



You deserve a little extra this year!







Work with your doctor to pick one free benefit for 2019



Please check with your sales agent or refer to your *Evidence of Coverage (EOC)* to make sure your plan includes these benefits.

Which benefit is best for you?

Choose the one you and your doctor believe will help you the most. All amounts listed apply to this plan year only.

	Transportation*	Get up to 60 one-way trips from an approved driver to or from health-related appointments, plan services or SilverSneakers® locations. Each trip has a 60-mile limit.
	Personal home helper	Get 31 visits (up to 4 hours each visit) from an in-home caregiver, if you need help with two or more daily living activities, such as cleaning, meal prep and bathing.
	Assistive devices	Get up to \$500 for safety devices, such as shower stools, raised toilet seats and temporary mobility ramps.
	Healthy food deliveries*	Get up to 16 healthy meals delivered to your door four times a year for qualifying events, such as a hospital discharge, or if your A1C is >9.0 or BMI >25.
	Alternative medicine	With plan pre-approval, get up to 24 medically appropriate alternative medicine services, such as acupuncture, acupressure or therapeutic massage.
	Day center visits	Receive reimbursement for one visit (up to 8 hours) per week at a licensed adult day center, if you need help with two or more daily living activities. This includes rides to and from the center.

Check your *EOC* for details and specific eligibility requirements, or call Customer Service at **1-844-879-3610** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

* If your plan already includes Transportation or Food Delivery, these benefits are in addition to that.



Essential Extras Selection Form - Complete form and fax to: **1-800-833-8554**, or mail to: P.O. Box 659403, San Antonio, TX 78265-9714.

Please PICK ONE of the following benefits:

- | | |
|---|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Healthy food deliveries |
| <input type="checkbox"/> Personal home helper | <input type="checkbox"/> Alternative medicine |
| <input type="checkbox"/> Assistive devices | <input type="checkbox"/> Day center visits |

Name: _____

Member ID: _____ Member Phone: _____

Member Attestation for Eligibility

☐ I acknowledge and understand that if my plan offers Essential Extras, I am entitled to **ONE** of those benefits for 2019, and I confirm my physician agrees my selection is appropriate for my care. My plan may contact my provider (listed below) if they need more information. I also understand unused benefits do not roll over to the next calendar year.

Provider Name: _____ Provider Phone: _____

Member Signature: _____ Date: _____

Power of Attorney Name: _____

Power of Attorney Signature: _____

For day center visits, reimbursement is contingent upon selected center being licensed by governing state and meeting any and all state requirements.

Name of Center: _____

Phone: _____

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