforts" that ensures "MA plans are better stewards of the rebate dollars directed towards these benefits."

Over the last few years, CMS has increased data collection requirements for supplemental benefits:

- In its May 2022 final rule, CMS finalized expanded medical loss ratio (MLR) reporting requirements, requiring MA organizations to report expenditures on supplemental benefit categories such as dental, vision, hearing, and transportation.[26]
- In March 2023, as part of its Part C reporting requirements, CMS announced its intent to collect data to better understand supplemental benefit utilization.[27]
- In a February 2024 memo, CMS reminded MA organizations that they are required to collect and submit encounter data not only for Medicare Part A- and B-covered items and services, but also for supplemental benefits provided to their enrollees.[28]

## KEY PROVISIONS OF THE CMS RULE ON MID-YEAR SUPPLEMENTAL BENEFIT MAILERS

### Eligibility criteria for beneficiaries

Any MA enrollee who has entirely unused mandatory or optional supplemental benefits as of June 30 of the plan year should receive a mailer. For plans offering SSBCI benefits, the mid-year notice must include the SSBCI disclaimer specified at § 422.2267(e)(34) and additional information about the SSBCI benefit. Therefore, plans need to keep in mind the following for SSBCI benefit offerings and eligibility, as specified by the final rule:

- "When an enrollee has not been deemed eligible, MA organizations must include an explanation of the SSBCI covered under the plan consistent with the format of other unused supplemental benefits, eligibility criteria for the SSBCI, and point-of-contact information for eligibility assessments, such as a customer service line or a separate dedicated line, to reach trained staff that can answer questions and initiate the SSBCI eligibility determination process."
- "When an enrollee has been determined by the plan to be eligible for one or more specific SSBCI—but has not accessed the SSBCI benefit by June 30 of the plan year—the mid-year notice for that enrollee must also include a description of the SSBCI to which the enrollee is entitled and must describe any limitations on the benefit, consistent with the format of other unused supplemental benefits."

**Specifications for the mailer content**

Plans must send mid-year notices customized to each individual member, and each notice must contain the following:

- Information on any benefits not utilized by the enrollee during the first six months of the year (January 1 to June 30). Specifically, each notice must include, for each unused benefit:
  - The scope of the supplemental benefit(s)
  - The applicable cost sharing
  - Instructions on how to access the benefit(s)
  - Applicable information on the use of network providers for each available benefit

Each benefit shown must list the benefits consistent with the format of the plan's EOC.

- As discussed above, for SSBCI benefits, the plan must include an explanation of the SSBCI covered under the plan, alongside the eligibility criteria, scope of services, and overview of limitations. Additional contact information must be provided such that members can reach out to a trained staff member to determine eligibility for each SSBCI offered. And, as noted above for SSBCI, the notice must also include the proposed new SSBCI disclaimer.
- Toll-free customer service phone number for any questions or additional help.

CMS explicitly states, "MA organizations are not required to include supplemental benefits that have been accessed, but are not yet exhausted, in this proposed mid-year notice," meaning if a beneficiary accesses a benefit at all in the first half of the year, the MAO is not required to remind them of that benefit.

**Distribution guidelines**

As MA plans already monitor their enrollees' benefit utilization patterns, CMS states in the final rule that the "primary burden" of this new requirement is the dissemination of the mid-year notices.[29] In addition to a one-time update to software systems to produce reports, and a one-time update of policies and procedures, MA organizations will be responsible for printing and sending notices to beneficiaries.

**Deadlines and timelines**

Beginning in 2026, MA organizations must mail a mid-year notice annually, no sooner than June 30 and not later than July 31 of the plan year. The notices must pertain to each supplemental benefit available through the plan year that the enrollee has not accessed by June 30 of the plan year. Plans are requested to use information that is as up to date as possible at the time of the mailing, given that there is often a lag between the time when a benefit is accessed and when a claim is processed, but CMS does not identify a specific timeframe.

# Appendix B: List of non-Medicare covered benefits and if prior authorization or referrals apply

If a supplemental benefit is not listed, you cannot apply prior authorization or referral requirements.

| NON-MEDICARE BENEFIT | PBP BENEFIT CATEGORY | BENEFIT NAME | SSBCI (19B) ONLY? | ALLOWS REFERRALS? | ALLOWS PRIOR AUTH? | NOTES |
|---|---|---|---|---|---|---|
| **Inpatient acute** | 1a1 | Additional days for inpatient hospital—acute | | Yes | Yes | |
| | 1a2 | Non-Medicare-covered stay for inpatient hospital—acute | | Yes | Yes | |
| | 1a3 | Upgrades for inpatient hospital—acute | | Yes | Yes | |
| **Inpatient psychiatric** | 1b1 | Additional days for inpatient hospital psychiatric | | Yes | Yes | |
| | 1b2 | Non-Medicare-covered stay for inpatient hospital psychiatric | | Yes | Yes | |
| **Skilled nursing facility (SNF)** | 2-1 | Additional days beyond Medicare-covered for SNF | | Yes | Yes | |
| **Rehabilitation** | 3-1 | Additional cardiac rehab services | | Yes | Yes | |
| | 3-2 | Additional intensive cardiac rehab services | | Yes | Yes | |
| | 3-3 | Additional pulmonary rehab services | | Yes | Yes | |
| | 3-4 | Additional SET for PAD Services | | Yes | Yes | |
| **Professional—chiropractic** | 7b1 | Routine chiropractic care | | Yes | Yes | |
| **Professional—podiatry** | 7f | Podiatry services: Routine foot care | | Yes | Yes | |
| **Blood** | 9d | Outpatient blood services | | Yes | Yes | |
| **Non-emergency transportation** | 10b1 | Transportation services—plan-approved health-related location | | Yes | Yes | |
| | 10b2 | Transportation services—any health-related location | Yes | Yes | Yes | Both 10b1 and 10b2 cannot be added to same SSBCI package |
| **Acupuncture** | 13a | Acupuncture | | Yes | Yes | |
| **Over-the-counter (OTC)** | 13b | OTC items | | No | Yes | Only asks if added in SSBCI package - not for mandatory benefit |
| **Meals** | 13c | Meal benefit | | Yes | Yes | |

| NON-MEDICARE BENEFIT | PBP BENEFIT CATEGORY | BENEFIT NAME | SSBCI (19B) ONLY? | ALLOWS REFERRALS? | ALLOWS PRIOR AUTH? | NOTES |
|---|---|---|---|---|---|---|
| **Special supplemental benefits for the chronically Ill (SSBCI)—specific benefits** | 13i1 | Food and produce | Yes | Yes | Yes | |
| | 13i2 | Meals (beyond limited basis) | Yes | Yes | Yes | |
| | 13i3 | Pest control | Yes | Yes | Yes | |
| | 13i4 | Transportation for nonmedical needs | Yes | Yes | Yes | |
| | 13i5 | Indoor air quality equipment services | Yes | Yes | Yes | |
| | 13i6 | Social needs benefit | Yes | Yes | Yes | |
| | 13i7 | Complementary therapies | Yes | Yes | Yes | |
| | 13i8 | Services supporting self-direction | Yes | Yes | Yes | |
| | 13i9 | Structural home modifications | Yes | Yes | Yes | |
| | 13i10 | General supports for living | Yes | Yes | Yes | |
| **14c preventive benefits** | 14c1 | Health education services | | Yes | Yes | |
| | 14c2 | Nutritional/dietary benefit | | Yes | Yes | |
| | 14c3 | Smoking and tobacco counseling | | Yes | Yes | |
| | 14c4 | Fitness benefit | | Yes | Yes | |
| | 14c5 | Disease management | | Yes | Yes | |
| | 14c6 | Telemonitoring services | | Yes | Yes | |
| | 14c7 | Remote technology service | | Yes | Yes | |
| | 14c8 | Home safety devices and modifications | | Yes | Yes | |
| | 14c9 | Counseling services | | Yes | Yes | |
| | 14c10 | Safety assessment | | Yes | Yes | |
| | 14c11 | Personal emergency response system | | Yes | Yes | |
| | 14c12 | Nutrition therapy | | Yes | Yes | |
| | 14c13 | In-home medication reconciliation | | Yes | Yes | |
| | 14c14 | Re-admission preventive service | | Yes | Yes | |
| | 14c15 | Wigs for chemotherapy-related hair loss | | Yes | Yes | |
| | 14c16 | Weight management service | | Yes | Yes | |
| | 14c17 | Therapy—other | | Yes | Yes | |
| | 14c18 | Therapeutic massage service | | Yes | Yes | |
| | 14c19 | Adult day health services | | Yes | Yes | |
| | 14c20 | Home-based palliative services | | Yes | Yes | |
| | 14c21 | In-home support services | | Yes | Yes | |
| | 14c22 | Support for caregivers | | Yes | Yes | |

| NON-MEDICARE BENEFIT | PBP BENEFIT CATEGORY | BENEFIT NAME | SSBCI (19B) ONLY? | ALLOWS REFERRALS? | ALLOWS PRIOR AUTH? | NOTES |
|---|---|---|---|---|---|---|
| **Dental—preventive** | 16b1 | Oral exams | | Yes | Yes | |
| | 16b2 | Dental X-rays | | Yes | Yes | |
| | 16b3 | Other diagnostic dental services | | Yes | Yes | |
| | 16b4 | Prophylaxis | | Yes | Yes | |
| | 16b5 | Fluoride treatment | | Yes | Yes | |
| | 16b6 | Other preventive dental services | | Yes | Yes | |
| **Dental—comprehensive** | 16c1 | Restorative services | | Yes | Yes | |
| | 16c2 | Endodontics | | Yes | Yes | |
| | 16c3 | Periodontics | | Yes | Yes | |
| | 16c4 | Orthodontics, removable | | Yes | Yes | |
| | 16c5 | Maxillofacial prosthetics | | Yes | Yes | |
| | 16c6 | Implant services | | Yes | Yes | |
| | 16c7 | Prosthodontics, fixed | | Yes | Yes | |
| | 16c8 | Oral and maxillofacial surgery | | Yes | Yes | |
| | 16c9 | Orthodontics | | Yes | Yes | |
| | 16c10 | Adjunctive general services | | Yes | Yes | |
| **Vision** | 17a1 | Routine eye exams | | Yes | Yes | |
| | 17b1 | Contact glasses | | Yes | Yes | |
| | 17b2 | Eyeglasses (lenses and frames) | | Yes | Yes | |
| | 17b3 | Eyeglass lenses | | Yes | Yes | |
| | 17b4 | Eyeglass frames | | Yes | Yes | |
| | 17b5 | Upgrades for inpatient hospital—acute | | Yes | Yes | |
| **Hearing** | 18a1 | Routine hearing test | | Yes | Yes | |
| | 18a2 | Fitting/evaluation for hearing aid | | Yes | Yes | |
| | 18b1 | Prescription hearing aids (all types) | | Yes | Yes | |
| | 18c | OTC hearing aids | | Yes | Yes | |

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# Endnotes


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