## PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 016, SEGMENT 0

Module:

Requested By:

vyqd

#### PLAN SYSTEM INFORMATION

Last entry Date:

05/30/2019

PBP Software Version:

2020.01

Plan Ready for Upload

05/30/2019 05:43:56 PM Eastern Daylight Time

Timestamp:

#### **PLAN STATUS**

Section A Status

Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed

Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed

Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed

Section B13 Status Completed Section B14 Status Completed

Section B15 Status Completed Section B16 Status Completed

Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed

Section C Status Completed Section D Status Completed

Section Mrx Status Completed

#### **SECTION A: SECTION A-1**

Organization Legal

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization

Humana

Marketing Name:

Organization Web Site: www.humana.com/medicare

Plan Name:

Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)

Organization Type:

Local CCP HMO

Plan Type: Enrollee Type:

Part A and Part B

Service Arca(s): Service Area(s):

40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR

Service Area(s): Service Area(s): Service Area(s): 40050 - Aibonito, PR

40040 - Aguas Buenas, PR

Service Area(s): Service Area(s): 40060 - Anasco, PR 40070 - Arecibo, PR

Service Area(s): Service Area(s): Service Area(s): 40080 - Arroyo, PR 40090 - Barceloneta, PR

40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR





Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s).	40040 - San Lorango DD

40650 - San Lorenzo, PR



5/30/2019

Service Area(s):

40660 - San Sebastian, PR 40670 - Santa Isabel, PR Service Area(s): Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Scrvice Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR Service Area(s): Service Area(s): 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR Service Area(s): 40740 - Vieques, PR 40750 - Villalba, PR Service Area(s): Service Area(s): 40760 - Yabucoa, PR 40770 - Yauco, PR Service Area(s): Contract Number: H4007 Plan ID: 016 Segment ID: 0 Contract Period: 2020 Plan Geographic Puerto Rico Island Wide Name: Is this an Employer-No Only plan? SECTION A: SECTION A-2 Does this Plan have a No CMS-approved Continuation Area? Do you intend to Yes participate in the . PLATINO program? Is this a Special Needs Yes Plan? Special Needs Plan Dual-Eligible Type: Is this D-SNP plan a No Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)? Under this D-SNP, has No the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? SECTION A: SECTION A-3 Participating Pharmacy https://www.humana.com/pharmacy/ Website Address: Formulary Website http://www.humana.com/medicare/medicare prescription drugs/medicare drug tools/medicare\_drug list/ Address: Physician Website www.humana.com/members/tools Address: (866)773-5959 Customer Service Contact Phone Number

for Current Medicare
Beneficiaries:
Customer Service (866)773-5959
Contact Local Phone
Number for Current
Medicare
Beneficiaries:
Customer Service (800)681-3625

Je .



Contact Phone Number

for Prospective Medicare

Beneficiaries:

Customer Service (800)681-3625

Contact Local Phone Number for

Prospective Medicare

Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D

Medicare

Beneficiaries:

Customer Service (866)773-5959 Contact Local Phone

Number for Current Part D Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D

Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Part D Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Current

Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare

Danafiaigniage

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Part D Medicare

Beneficiaries:

Customer Service (711)-Contact Local

TTY/TDD for Current Part D Medicare

Beneficiaries:
Customer Service (711)-

Contact TTY/TDD for Prospective Part D Medicare

Beneficiaries:
Customer Service (711)-



Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:

# **SECTION A: SECTION A-5**

Is your organization filing a standard bid for Section B of the PBP? Is your organization No filing a standard bid for Section C of the PBP?

### **SECTION A: SECTION A-6**

Is your organization filing a standard bid for Section D of the PBP? Do any of your No outpatient services

have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

Select enhanced benefits:

: Additional Days

Select type of benefit

for Additional Days:

Mandatory

Is this benefit unlimited for

Yes

No

No

Additional Days?

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Is there an enrollce

No

Coinsurance?

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollce obtains care?

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes



Do you charge the Medicare-defined cost shares? (These are the

total charges for all services provided to the enrollee in the

inpatient facility.) Indicate Copayment

\$0.00

No

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 9

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve

Days:

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 10

Indicate the number of

Zero (No Copayment per Day)

Per Admission or Per Stay

day intervals for Additional Days:

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit

period?

Do you charge cost

sharing on the day of

discharge?

Is authorization

Yes

No

No

required?

Is a referral required

for Inpatient Hospital-

Acute Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Is there an enrollee

No

Coinsurance?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?

Do you charge the Medicare-defined cost shares? (These are the

No





total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 9

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve

Days:

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required?

Yes

Is a referral required

No

for Inpatient

Psychiatric Hospital

Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay prior to SNF

Yes

Zero

admission? Indicate the Number of

Hospital Days Required Prior to SNF

Admission (0-2):

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's No Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF

Original Medicare



benefit period?

Is authorization

Yes

required?

Is a referral required

No

for SNF Services?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Cardiac

: Medicare-covered Cardiac Rehabilitation Services

and Pulmonary

: Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

: Mcdicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease

(Select all that apply): (PAD) Services

Indicate Minimum

\$0.00

Copayment amount per service for Medicarecovered Cardiac Rehabilitation Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicarecovered Cardiac Rehabilitation

Services:

\$0.00

Indicate Minimum Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum \$0.00 Copayment amount per

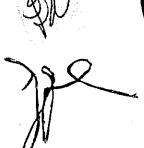
service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicare-

covered Pulmonary

Rehabilitation

\$0.00





Services:

Indicate Minimum

\$0.00

Copayment amount per service for Medicarecovered Supervised **Exercise Therapy** (SET) for Symptomatic

Peripheral Artery Disease (PAD)

Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarccovered Supervised **Exercise Therapy** (SET) for Symptomatic Peripheral Artery Disease (PAD)

### SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization

required?

Services?

Services:

Is a referral required

No

for Cardiac and Pulmonary Rehabilitation

#### SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

# SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Is the Copayment for

\$0.00

Medicare-covered

Yes

Benefits waived if admitted to hospital? Select either Days or

Hours

Hours within which

admission must occur

for waiver:

Enter number of Days or Hours:

24

Does the Emergency Care/Post-Stabilization Care cost sharing count

No

towards any plan-level deductible?

# SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a servicespecific Maximum No

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Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Does the Urgently Needed Services cost

sharing count towards any plan-level

deductible?

Is the Copayment for

No

No

Medicare-covered Benefits waived if admitted to hospital?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide

Worldwide

Yes

Emergency/Urgent Coverage as a supplemental benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit

for Worldwide

**Emergency Coverage:** 

Select type of benefit

for Worldwide Urgent

Coverage:

Mandatory

Mandatory

Mandatory

Select type of benefit for Worldwide

Emergency

Transportation:

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

No

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee

Copayment?

Yes

Select which Worldwide Services : Worldwide Emergency Coverage : Worldwide Urgent Coverage

have a Copayment (Select all that apply): : Worldwide Emergency Transportation



\$0.00 Indicate Minimum Copayment amount for Worldwide Emergency Coverage: Indicate Maximum

\$0.00

Yes

Yes

\$0.00

Copayment amount for Worldwide Emergency

Coverage:

Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?

Indicate Minimum \$0.00 Copayment amount for Worldwide Urgent

Coverage:

\$0.00 Indicate Maximum Copayment amount for Worldwide Urgent

Coverage:

Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?

Indicate Minimum Copayment amount for Worldwide Emergency

Transportation:

\$0.00 Indicate Maximum Copayment amount for Worldwide Emergency

Transportation:

Is this Copayment waived for Worldwide Emergency

Transportation if admitted to hospital?

Is there an enrollee Deductible?

No

Yes

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Yes Copayment? \$0.00 Indicate Minimum Copayment amount for

Medicare-covered Benefits per day:

\$0.00 Indicate Maximum Copayment amount for

Medicare-covered Benefits per day:

Is authorization Yes required?

Is a referral required

No

for Partial



about:blank

Hospitalization?

#### SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

### SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

#### SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required No

for Home Health

Services?

#### SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

\$0.00

Indicate Minimum

Copayment amount per visit for Medicare-

covered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

# SECTION B: #7B CHIROPRACTIC SERVICES

Does the plan provide Chiropractic Services

as a supplemental benefit under Part C?

No

No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

# SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance? Is there an enrollee

Yes

Copayment? Select which

: Medicare-covered Chiropractic Services



Chiropractic Services have a Copayment (Select all that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is there an enrollee Deductible?

No

Is authorization

No

required?

Yes

Is a referral required for Chiropractic

Services?

## SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-No specific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

# SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization

Yes

required?

Yes

Is a referral required for Occupational Therapy Services?

# SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

\$0.00



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### SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization

No

required?

Is a referral required for Physician Specialist Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

Select which Mental

: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

Health Specialty Services have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Group Sessions:

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required

Yes

for Mental Health Specialty Services -Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

No

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Is there a servicespecific Maximum

Cost?

Enrollee Out-of-Pocket

Is there an enrollee

SECTION B: #7F PODIATRY SERVICES - BASE No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?



Select which Podiatry

: Medicare-covered Podiatry Services

Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicare-covered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization

No

required?

Is a referral required No

for Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization

No

No

required?

Is a referral required for Other Health Care

Professional Services?
SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Select which

: Medicare-covered Individual Sessions

Psychiatric Services have a Copayment

: Medicare-covered Group Sessions

(Select all that apply): Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:



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Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions:

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered **Group Sessions:** 

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Group Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required

No

for Psychiatric Services?

**SECTION B: #7I PT AND SP SERVICES - BASE 1** 

Is there a servicespecific Maximum No

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization

required?

Is a referral required No

for Physical Therapy and Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an

Yes

Additional Telehealth benefit for Part B

services?

Select the Medicarecovered benefits that : 4b: Urgently Needed Services

: 7a: Primary Care Physician Services

will have Additional

: 7e1: Individual Sessions for Mental Health Specialty Services

Telehcalth available: : 7h1: Individual Sessions for Psychiatric Services

: 9c1: Individual Sessions for Outpatient Substance Abuse

Is there a service-

specific Maximum Enrollee Out-of-Pocket Cost for Additional

SECTION B: #7J ADDITIONAL TELEHEALTH SEA

Is there an enrollee

Coinsurance?

about:blank

Telehealth?



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Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization

required for Additional Telehealth Services?

Is a referral required

No

for Additional Telehealth Services?

SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 2

Is authorization

No

required?

Is a referral required

No

for Opioid Treatment

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Yes

Copayment?

Is there an enrollee

Select which

: Medicare-covered Diagnostic Procedures/ : Medicare-covered Lab Services

Outpatient Diag Procs/Tests/Lab

Services have a

Copayment (Select all



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that apply):

Indicate Minimum

Copayment amount for Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Lab

Services:

If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization

Yes

\$0.00

required?

Is a referral required

Yes

for Outpatient Diagnostic

Procedures/Test/Lab

Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service- N specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

: Medicare-covered X-Ray Services

Is there an enrollee

Deductible?

No

No

Is there an enrollee

Is there an enro Copayment? Yes

Select which

: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services

Outpatient Diag/Therapeutic Rad Services have a

Copayment (Select all

that apply):

Indicate Minimum Copayment amount for other Medicarecovered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Copayment amount for other Medicarecovered Diagnostic Radiological Services

(e.g., CT, MRI, etc):

\$0.00







Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Therapeutic

Radiological Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Therapeutic

Radiological Services:

Indicate Minimum \$0.00 Copayment amount for

Medicare-covered X-

Ray Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-

Ray Services:

If a member receives multiple services at the same location on the same day, does only the maximum copay

apply?

# SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization

required?

Is a referral required

for Outpatient Diagnostic/Therapeutic Radiological, and X-

Ray Services?

# SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Yes

No

Coinsurance?

# SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Services

: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services

have a Copayment

(Select all that apply):

\$0.00

Indicate Minimum Copayment amount per visit for Medicarecovered Outpatient

Hospital Services:

Indicate Maximum \$0.00 Copayment amount per

visit for Medicarecovered Outpatient Hospital Services:

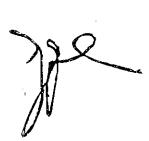
Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Observation

Services:

Indicate Maximum \$0.00







Copayment amount per visit for Medicarecovered Observation

Services:

Is authorization required for Medicarecovered Outpatient Hospital Services?

Yes

Yes

Is authorization required for Medicarecovered Observation

Services?

Is a referral required for Medicare-covered Outpatient Hospital Services?

Yes

Is a referral required for Medicare-covered Observation Services? Yes

#### SECTION B: #9B ASC SERVICES - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

### SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Is authorization

Yes

required? Is a referral required

No

for Ambulatory Surgical Center Services?

# SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Outpatient Substance Abuse services have a Copayment (Select all : Medicare-covered Individual Sessions : Medicare-covered Group Sessions

that apply):





Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions: Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

**Group Sessions:** 

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization

No

required?

Is a referral required

No

for Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide

Outpatient Blood Services as a supplemental benefit

under Part C? Select enhanced

: Three (3) Pint Deductible Waived

benefit:

Select type of benefit

Mandatory

for Three (3) Pint Deductible Waived:

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollec

No

Copayment?

No

No

Is authorization required?

Is a referral required

for Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a servicespecific Maximum No

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

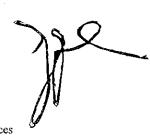
Yes

Is there an enrollee Copayment?

Select which Services

: Medicare-covered Ground Ambulance Services





have a Copayment

: Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum

\$0.00

\$0.00

\$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum

Copayment amount for Medicare-covered Air Ambulance Services:

Indicate Maximum

\$0.00

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

hospital?

Is authorization

required for nonemergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Mandatory

No

Does the plan provide

Transportation Services as a

supplemental benefit under Part C?

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-related

Location: Is this benefit

unlimited for number

of trips for Plan Approved Healthrelated Location?

48 Indicate number of

trips for Plan Approved Healthrelated Location:

Select Plan Approved Every year

Health-related Location Trips periodicity:

Select Type of One-way

Transportation for Plan Approved Healthrelated Location:

Select Mode of : Van

Transportation for Plan : Other, Describe

Approved Healthrelated Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-

No



specific Maximum Plan Benefit Coverage

amount?

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

Indicate Maximum

\$0.00

Copayment amount per

trip:

Is authorization

required?

Yes No

Is a referral required

for Transportation

Services?

Notes:

Services arranged by the plan's transportation provider to approved locations by means of car, van, or

wheelchair access vehicle that provide members access to health benefits.

#### SECTION B: #11A DME - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes \$0.00

Indicate Minimum

Copayment amount per item for Medicare-

covered Benefits:

Indicate Maximum

\$0.00

item for Medicare-

Copayment amount per

covered Benefits:

SECTION B: #11A DME - BASE 2

Are there preferred No vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization

Yes

required?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-No specific Maximum

Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2







Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes

\$0.00

Select which Prosthetics/Medical Supplies have a

: Medicarc-covered Prosthetic Devices : Medicarc-covered Medical Supplies

Copayment (Select all

that apply):

Indicate Minimum Copayment amount per

item for Medicarecovered Prosthetic Devices:

\$0.00 Indicate Maximum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Medical

Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Medical Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization

Yes

required?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Diabetic

: Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per item for Medicarecovered Diabetes Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetes Supplies:

\$0.00

Indicate Minimum Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or





Inserts:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Diabetic

Therapeutic Shoes or

Inserts:

Do you limit Diabetic Yes Supplies and Services

to those from specified manufacturers?

Is authorization

No

required?

# SECTION B: #12 DIALYSIS SERVICES - BASE 1 No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per session for Medicare-

covered Benefits:

Indicate Maximum \$0.00

Copayment amount per session for Medicarecovered Benefits:

# SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

required?

No

Is a referral required

for Dialysis Services?

### SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

supplemental benefit

under Part C?

# SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide

Over-The-Counter (OTC) Items as a supplemental benefit

under Part C?

Select type of benefit

for OTC Items:

Mandatory

Is there a service-

Yes

specific Maximum Plan Benefit Coverage

amount?

Indicate Maximum

50.00

Plan Benefit Coverage

amount:

Select Maximum Plan

Every three months

Benefit Coverage periodicity:

Does your Maximum

Plan Benefit Coverage

No







amount carry forward to the next period if it

is unused?

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

No

Are you offering

Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Yes

Nicotine Replacement Therapy (NRT)

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or

formulary drugs.

Attestation:

# SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

No

# **SECTION B: #13B OTC ITEMS - BASE 3**

Notes:

The plan will provide \$0 copayment for adult diapers box up to one (1) every month. Members who meet medical criteria. Brand according to exclusive contracted DME provider. Quantity varies by size. The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

# SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal

Benefit as a supplemental benefit under Part C? Note: Only primarily healthrelated meals offered in accordance with Chapter 4 of the MMCM should be

entered in this section.

Select type of benefit

Mandatory

for Meals:

How many days does your Meal Benefit last?

20

What is the maximum number of meals the benefit provides?

40

Is there a servicespecific Maximum

No

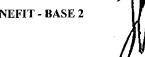
Plan Benefit Coverage amount?

Is there a servicespecific Maximum Enrollee Out-of-Pocket No

Cost?

# SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?





about:blank 5/30/2019 Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required

No

for the Meal Benefit?

#### SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

Up to 10 meals over 5 days after an overnight stay in a hospital or nursing facility, limited to 4 times per

year.

# SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive

services that are offered at zero dollar cost sharing.

Services Attestation

Is authorization

No

required?

Is a referral required? No

#### SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Yes

Does the plan provide

the Annual Physical

Exam as a

supplemental benefit

under Part C?

Select type of benefit

Mandatory

for the Annual

Physical Exam:

Is there a service-

No

specific Maximum Plan Benefit Coverage

amount?

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

# SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

\$0.00

Indicate Minimum

Copayment amount for

each Annual Physical

Indicate Maximum

\$0.00

Copayment amount for each Annual Physical

Exam:

# SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization

No

required?

Is a referral required for the Annual

No

Physical Exam?

Notes:

An examination performed by a primary care physician that collects health information and measures

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different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

10

Select enhanced

: Additional Sessions of Smoking and Tobacco Cessation Counseling : Fitness Benefit\*

benefit (Select all that

: Bathroom Safety Devices\*

apply):

: Medical Nutrition Therapy (MNT)

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

: Wigs for Hair Loss Related to Chemotherapy

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Mandatory

Counseling: Indicate number of visits offered in addition to Medicare:

4

Select type of benefit

Mandatory

for Fitness Benefit:

ess Benefit:

Mandatory

Mandatory

Select type of benefit for Bathroom Safety

Devices:

Select type of benefit

for Medical Nutrition

Therapy (MNT):

Yes

Do you offer Additional Sessions for

Medicare-covered

diseases?

Indicate the limit for

Additional Sessions:

Indicate numerical limit on the services

provided for

Additional Sessions:

Do you offer Coverage for Non-Medicare-covered diseases?

(Specify the diseases and describe the coverage in the notes

field)

Indicate units a limit will be provided in for Coverage for Non-Medicare covered

diseases:

Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:

Select type of benefit for Wigs for Hair Loss Related to Mandatory

Yes

Hours

Visits

\$ D

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Chemotherapy:

# SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-

specific Maximum

Plan Benefit Coverage

amount for Other

Defined Supplemental

Benefits?

Select which Other

: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental

Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Indicate Maximum

500.00

Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:

Select Maximum Plan

Every year

Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee

Deductible?

No No

Is there an enrollee Copayment?

EFITS - BASE 13 SECTION B: #14C OTHER DEFINED SUPPLEME

Is authorization required?

Is a referral required for Other Defined

No

Supplemental Benefits?

No authorization required for this service.

Additional Sessions of Smoking and Tobacco Cessation Counseling

Notes:

Fitness Benefit Notes:\*

SilverSneakers is a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. Partner clubs provide access to an orientation to the facility and equipment along with access to club amenities. In addition, this program includes a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. The at home package includes information and tools for the member to exercise in their own home. No authorization required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Bathroom Safety Devices Notes:\*

The plan will provide 1 bath chair every 5 years. Authorization is required for this service.

Medical Nutrition

Members with ESRD or Diabetes will receive 1 one-hour session in addition to the Medicare-covered

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Therapy (MNT) Notes:

benefit every 12 months. Other conditions may be covered as directed by the physician's discretion and

member will receive 4 one-hour sessions every 12 months as medically necessary. No authorization

required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Wigs for Hair Loss

Authorization is required for this service.

Related to

Chemotherapy Notes:

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization

No

required?

Is a referral required

No

for Kidney Disease **Education Services?** 

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-

specific Maximum

Enrollee Out-of-Pocket Cost for Other

Medicare-covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee

Copayment?

Select which Services

: Medicare-covered Glaucoma Screening

have a Copayment

: Medicare-covered Diabetes Self-Management Training

(Select all that apply):

: Medicare-covered Barium Enemas

: Medicare-covered Digital Rectal Exams

: Medicare-covered EKG following Welcome Visit

: Other Medicare-covered Preventive Services

\$0 Indicate Minimum

Copayment amount for Medicare-covered Glaucoma Screening:

\$0

Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:

Indicate Minimum \$0







Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Maximum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Minimum \$0 Copayment amount for Medicare-covered Barium Enemas: \$0 Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: \$0 Indicate Minimum Copayment amount for Medicare-covered **EKG** following Welcome Visit: \$0 Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Minimum \$0 Copayment amount for Other Medicarecovered Preventive Services: \$0 Indicate Maximum Copayment amount for Other Medicarecovered Preventive Services: Is authorization No required for Medicarecovered Glaucoma Screening? Is authorization No required for Medicarecovered Diabetes Self-Management Training? Is authorization No required for Medicarecovered Barium Enemas? Is authorization No required for Medicarecovered Digital Rectal Exams? Is authorization No

required for Medicarecovered EKG



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following Welcome

Visit?

Is authorization

No

required for Other Medicare-covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required

for any Services?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee

Copayment?

Yes

Select which Medicare

: Medicare Part B Chemotherapy Drugs : Other Medicare Part B Drugs

Part B Rx Drugs have a Copayment (Select

all that apply):

Indicate Minimum

\$0.00

Copayment Amount for Medicare Part B

Chemotherapy Drugs:

Indicate Maximum \$0.00

Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum

Copayment Amount for other Medicare Part

B Drugs:

Indicate Maximum Copayment Amount

\$0.00

\$0.00

for other Medicare Part B Drugs:

No

Is there an enrollee Deductible?

Is Authorization

Required?

Yes

Does the plan offer

Yes

step therapy?

Does the benefit step

: Part B to Part B?

from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SER'

Does the plan provide No Part D home infusion drugs as part of a bundled service as a mandatory

supplemental benefit? SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

Preventive Dental

Items as a

supplemental benefit under Part C?

Select enhanced

: Oral Exams

benefits: : Prophylaxis (Cleaning)

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: Dental X-Rays

Select type of benefit

Mandatory

for Oral Exams: Is this benefit

No, indicate number

unlimited for Oral

Exams?

3

Indicate number of

visits for Oral Exams:

periodicity:

Select the Oral Exams Other, Describe

Select type of benefit for Prophylaxis

Mandatory

(Cleaning): Is this benefit

No, indicate number

unlimited for Prophylaxis (Cleaning)?

Indicate number of visits for Prophylaxis

2

(Cleaning):

Select the Prophylaxis

Every year

(Cleaning) periodicity:

### SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit

Mandatory

for Dental X-Rays:

Is this benefit

No, indicate number

unlimited for Dental

X-Rays?

Indicate number of

visits for Dental X-

2

Rays:

Select the Dental X-

Other, Describe

Rays periodicity:

Is there a service-

specific Maximum Plan Benefit Coverage

amount?

# SECTION B: #16A PREVENTIVE DENTAL - BASE 3 No

No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

#### Coinsurance? SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which

: Oral Exams : Prophylaxis (Cleaning)

Preventive Dental

: Dental X-Rays

Services have a Copayment (Select all

that apply):

Is there a combination of services included in No

a single cost per Office

Visit?

Indicate Minimum

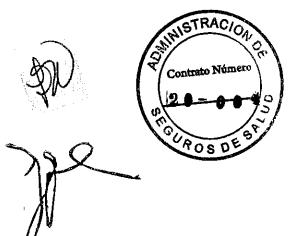
Copayment amount for

Oral Exams:

Indicate Maximum

\$0.00

\$0.00



Copayment amount for

Oral Exams:

Indicate Minimum

\$0.00

Copayment amount for

Prophylaxis (Cleaning):

Indicate Maximum

\$0.00

Copayment amount for

Prophylaxis (Cleaning):

Indicate Minimum

\$0.00

Copayment amount for

Dental X-Rays:

Indicate Maximum

\$0.00

Copayment amount for

Dental X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization

required?

No

Is a referral required

No

for Preventive Dental

Services?

Notes:

Dental X-Rays include bitewing x-rays up to 1 set(s) every 2 years, panoramic film up to 1 every 3 years.

Oral exams include periodic oral exam up to 2 per year and comprehensive oral evaluation up to 1 every 3

### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Comprehensive Dental

Items as a

supplemental benefit under Part C?

Select enhanced

: Restorative Services

benefits:

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit

for Restorative

Services:

Mandatory

Is this benefit

No, indicate number

unlimited for Restorative Services?

Indicate number of

visits for Restorative

Services:

Other, Describe

Select the Restorative Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit

Mandatory

for Endodontics:

Is this benefit

Yes

2

unlimited for

Endodontics?

Mandatory

Select type of benefit

for Periodontics:

Is this benefit

No, indicate number

unlimited for Periodontics?

Indicate number of

visits for Periodontics: Select the Periodontics

Every year '

periodicity:



Select type of benefit

Mandatory

for Extractions:

Is this benefit

Yes

unlimited for Extractions?

Select type of benefit for Prosthodontics,

Mandatory

Other

Oral/Maxillofacial Surgery, Other Services:

No, indicate number

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?

Indicate number of

visits for

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services;

Other, Describe

2

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

Select the

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

1500,00

Every year

Yes

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Indicate Maximum

Plan Benefit Coverage

amount:

Select the Maximum

Plan Benefit Coverage

periodicity:

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

Cost?

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollce

No

Copayment?

: Medicare-covered Benefits Select which Comprehensive Dental

: Restorative Services

Services have a

: Endodontics

Copayment (Select all

: Periodontics

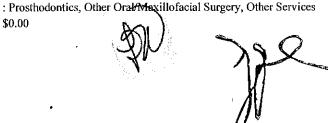
that apply):

: Extractions

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered





Benefits:

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum Copayment amount for

\$0.00

\$0.00

Restorative Services:

Indicate Maximum Copayment amount for \$0.00

Restorative Services: Indicate Minimum

\$0.00

Copayment amount for Endodontics:

Indicate Maximum Copayment amount for **Endodontics:** 

\$0.00

Indicate Minimum Copayment amount for \$0.00

Periodontics:

Indicate Maximum Copayment amount for \$0.00

Periodontics:

Indicate Minimum Copayment amount for **Extractions:** 

\$0.00

Indicate Maximum

\$0.00

Copayment amount for Extractions:

Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

\$0.00

Services: Indicate Maximum

\$0.00

Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

Services:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization

Yes

required?

No

Is a referral required for Comprehensive

Dental Services?

Notes:

Endodontics includes root canal up to unlimited per year. Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year. Partial dentures and complete dentures up to 1 set(s) every 5 years. Restorative services include fillings 0% up to 1 per tooth every 3 years, crown

Contrato Númer

0% up to 1 per tooth every 5 years.

**SECTION B: #17A EYE EXAMS - BASE 1** 

Does the plan provide Eye Exams as a supplemental benefit

Yes

under Part C? Select enhanced

: Routine Eye Exams

benefit:

Select type of benefit for Routine Eye

Mandatory

Exams:

5/30/2019

Is this benefit

No, indicate number

unlimited for Routine

Eye Exams?

Indicate number of exams for Routine Eye

Exams:

Every year

I

Select the Routine Eye Exams periodicity:

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

No

No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

**SECTION B: #17A EYE EXAMS - BASE 2** 

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Yes

Copayment? Select which Eye

\$0.00

\$0.00

\$0.00

\$0.00

Exams have a

: Medicare-covered Benefits ; Routine Eye Exams

Copayment (Select all

that apply):

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for

Routine Eye Exams:

Indicate Maximum

Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

No

**SECTION B: #17A EYE EXAMS - BASE 3** 

Is authorization

No

No

required?

Is a referral required

for Eye Exams? **SECTION B: #17B EYEWEAR - BASE 1** 

Does the plan provide

Eyewear as a supplemental benefit

under Part C?

benefits:

Select enhanced

: Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for Contact lenses:

Mandatory

Is this benefit

No, indicate number

unlimited for Contact

lenses?

Indicate quantity

(number of pairs) for Contact lenses:

1

Select Contact lenses

Every year







periodicity:

Select type of benefit

for Eyeglasses (lenses

and frames):

Is this benefit

No, indicate number

Mandatory

unlimited for

Eyeglasses (lenses and

frames)?

Indicate quantity for Eyeglasses (lenses and

frames):

Select Eyeglasses (lenses and frames) Every year

periodicity:

**SECTION B: #17B EYEWEAR - BASE 3** 

Is there a service-

1

specific Maximum Plan Benefit Coverage

amount?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Do you offer a

Yes

Combined Max Plan Benefit Coverage Amount for all

Eyewear?

Indicate Combined

600.00

Maximum Plan Benefit Coverage amount:

Select the Combined

Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Eyewear

: Medicare-covered Benefits

Benefits have a

: Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

\$0.00

Copayment amount for

Contact lenses:

Indicate Maximum

\$0.00

Copayment amount for



Contact lenses:

Indicate Minimum

\$0.00

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum

\$0.00

Copayment amount for Eyeglasses (lenses and

frames):

#### **SECTION B: #17B EYEWEAR - BASE 6**

Is authorization

No

required?

Is a referral required

No

for Eyewear?

## SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide

Hearing Exams as a supplemental benefit under Part C?

Select enhanced

: Routine Hearing Exams

benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing

Mandatory

Exams:

Is this benefit

No, indicate number

No, indicate number

unlimited for Routine Hearing Exams?

Indicate number for

Routine Hearing

Exams:

Select Routine Hearing Exams periodicity:

Every year

Select type of benefit

Mandatory

for Fitting/Evaluation for Hearing Aid:

1

Is this benefit

unlimited for

Fitting/Evaluation for

Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select

Fitting/Evaluation for

Hearing Aid periodicity:

Every year

# SECTION B: #18A HEARING EXAMS - BASE 2

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Is there an enrollee

No

Deductible?

No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

## **SECTION B: #18A HEARING EXAMS - BASE 3**

Is there an enrollee

Yes

Copayment?





Contrato Número

Select which Hearing

: Medicare-covered Benefits Exam Benefits have a : Routine Hearing Exams

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

No

No

Copayment (Select all

: Fitting/Evaluation for Hearing Aid

that apply):

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum Copayment amount for

Routine Hearing

Exams:

Indicate Maximum

Copayment amount for Routine Hearing

Exams:

Indicate Minimum

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum

Copayment amount for Fitting/Evaluation for Hearing Aid:

Is authorization

required?

Is a referral required

for Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Select enhanced

benefits: Mandatory

Select type of benefit for Hearing Aids (all

types): Is this benefit

No, indicate number

: Hearing Aids (all types)

unlimited for Hearing Aids (all types)? Indicate quantity for Hearing Aids (all

types):

Select Hearing Aids

Every year

2

(all types) periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a servicespecific Maximum Plan Benefit Coverage

amount?

Does the Maximum

Plan Benefit Coverage Amount apply per ear or for both ears combined?

Select the Maximum Plan Benefit Coverage

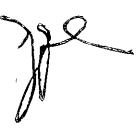
type:

Per ear

Yes

Plan-specified amount per period





Contrato Número

OSDE



Indicate Maximum

1000.00

Plan Benefit Coverage

amount:

Indicate Maximum

Every year

Plan Benefit Coverage

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

Hearing Aid (all

types):

Indicate Maximum

\$0.00

Copayment amount per

Hearing Aid (all

types).

Is there an enrollee

No

Deductible?

**SECTION B: #18B HEARING AIDS - BASE 5** 

Is authorization

required?

Is a referral required

No

for Hearing Aids?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include

MA Uniformity

Flexibility with

reductions in cost or

additional benefits?

Do you offer Special No

Supplemental Benefits

for the Chronically Ill?

SECTION C: V/T - GENERAL - US

Do you offer a US

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK) Is there an In-Network

No

Plan Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network

Voluntary

Maximum Enrollee

Out-of-Pocket Cost?

Is your In-Network

Maximum Enrollee

Out-of-Pocket

(MOOP) Cost at the

Voluntary or

Mandatory Level?

Indicate In-Network

3400.00

Maximum Enrollee Out-of-Pocket Cost

Amount:

Select the benefits that

: In-Network Medicare-covered benefits



apply to the In-Network Maximum Enrollee Out-of-Pocket

Does the In-Network

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan

services?

## SECTION D: MAX PLAN BENEFIT COVERAGE No

Yes

Is there a Maximum

Plan Benefit Coverage

Amount?

#### SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug

Defined Standard Benefit

benefit:

Describe the components of your network (select all that : Standard Retail Cost-Sharing ; Out-of-Network Pharmacy : Standard Mail Order Cost-Sharing

apply):

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42

: Sponsor attests that it will comply with 42 CFR 423.154.

## **SECTION RX: MEDICARE RX GENERAL 2**

Does plan utilize floor

pricing?

Yes

Does plan utilize

CFR 423.154.

Yes

ceiling pricing?

Are there quantity limits on certain

Yes

prescription drugs?

Is prior authorization

Yes

required for certain prescription drugs?

Will your plan be No

limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your

formulary require a step therapy plan?

Yes

Do you pay for Over-

No

the-Counter

medications (OTCs) under the Utilization Management Program?

#### SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard

: In-Network Retail Pharmacy - one month supply

Retail Cost-sharing Location/supply

: In-Network Retail Pharmacy - three month supply

amount(s) that apply: Enter number of days

30

for Standard Retail Cost-sharing one month supply:



Enter number of days for Standard Retail Cost-sharing three month supply:	90
Select all Out-of- Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy one month supply:	30
Select all Standard Mail Order Cost- Sharing Location/supply amount(s) that apply:	: Standard Mail Order - one month supply : Standard Mail Order - three month supply
Enter number of days for Standard Mail Order Cost-Sharing one month supply:	30
Enter number of days for Standard Mail Order Cost-Sharing three month supply:	90
Select the Long Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long Term Care Pharmacy - one month supply
Enter number of days for Long Term Care Pharmacy one month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No



#### PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 018, SEGMENT 0

Module:

PBP

Requested By:

vygd

PLAN SYSTEM INFORMATION

Last entry Date:

05/30/2019

PBP Software Version:

2020.01

Plan Ready for Upload

05/30/2019 05:50:44 PM Eastern Daylight Time

Timestamp:

PLAN STATUS

Section A Status

Plan Ready for Upload

Section B1 Status

Completed

Section B2 Status

Completed

Section B3 Status

Completed

Section B4 Status

Completed

Section B5 Status

Completed

Section B6 Status

Section B7 Status

Completed

Section B8 Status

Completed

Completed

Section B9 Status

Section B10 Status

Completed

Section B11 Status

Completed Completed

Section B12 Status

Section B13 Status

Completed

Section B14 Status

Completed

Section B15 Status

Completed

Section B16 Status

Completed Completed

Section B17 Status

Completed

Section B18 Status Section B19 Status Completed Completed

Section C Status

Completed

Section D Status

Completed

Section Mrx Status

Completed

### SECTION A: SECTION A-1

Organization Legal

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization

Humana

Marketing Name:

Organization Web Site:

www.humana.com/medicare

Plan Name:

Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)

Organization Type:

Local CCP

Plan Type:

HMO

Enrollee Type:

Part A and Part B

Service Area(s):

40010 - Adjuntas, PR

Service Area(s):

40020 - Aguada, PR

Service Area(s):

40030 - Aguadilla, PR

Service Area(s):

40040 - Aguas Buenas, PR

Service Area(s):

40050 - Aibonito, PR

Service Area(s):

40060 - Anasco, PR 40070 - Arecibo, PR

Service Area(s): Service Area(s):

40080 - Arroyo, PR

Service Area(s): Service Area(s): 40090 - Barceloneta, PR 40100 - Barranquitas, PR

Service Area(s):

40110 - Bayamon, PR





Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Arca(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s): Service Area(s):	40510 - Naguabo, PR 40520 - Naranjito, PR
` '	40530 - Orocovis, PR
Service Area(s): Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
- 5	



about:blank 5/30/2019

40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR Service Area(s): Service Area(s): 40720 - Vega Alta, PR 40730 - Vega Baja, PR Service Area(s): 40740 - Vieques, PR Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR Service Area(s): 40770 - Yauco, PR Service Area(s): Contract Number: H4007 Plan ID: 018 0 Segment ID: 2020 Contract Period: Puerto Rico Island Wide Plan Geographic Name: Is this an Employer-Only plan? SECTION A: SECTION A-2 Does this Plan have a CMS-approved Continuation Area? Yes Do you intend to participate in the PLATINO program? Is this a Special Needs Yes Plan? Special Needs Plan Dual-Eligible Type: Is this D-SNP plan a No Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)? Under this D-SNP, has No the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? SECTION A: SECTION A-3 https://www.humana.com/pharmacy/ Participating Pharmacy Website Address: http://www.humana.com/medicare/medicare prescription\_drugs/medicare\_drug\_tools/medicare\_drug\_list/ Formulary Website Address: Physician Website www.humana.com/members/tools Address: (866)773-5959 Customer Service Contact Phone Number Contreto Número for Current Medicare Beneficiaries: (866)773-5959 Customer Service Contact Local Phone Number for Current Medicare POSDE Beneficiaries: (800)681-3625 Customer Service

5/30/2019

Contact Phone Number

for Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone (800)681-3625

Number for

Prospective Medicare

Beneficiaries:

Customer Service

(866)773-5959

Contact Phone Number for Current Part D

Medicare Beneficiaries:

Customer Service

(866)773-5959

Contact Local Phone Number for Current

Part D Medicare Beneficiaries:

Customer Service

(800)681-3625

(800)681-3625

(711)-

(711)-

(711)-

(711)-

Contact Phone Number for Prospective Part D

Medicare

Beneficiaries:

#### SECTION A: SECTION A-4

Customer Service

Contact Local Phone Number for

Prospective Part D

Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for

Current Medicare Beneficiaries:

Customer Service

Sustomer Service

Contact Local

TTY/TDD for Current

Medicare

Beneficiaries:

Customer Service

Contact TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service

Contact Local TTY/TDD for

Prospective Medicare

Beneficiaries:

Customer Service

Contact TTY/TDD for

Current Part D Medicare

Beneficiaries:

Customer Service (711)-

Contact Local

TTY/TDD for Current Part D Medicare

Part D Medicare Beneficiaries:

Customer Service Contact TTY/TDD for

Prospective Part D Medicare

Beneficiaries: Customer Service

(711)-

(711)-



Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:

#### SECTION A: SECTION A-5

Is your organization No filing a standard bid for Section B of the PBP? Is your organization No filing a standard bid for Section C of the PBP?

#### SECTION A: SECTION A-6

Is your organization No filing a standard bid for Section D of the PBP? No Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have

tiered cost sharing are entered in Section B of the PBP software)

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

: Additional Days

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit

under Part C?

Select enhanced

benefits:

Select type of benefit

for Additional Days:

Is this benefit

unlimited for

Yes

Additional Days?

## SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

No

Mandatory

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Is there an enrollee No

Coinsurance?

## SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's No Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?



Do you charge the

No

Medicare-defined cost shares? (These are the

total charges for all services provided to the enrollee in the

inpatient facility.) Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

#### SECTION B: #1A INPATIENT HOSPITAL-A'CUTE - BASE 9

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve Days:

## SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 10

Indicate the number of

Zero (No Copayment per Day)

day intervals for Additional Days:

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient

Per Admission or Per Stay

Hospital-Acute benefit

period?

Do you charge cost

No

sharing on the day of

discharge?

Is authorization required?

Yes

Is a referral required

No

for Inpatient Hospital-

Acute Services?

## SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide

Inpatient Hospital Psychiatric Services as

a supplemental benefit under Part C?

No

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's

Medicare-covered benefit cost sharing

vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee

No

Coinsurance?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE

Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?

Do you charge the Medicare-defined cost shares? (These are the





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total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 9

Indicate the number of

number of Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve

Days:

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient

Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost

No

sharing on the day of

discharge?

Yes

Zero

Is authorization required?

Is a referral required

No

for Inpatient

Psychiatric Hospital

Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide No Skilled Nursing

Facility Services as a supplemental benefit

under Part C?

Do you allow less than Yes 3 day inpatient hospital

stay prior to SNF admission?

Indicate the Number of

Hospital Days

Required Prior to SNF

Admission (0-2):

Is there a service- No specific Maximum

Enrollee Out-of-Pocket

Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee

obtains care?
Is there an enrollee

No

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF

Original Medicare



benefit period?

Is authorization

Yes

required?

Is a referral required

No

for SNF Services?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee

Deductible?

N

Is there an enrollee

Yes

Copayment?

Select which Cardiac

: Medicare-covered Cardiac Rehabilitation Services

and Pulmonary

: Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

: Medicarc-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease

(Select all that apply): (PAD) Services

Indicate Minimum

Copayment amount per service for Medicarecovered Cardiac Rehabilitation Services:

\$0.00

\$0.00

Indicate Maximum
Copayment amount per
service for Medicarecovered Cardiac
Rehabilitation
Services:

Indicate Minimum

\$0.00

Copayment amount per service for Mcdicarecovered Intensive Cardiac Rehabilitation

Services:

\$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Indicate Maximum

Services:

Indicate Minimum \$0.9 Copayment amount per

Copayment amount pe service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum
Copayment amount per
service for Medicarecovered Pulmonary

\$0.00

\$0.00





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about:blank

Rehabilitation

Services:

Indicate Minimum

\$0.00

Copayment amount per service for Medicarecovered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery

Disease (PAD) Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicarecovered Supervised **Exercise Therapy** (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

## SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization

Yes

required?

Is a referral required

No

for Cardiac and Pulmonary Rehabilitation Services?

#### SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-

specific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

### SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

\$0.00

Yes

Hours

24

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Is the Copayment for

Medicare-covered Benefits waived if

admitted to hospital?

Select either Days or

Hours within which

admission must occur

for waiver:

Enter number of Days

or Hours:

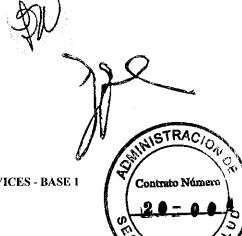
towards any plan-level

Does the Emergency No Care/Post-Stabilization Care cost sharing count

deductible?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a servicespecific Maximum No



Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Does the Urgently No Needed Services cost sharing count towards any plan-level

deductible?

Is the Copayment for

No

Medicare-covered Benefits waived if admitted to hospital?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide

Yes

Worldwide

Emergency/Urgent Coverage as a supplemental benefit under Part C?

Select enhanced

benefit:

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit

for Worldwide

Emergency Coverage:

Select type of benefit

for Worldwide Urgent

Coverage:

Mandatory

Mandatory

No

No

Mandatory

Select type of benefit

for Worldwide Emergency

Transportation:

Is there a Maximum Plan Benefit Coverage amount for Worldwide

Emergency/Urgent

Coverage?

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Yes

Copayment? Select which

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

Worldwide Services have a Copayment

: Worldwide Emergency Transportation

(Select all that apply):



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Indicate Minimum Copayment amount for Worldwide Emergency Coverage:

\$0.00

Indicate Maximum Copayment amount for Worldwide Emergency \$0.00

Coverage:

Is this Copayment waived for Worldwide **Emergency Coverage** if admitted to hospital? Yes

Indicate Minimum Copayment amount for Worldwide Urgent

\$0.00

Coverage: Indicate Maximum

\$0.00

Copayment amount for Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?

Yes

Indicate Minimum Copayment amount for Worldwide Emergency \$0.00

Transportation: Indicate Maximum

\$0.00

Copayment amount for Worldwide Emergency Transportation:

Is this Copayment waived for Worldwide

Yes

Emergency Transportation if admitted to hospital?

No

Is there an enrollee

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Is authorization required?

Yes

Is a referral required

No

for Partial



Hospitalization?

## SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

## SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

#### SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required

No

for Home Health

Services?

#### SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-

specific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

No

Is there an enrollee

Deductible?

Nο

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

## SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide

Chiropractic Services as a supplemental benefit under Part C?

No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

#### **SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2**

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Yes

Copayment? Select which

: Medicare-covered Chiropractic Services



Chiropractic Services have a Copayment (Select all that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Is there an enrollee Deductible?

No

\$0.00

\$0.00

Is authorization

No

required?

Is a referral required

Yes

for Chiropractic

Services?

### SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

### SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization

Yes

Yes

required?

Is a referral required

for Occupational

Therapy Services?

## SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a servicespecific Maximum No

Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:





SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization

required?

Is a referral required

Yes

for Physician Specialist

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollec

Coinsurance?

No

Is there an enrollec

Deductible?

Is there an enrollec

No Yes

Copayment?

Select which Mental

: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

Health Specialty

Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group Sessions:

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization

required?

Yes

Is a referral required

Yes

for Mental Health Specialty Services -Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible? Is there an enrollee

Copayment?

Yes



Select which Podiatry

: Medicare-covered Podiatry Services

Services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization

No

required?

Is a referral required for Podiatrist Services?

No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-

No

specific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

No

Deductible?

Is there an enrollee Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

\$0.00

Indicate Maximum Copayment amount per

visit for Medicarecovered Benefits:

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization

No

required?

No

Is a referral required for Other Health Care

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

Select which Psychiatric Services : Medicare-covered Individual Sessions : Medicare-covered Group Sessions

have a Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:



POSDE

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions: Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Group Sessions: Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Group Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required

No

for Psychiatric Services?

SECTION B: #71 PT AND SP SERVICES - BASE 1 No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization

Yes

required? Is a referral required

No

for Physical Therapy and Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?

Yes

Select the Medicare-

: 4b: Urgently Needed Services

covered benefits that will have Additional

: 7a: Primary Care Physician Services

: 7e1: Individual Sessions for Mental Health Specialty Services

Telehealth available: : 7h1: Individual Sessions for Psychiatric Services

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?

: 9c1: Individual Sessions for Outpatient Sub

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?



Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization

required for Additional Telehealth Services?

No

Is a referral required for Additional

Telehealth Services?

SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

No Yes

Copayment?

Indicate Minimum

\$0.00

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 2

Is authorization

No

required?

Is a referral required

No

for Opioid Treatment

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes

Select which

: Medicare-covered Diagnostic Procedures/Tests

Outpatient Diag Procs/Tests/Lab : Medicare-covered Lab Services

Services have a Copayment (Select all

Contrato Número

OSDE

that apply):

Indicate Minimum

\$0.00 Copayment amount for Medicare-covered

Diagnostic

Procedures/Tests:

Indicate Maximum \$0.00

\$0.00

\$0.00

Yes

Yes

Copayment amount for Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum

Copayment amount for Medicare-covered Lab

Services:

If a member receives multiple services at the same location on the same day, does only

the maximum copay apply?

## SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization

required?

Is a referral required

for Outpatient Diagnostic

Procedures/Test/Lab

Services?

### SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

### SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

: Medicare-covered X-Ray Services

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Select which Outpatient

: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services

Diag/Therapeutic Rad

Services have a

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for other Medicarecovered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum

Copayment amount for other Medicarecovered Diagnostic Radiological Services (e.g., CT, MRI, etc):

\$0.00

\$0.00





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Indicate Minimum

\$0.00

\$0.00

\$0.00

\$0.00

Yes

Copayment amount for Medicare-covered

Therapeutic

Radiological Services:

Indicate Maximum

Copayment amount for Medicare-covered

Therapeutic

Radiological Services:

Indicate Minimum Copayment amount for Medicare-covered X-

Ray Services:

Indicate Maximum

Copayment amount for Medicare-covered X-

Ray Services:

If a member receives multiple services at the same location on the

same day, does only the maximum copay

apply?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required No

for Outpatient

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Yes

\$0.00

\$0.00

\$0.00

No

Select which Services

have a Copayment

: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services

(Select all that apply):

Indicate Minimum

Copayment amount per visit for Medicare-

covered Outpatient

Hospital Services:

Indicate Maximum Copayment amount per visit for Medicarc-

covered Outpatient Hospital Services:

Indicate Minimum

Copayment amount per visit for Medicarecovered Observation

Services:

\$0.00 Indicate Maximum



Copayment amount per visit for Medicarecovered Observation

Services:

Is authorization Yes required for Medicarecovered Outpatient Hospital Services?

Is authorization required for Medicarecovered Observation

Services?

Is a referral required Yes for Medicare-covered Outpatient Hospital

Services?

Is a referral required

for Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Yes

Yes

No

No

Yes

\$0.00

\$0.00

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Indicate Minimum

Copayment amount per

visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per visit for Medicarecovered Benefits:

Is authorization

required?

Yes No

Is a referral required for Ambulatory

Surgical Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

No Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BAS

Is there an enrollec

Coinsurance?

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which

: Medicare-covered Individual Sessions

Outpatient Substance Abuse services have a Copayment (Select all

that apply):

: Medicare-covered Group Sessions



Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions: Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for Medicare-covered

\$0.00

Group Sessions:

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3 Is authorization

No

required?

Is a referral required

No

for Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide

Outpatient Blood Services as a

supplemental benefit

under Part C?

Select enhanced

: Three (3) Pint Deductible Waived

benefit:

Select type of benefit

Mandatory

for Three (3) Pint Deductible Waived:

Is there a servicespecific Maximum No

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization

Nο

required?

Is a referral required

No

for Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-

No

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Yes

Is there an enrollee Copayment?

Select which Services

: Medicare-covered Ground Ambulance Services



have a Copayment

: Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum

\$0.00

\$0.00

\$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum

Copayment amount for Medicare-covered Air Ambulance Services:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

hospital?

No

### SECTION B: #10A AMBULANCE SERVICES - BASE 3 Yes

Is authorization

required for nonemergency Medicare

services?

## SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide

Yes

Transportation Services as a supplemental benefit

under Part C?

Select enhanced

Plan Approved Health-related Location

benefit: Select type of benefit

for Plan Approved

Mandatory

No

Health-related Location:

Is this benefit unlimited for number of trips for Plan Approved Healthrelated Location?

Indicate number of 36

trips for Plan Approved Healthrelated Location:

Select Plan Approved Every year

Health-related Location Trips periodicity:

Select Type of One-way

Transportation for Plan Approved Healthrelated Location:

Select Mode of

Transportation for Plan Approved Health: Van

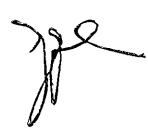
: Other, Describe

related Location: SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-

No





specific Maximum Plan Benefit Coverage

amount?

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

#### SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per

trip:

\$0.00 Indicate Maximum

Copayment amount per

trip:

Is authorization

Yes

required?

Is a referral required

No

for Transportation

Services?

Notes:

Services arranged by the plan's transportation provider to approved locations by means of car, van, or

wheelchair access vehicle that provide members access to health benefits.

#### SECTION B: #11A DME - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

Is there an enrollee

Copayment?

Yes

Indicate Minimum

Copayment amount per

\$0.00

item for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Benefits:

#### SECTION B: #11A DME - BASE 2

Are there preferred No vendors/manufacturers for Durable Medical Equipment (DME)? Is authorization

Yes

required?

#### SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

# SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

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Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes

\$0.00

\$0.00

\$0.00

\$0.00

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

Select which

Prosthetics/Medical Supplies have a

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Maximum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum

Copayment amount per item for Medicarecovered Medical

Supplies:

Indicate Maximum

Copayment amount per item for Medicarecovered Medical

Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization

Yes

No

required?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance? Is there an enrollee

Deductible?

No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee

Copayment?

Yes

Select which Diabetic

: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts

Supplies and Services

have a Copayment (Select all that apply):

Indicate Minimum Copayment amount per

item for Medicarecovered Diabetes

Supplies:

Indicate Maximum

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Minimum

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

\$0.00

\$0.00

\$0.00





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Inserts:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Do you limit Diabetic Supplies and Services

to those from specified manufacturers?

Yes

Is authorization

No

required?

## SECTION B: #12 DIALYSIS SERVICES - BASE 1 No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per session for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per session for Medicare-

covered Benefits:

## SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

required?

Is a referral required

No

for Dialysis Services?

## SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Acupuncture as a supplemental benefit

under Part C?

## SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide

Over-The-Counter (OTC) Items as a supplemental benefit

under Part C?

Mandatory

Select type of benefit

for OTC Items:

Yes

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

30.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Does your Maximum Plan Benefit Coverage

periodicity:

No

Every three months





amount carry forward to the next period if it is unused?

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Are you offering

Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement

Therapy (NRT) Attestation:

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or

formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

No

No

Yes

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

No

Does this cover all of

the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

### SECTION B: #13C MEAL BENEFIT - BASE 1

Yes

Does the plan provide a limited duration Meal Benefit as a

supplemental benefit under Part C? Note: Only primarily healthrelated meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit

for Meals:

Mandatory

How many days does

your Meal Benefit last?

What is the maximum number of meals the benefit provides?

Is there a servicespecific Maximum

Plan Benefit Coverage amount?

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost?

No

No

20

40

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No



Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required

No

for the Meal Benefit?

#### SECTION B: #13C MEAL BENEFIT - BASE 3

Up to 10 meals over 5 days after an overnight stay in a hospital or nursing facility, limited to 4 times per

## SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive

services that are offered at zero dollar cost sharing.

Services Attestation

Is authorization

No

required?

Is a referral required? No

#### SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide

the Annual Physical

Exam as a

supplemental benefit

under Part C?

Select type of benefit

Mandatory

No

No

for the Annual

Physical Exam:

Is there a service-

specific Maximum

Plan Benefit Coverage

amount?

Is there a service-

specific Maximum

Enrollee Out-of-Pocket

### SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?

Indicate Minimum

Copayment amount for

each Annual Physical Exam:

Indicate Maximum

\$0.00

\$0.00

Copayment amount for each Annual Physical

Exam:

## SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization required?

No

Is a referral required for the Annual

No

Physical Exam? Notes:

An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the

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following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

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#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide

Other Defined

Supplemental Benefits as a benefit under Part

Select enhanced

apply):

benefit (Select all that

: Bathroom Safety Devices\*

: Medical Nutrition Therapy (MNT)

Select type of benefit

for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in

addition to Medicare:

Select type of benefit

for Fitness Benefit:

Select type of benefit

for Bathroom Safety

Devices:

: Additional Sessions of Smoking and Tobacco Cessation Counseling

: Fitness Benefit\*

: Wigs for Hair Loss Related to Chemotherapy

Mandatory

Mandatory

Mandatory

Select type of benefit

for Medical Nutrition Therapy (MNT):

Do you offer

Additional Sessions for

Medicare-covered diseases?

Indicate the limit for

Additional Sessions: Indicate numerical

limit on the services provided for

Additional Sessions:

Do you offer Coverage for Non-Medicarecovered diseases? (Specify the diseases and describe the coverage in the notes

field)

Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:

Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:

Select type of benefit for Wigs for Hair Loss

Related to Chemotherapy:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Mandatory

Yes

Hours

1

Yes

Visits

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

OSDE

Is there a service-

Yes

specific Maximum Plan Benefit Coverage

amount for Other Defined Supplemental

Benefits?

Select which Other

: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Indicate Maximum

500.00

Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:

Select Maximum Plan

Every year

Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

Nο

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

Is a referral required for Other Defined Supplemental Benefits?

No

Additional Sessions of Smoking and Tobacco

No authorization required for this service.

Cessation Counseling Notes:

Fitness Benefit Notes:\*

SilverSneakers is a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. Partner clubs provide access to an orientation to the facility and equipment along with access to club amenities. In addition, this program includes a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. The at home package includes information and tools for the member to exercise in their

own home. No authorization required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Bathroom Safety Devices Notes:\*

The plan will provide 1 bath chair every 5 years. Authorization is required for this service.

Medical Nutrition Therapy (MNT) Notes: Members with ESRD or Diabetes will receive 1 one-hour session in addition to the Medicare-covered benefit every 12 months. Other conditions may be covered as directed by the physician's discretion and member will receive 4 one-hour sessions every 12 months as medically necessary. No authorization

required for this service.

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Wigs for Hair Loss

Authorization is required for this service.

Related to

Chemotherapy Notes:

#### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

#### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization

No

required?

Is a referral required

for Kidney Disease Education Services? No

### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1 No

Is there a service-

specific Maximum

Enrollee Out-of-Pocket

Cost for Other

Medicare-covered

Preventive Services?

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

## SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee

Copayment?

Yes

Select which Services

have a Copayment

: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training

: Medicare-covered Barium Enemas

(Select all that apply):

: Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit : Other Medicare-covered Preventive Services

Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:

\$0

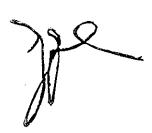
Indicate Maximum Copayment amount for

\$0

\$0

Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for Medicare-covered





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about:blank

Diabetes Self-

Management Training:	
Indicate Maximum Copayment amount for	\$0
Medicare-covered	
Diabetes Self-	
Management Training:	
Indicate Minimum	\$0
Copayment amount for	
Medicare-covered Barium Enemas:	
Indicate Maximum	\$0
Copayment amount for	фU
Medicare-covered	
Barium Enemas:	
Indicate Minimum	\$0
Copayment amount for	
Medicare-covered Digital Rectal Exams:	
Indicate Maximum	\$0
Copayment amount for	40
Medicare-covered	
Digital Rectal Exams:	
Indicate Minimum	<b>\$</b> 0
Copayment amount for	
Medicare-covered EKG following	
Welcome Visit:	
Indicate Maximum	\$0
Copayment amount for	
Medicare-covered	
EKG following	
Welcome Visit:	¢Λ
Indicate Minimum Copayment amount for	\$0
Other Medicare-	
covered Preventive	
Services:	
Indicate Maximum	<b>\$</b> 0
Copayment amount for	
Other Medicare- covered Preventive	
Services:	
Is authorization	No
required for Medicare-	
covered Glaucoma	
Screening?	
Is authorization required for Medicare-	No
covered Diabetes Self-	
Management Training?	
Is authorization	No
required for Medicare-	
covered Barium	
Enemas?	
Is authorization required for Medicare-	No
covered Digital Rectal	
Exams?	
Is authorization	No
required for Medicare-	
covered EKG	
following Welcome Visit?	
A 191f.	

No

Is authorization



about:blank 5/30/2019

required for Other Medicare-covered Preventive Services?

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required

for any Services?

#### SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

# SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee

Yes

Copayment?

Select which Medicare

: Medicare Part B Chemotherapy Drugs

Part B Rx Drugs have a Copayment (Select

: Other Medicare Part B Drugs

\$0.00

all that apply):

Indicate Minimum

Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum

\$0.00

Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum \$0.00

Copayment Amount for other Medicare Part

B Drugs:

Indicate Maximum

\$0.00

Copayment Amount for other Medicare Part

B Drugs:

Is there an enrollee

No

Deductible?

Is Authorization

Yes

Required?

Does the plan offer

Yes

step therapy?

Does the benefit step

: Part B to Part B?

from (select all that

apply):

# SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide

Part D home infusion drugs as part.of a bundled service as a

mandatory

supplemental benefit?

## SECTION B: #16A PREVENTIVE DENTAL - BASE 1 Yes

Does the plan provide

Preventive Dental

Items as a

supplemental benefit

under Part C?

Select enhanced

: Oral Exams

benefits:

: Prophylaxis (Cleaning) : Dental X-Rays

Mandatory

Select type of benefit

for Oral Exams:



Is this benefit unlimited for Oral No, indicate number

Exams?

Indicate number of visits for Oral Exams: 3

Select the Oral Exams

periodicity:

Other, Describe

Select type of benefit for Prophylaxis

Mandatory

(Cleaning): Is this benefit

No, indicate number

unlimited for Prophylaxis (Cleaning)?

Indicate number of visits for Prophylaxis

2

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every year

# SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit

No, indicate number

unlimited for Dental

X-Rays?

2

Indicate number of visits for Dental X-

Rays:

Select the Dental X-Rays periodicity:

Other, Describe

Is there a servicespecific Maximum

No

Plan Benefit Coverage

amount?

### SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Yes

Coinsurance? Select which

: Oral Exams

Preventive Dental

: Prophylaxis (Cleaning) : Dental X-Rays

Services have a Coinsurance (Select all

that apply):

Is there a combination of services included in a single cost per Office

No

Visit?

Indicate Minimum Coinsurance

0%

percentage for Oral Exams:

0%

Indicate Maximum Coinsurance

percentage for Oral

Exams:

Indicate Minimum

0%

Coinsurance percentage for Prophylaxis





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(Cleaning):

Indicate Maximum

0%

Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum

0%

Coinsurance

percentage for Dental

X-Rays:

Indicate Maximum

0%

Coinsurance

percentage for Dental

X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization

No

required?

Is a referral required No

for Preventive Dental

Services?

Notes:

Dental X-Rays include bitewing x-rays up to 1 set(s) every 2 years, panoramic film up to 1 every 3 years.

Oral exams include periodic oral exam up to 2 per year and comprehensive oral evaluation up to 1 every 3

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years.

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Comprehensive Dental

Items as a

supplemental benefit under Part C?

Select enhanced

: Restorative Services

benefits:

: Endodontics : Periodontics

: Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit

for Restorative

Services:

Is this benefit

No, indicate number

unlimited for

Restorative Services?

Indicate number of visits for Restorative

Services:

Select the Restorative

Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL

Other, Describe

Select type of benefit

for Endodontics:

Mandatory

Is this benefit

Yes

unlimited for Endodontics?

Select type of benefit

1

for Periodontics:

Mandatory

Is this benefit unlimited for

No, indicate number

Periodontics?

Indicate number of

visits for Periodontics:

Select the Periodontics

Every year

periodicity:

Select type of benefit

Mandatory

Mandatory

for Extractions:

Is this benefit

Yes

unlimited for Extractions?

Select type of benefit

for Prosthodontics,

Other

Oral/Maxillofacial Surgery, Other Services:

No, indicate number Is this benefit

2

unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?

Indicate number of

visits for

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the

Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Select the Maximum

Plan Benefit Coverage type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

amount:

3000.00

Every year

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-No

specific Maximum Enrollee Out-of-Pocket

Cost?

### SECTION B: #16B COMPREHENSIVE DENTAL

Is there an enrollee

Coinsurance?

Select which

: Restorative Services

Comprehensive Dental Services have a

: Endodontics : Periodontics

Coinsurance (Select all

: Extractions

that apply): Indicate Minimum

0%

Coinsurance percentage for

Restorative Services: Indicate Maximum

25%

Coinsurance





percentage for Restorative Services:

Indicate Minimum

0%

Coinsurance percentage for **Endodontics:** 

Indicate Maximum

Coinsurance percentage for **Endodontics:** 

0%

Indicate Minimum

0%

Coinsurance percentage for Periodontics:

Indicate Maximum Coinsurance percentage for Periodontics:

0%

Indicate Minimum Coinsurance percentage for

0%

Extractions: Indicate Maximum

0%

Coinsurance percentage for Extractions:

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

25%

Services: Indicate Maximum

25%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is there an enrollee

No

Deductible?

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee

Copayment?

Yes

Select which

: Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization

Yes

required? Is a referral required

for Comprehensive

No



Dental Services?

Notes:

Endodontics includes root canal up to unlimited per year. Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year. Partial dentures and complete dentures up to 1 set(s) every 5 years. Restorative services include amalgam or composite filling 0% up to 1 every 3 years, crown 25% up 1 every 5 years.

#### SECTION B: #17A EYE EXAMS - BASE 1

Yes

Does the plan provide

Eye Exams as a supplemental benefit under Part C?

Select enhanced

: Routine Eye Exams

No, indicate number

Mandatory

Every year

ı

No

No

No

Yes

\$0.00

\$0.00

\$0.00

: Medicare-covered Benefits : Routine Eye Exams

benefit:

Select type of benefit

Exams:

for Routine Eye

Is this benefit unlimited for Routine

Eye Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye

Exams periodicity: Is there a service-

specific Maximum Plan Benefit Coverage

amount?

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

Copayment?

Select which Eye

Exams have a

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum

\$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum

Copayment amount for

Routine Eye Exams: Is there an enrollee

No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

No

No



#### **SECTION B: #17B EYEWEAR - BASE 1**

Does the plan provide

Eyewear as a

supplemental benefit

under Part C?

Select enhanced : Contact lenses : Eyeglasses (lenses and frames)

benefits: Select type of benefit

Mandatory

for Contact lenses:

Is this benefit unlimited for Contact No, indicate number

No, indicate number

lenses?

Indicate quantity (number of pairs) for Contact lenses:

Select Contact lenses

Every year

1

Yes

1

periodicity:

Select type of benefit

Mandatory

for Eyeglasses (lenses

and frames):

Is this benefit unlimited for

Eyeglasses (lenses and

frames)?

Indicate quantity for Eyeglasses (lenses and

frames):

Select Eyeglasses

Every year

(lenses and frames)

periodicity:

### **SECTION B: #17B EYEWEAR - BASE 3**

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Do you offer a

Combined Max Plan Benefit Coverage Amount for all

Eyewear?

Indicate Combined

500.00

Yes

Maximum Plan Benefit Coverage amount:

Select the Combined

Every year

Maximum Plan Benefit

Coverage periodicity:

### **SECTION B: #17B EYEWEAR - BASE 4**

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee No

Coinsurance?

**SECTION B: #17B EYEWEAR - BASE 5** 

Is there an enrollee

Is there an enrollee

No

No

Deductible?

Yes

Copayment?

Select which Eyewear

: Medicare-covered Benefits



Benefits have a

: Contact lenses

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for

Contact lenses:

Indicate Maximum

Copayment amount for Contact lenses:

Indicate Minimum

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum

Copayment amount for Eyeglasses (lenses and

Is a referral required

for Eyewear?

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

under Part C?

benefits:

Select type of benefit

for Routine Hearing

Exams:

Is this benefit

unlimited for Routine Hearing Exams?

Indicate number for

Routine Hearing

Exams:

Select Routine Hearing

Exams periodicity:

Select type of benefit for Fitting/Evaluation

for Hearing Aid: Is this benefit

unlimited for

Fitting/Evaluation for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for

Hearing Aid periodicity:

: Eyeglasses (lenses and frames)

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

No

No

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization

required?

Yes supplemental benefit

Select enhanced

: Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Mandatory

No, indicate number

Every year

Mandatory

No, indicate number

Every year





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#### SECTION B: #18A HEARING EXAMS - BASE 2

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Is there an enrollec

Deductible?

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

#### SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Yes

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

Select which Hearing Exam Benefits have a

: Medicarc-covered Benefits : Routine Hearing Exams

Copayment (Select all

: Fitting/Evaluation for Hearing Aid

that apply):

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for Routine Hearing

Exams:

Indicate Maximum Copayment amount for

Routine Hearing

Exams:

Indicate Minimum

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum \$0.00

Copayment amount for Fitting/Evaluation for Hearing Aid:

Is authorization

No

required?

Is a referral required

Yes

Mandatory

for Hearing Exams?

## SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Select enhanced

: Hearing Aids (all types)

benefits:

Select type of benefit

for Hearing Aids (all

types):

Is this benefit

No, indicate number

unlimited for Hearing Aids (all types)?

Indicate quantity for 2 Contrato Numero

about:blank 5/30/2019 Hearing Aids (all

types):

Select Hearing Aids

Every year

(all types) periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-

specific Maximum Plan Benefit Coverage

amount?

Does the Maximum

Per ear

Plan Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

Indicate Maximum

500.00

Plan Benefit Coverage

amount:

Indicate Maximum

Every year

Plan Benefit Coverage

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-

specific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

\$0.00

Copayment amount per

Hearing Aid (all

types):

Indicate Maximum

Copayment amount per

Hearing Aid (all

types):

Is there an enrollee

No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization

required?

No

Is a referral required

No

for Hearing Aids?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SŞBCI

Does your plan include

MA Uniformity Flexibility with

reductions in cost or

additional benefits?

for the Chronically III?

Do you offer Special Supplemental Benefits

No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel

Νo

Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)



Is there an In-Network

Plan Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

: In-Network Medicare-covered benefits

Is there an In-Network

Maximum Enrollee

Out-of-Pocket Cost?

Is your In-Network

Voluntary

No

Maximum Enrollee Out-of-Pocket

(MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee

3400.00

Out-of-Pocket Cost Amount:

Select the benefits that

apply to the In-Network Maximum Enrollee Out-of-Pocket

cost:

Does the In-Network

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan

services?

SECTION D: MAX PLAN BENEFIT COVERAGE No

Yes

Is there a Maximum Plan Benefit Coverage

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription

drug (Part D) benefit?

Select the type of drug

benefit:

Describe the components of your

network (select all that

Sponsor attests that it will comply with 42

Defined Standard Benefit

: Standard Retail Cost-Sharing : Out-of-Network Pharmacy : Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor

pricing?

CFR 423.154.

Yes Yes

Yes

No

Does plan utilize

ceiling pricing?

Are there quantity Yes

limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?





Do any drugs in your

Yes

formulary require a step therapy plan?

No

Do you pay for Overthe-Counter

medications (OTCs) under the Utilization Management Program?

### SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard

: In-Network Retail Pharmacy - one month supply

Retail Cost-sharing

Location/supply

: In-Network Retail Pharmacy - three month supply

amount(s) that apply:

Enter number of days for Standard Retail

30

Cost-sharing one month supply:

Enter number of days

90

for Standard Retail Cost-sharing three

month supply: Select all Out-of-

: Out-of-Network Pharmacy - one month supply

Network Pharmacy Location/supply amount(s) that apply:

Enter number of days 30 for Out-of-Network

Pharmacy one month

supply:

Select all Standard Mail Order Cost-

: Standard Mail Order - one month supply : Standard Mail Order - three month supply

Sharing Location/supply

amount(s) that apply: Enter number of days for Standard Mail

Order Cost-Sharing one month supply: Enter number of days

for Standard Mail Order Cost-Sharing three month supply:

Select the Long Term Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for Long Term Care Pharmacy one month supply:

Are all of the drugs on your formulary available with an extended day supply? Are any of the drugs available at an

extended day supply limited to a 1-month supply for the first fill?

: Long Term Care Pharmacy - one month supply

No

31

30

90

No





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#### PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 019, SEGMENT 0

Module:

**PBP** 

Requested By:

vyqd

PLAN SYSTEM INFORMATION

Last entry Date:

05/30/2019

PBP Software Version:

2020,01

Plan Ready for Upload

05/30/2019 05:51:41 PM Eastern Daylight Time

Timestamp:

**PLAN STATUS** 

Section A Status

Plan Ready for Upload

Section B1 Status

Completed

Section B2 Status

Completed

Section B3 Status

Completed Completed

Section B4 Status Section B5 Status

Completed

Section B6 Status

Completed

Section B7 Status

Completed

Section B8 Status

Completed

Section B9 Status

Completed

Section B10 Status

Section B11 Status

Completed

Completed

Section B12 Status

Completed

Section B13 Status

Completed

Section B14 Status

Section B15 Status

Completed

Section B16 Status

Completed Completed

Section B17 Status

Completed

Section B18 Status

Completed Completed

Section B19 Status

Section C Status

Completed

Section D Status

Completed

Section Mrx Status

Completed

## SECTION A: SECTION A-1

Organization Legal

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization

Marketing Name:

www.humana.com/medicare

Organization Web Site: Plan Name:

Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)

Organization Type:

Local CCP

Plan Type:

**HMO** 

Enrollee Type:

Part A and Part B

Service Area(s):

40010 - Adjuntas, PR

Service Area(s):

40020 - Aguada, PR

Service Area(s):

40030 - Aguadilla, PR

Service Area(s):

40040 - Aguas Buenas, PR

Service Area(s):

40050 - Aibonito, PR

Service Area(s):

40060 - Anasco, PR

Service Area(s):

40070 - Arecibo, PR

Service Area(s):

Service Area(s):

40080 - Arroyo, PR 40090 - Barceloneta, PR

Service Area(s): Service Area(s):

40100 - Barranquitas, PR 40110 - Bayamon, PR

Contrato Número

Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Arca(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
• •	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	*
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR .
Service Area(s):	40590 - Riio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
· ·	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR



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Customer Service

Contact Phone Number

(800)681-3625

40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): Service Area(s): 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR 40730 - Vega Baja, PR Service Area(s): 40740 - Vieques, PR Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR Service Area(s): Service Area(s): 40770 - Yauco, PR Contract Number: H4007 019 Plan ID: 0 Segment ID: 2020 Contract Period: Puerto Rico Island Wide Plan Geographic Name: Is this an Employer-No Only plan? **SECTION A: SECTION A-2** Does this Plan have a CMS-approved Continuation Area? Do you intend to Yes participate in the PLATINO program? Is this a Special Needs Yes Plan? Special Needs Plan Dual-Eligible Type: Is this D-SNP plan a No Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)? Under this D-SNP, has No the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? SECTION A: SECTION A-3 Participating Pharmacy https://www.humana.com/pharmacy/ Website Address: Formulary Website http://www.humana.com/medicare/medicare\_prescription\_drugs/medicare\_drug\_tools/medicare\_drug\_list/ Address: Physician Website www.humana.com/members/tools Address: Customer Service (866)773-5959 Contact Phone Number for Current Medicare Beneficiaries: Contrato Número Customer Service (866)773-5959 Contact Local Phone Number for Current Medicare Beneficiaries:

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OSDE

for Prospective Medicare Beneficiaries:

Customer Service (800)681-3625 Contact Local Phone

Number for

Prospective Medicare

Beneficiaries:

**Customer Service** (866)773-5959

Contact Phone Number for Current Part D Medicare

Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D

Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:

(711)-Customer Scrvice Contact TTY/TDD for

Current Medicare Beneficiaries:

Customer Service (711)-

Contact Local

TTY/TDD for Current

Medicare Beneficiaries:

**Customer Service** (711)-Contact TTY/TDD for

Prospective Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for

Prospective Medicare

Beneficiaries:

(711)-Customer Service

Contact TTY/TDD for Current Part D Medicare

Beneficiaries: Customer Service (711)-

Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:

Customer Service (711)-Contact TTY/TDD for

Prospective Part D Medicare Beneficiaries:

(711)-Customer Service







Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:

#### SECTION A: SECTION A-5

Is your organization No filing a standard bid for Section B of the PBP? Is your organization No filing a standard bid for Section C of the PBP?

#### **SECTION A: SECTION A-6**

Is your organization No filing a standard bid for Section D of the PBP? Do any of your No outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have

tiered cost sharing are entered in Section B of the PBP software)

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE I

Yes

Does the plan provide Inpatient Hospital-

Acute Services as a supplemental benefit under Part C?

Select enhanced benefits:

: Additional Days

Select type of benefit

for Additional Days:

Mandatory

Is this benefit

Yes

unlimited for Additional Days?

### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-No specific Maximum Enrollee Out-of-Pocket Cost?

Does this plan's

No

Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Is there an enrollee Coinsurance?

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's No Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?



Do you charge the No Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 9

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve Days:

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 10

Indicate the number of

Zero (No Copayment per Day)

day intervals for Additional Days:

# SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient

Per Admission or Per Stay

Hospital-Acute benefit

period?

Do you charge cost

No

sharing on the day of

discharge?

Is authorization

Yes

No

required?

Is a referral required No

for Inpatient Hospital-Acute Services?

# SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Is there a service-No specific Maximum

Enrollee Out-of-Pocket

### SECTION B: #1B INPATIENT HOSPITAL PSYCMATRIC - BASE 2

Does this plan's Medicarc-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Coinsurance?

No

Is there an enrollee

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

No

Do you charge the Medicare-defined cost shares? (These are the



about:blank

total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 9

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve Days:

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient

Per Admission or Per Stay

Hospital Psychiatric benefit period?

Do you charge cost No

sharing on the day of

110

discharge?

Is authorization

Yes

required?

Is a referral required

No

for Inpatient

Psychiatric Hospital

Services?

#### SECTION B: #2 SNF - BASE 1

Does the plan provide No Skilled Nursing Facility Services as a supplemental benefit

under Part C?

Do you allow less than Yes

3 day inpatient hospital stay prior to SNF

admission?

Indicate the Number of Zero

Hospital Days Required Prior to SNF

Admission (0-2):

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

## SECTION B: #2 SNF - BASE 2

Does this plan's No
Medicare-covered
benefit cost sharing
vary by the Skilled
Nursing Facility in
which an enrollee
obtains care?

Is there an enrollee

No

No

Coinsurance?

#### SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

#### SECTION B: #2 SNF - BASE 10

What is your SNF

Original Medicare



benefit period?

Is authorization

Yes

required?

Is a referral required

No

for SNF Services?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide No Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a servicespecific Maximum Enrollee Out-of-Pocket No

Is there an enrollee

No

Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee

Deductible?

Is there an enrollee

Yes -

Copayment?

: Medicare-covered Cardiac Rehabilitation Services

Select which Cardiac and Pulmonary

: Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

: Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease

(PAD) Services (Select all that apply):

Indicate Minimum

\$0.00

\$0.00

Copayment amount per service for Medicarecovered Cardiac Rehabilitation Services:

Indicate Maximum

Copayment amount per service for Medicarecovered Cardiac Rehabilitation

\$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Indicate Minimum

Services:

Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum Copayment amount per service for Medicarecovered Pulmonary

Rehabilitation

Services:

Indicate Maximum Copayment amount per service for Medicarecovered Pulmonary Rehabilitation

\$0.00

\$0.00



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Services:

Indicate Minimum

\$0.00

Copayment amount per service for Medicarecovered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery

Disease (PAD) Services:

Indicate Maximum

\$0.00

Copayment amount per service for Medicarecovered Supervised **Exercise Therapy** (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

# SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization

Yes

required?

Is a referral required

No

for Cardiac and Pulmonary Rehabilitation Services?

## SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

# SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Is the Copayment for

Yes

Medicare-covered Benefits waived if

admitted to hospital? Select either Days or

Hours

Hours within which

admission must occur

for waiver:

Enter number of Days

or Hours:

24

Does the Emergency Care/Post-Stabilization

No

Care cost sharing count towards any plan-level

deductible?

# SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a servicespecific Maximum No



Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Does the Urgently

No

Needed Services cost sharing count towards

any plan-level deductible?

Is the Copayment for No

Medicare-covered Benefits waived if admitted to hospital?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide

Yes

Mandatory

Mandatory

Mandatory

No

Worldwide

Emergency/Urgent Coverage as a supplemental benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit

for Worldwide

Emergency Coverage:

Select type of benefit

for Worldwide Urgent

Coverage:

Select type of benefit

for Worldwide Emergency Transportation:

Is there a Maximum

Plan Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a servicespecific Maximum

No

Enrollee Out-of-Pocket

Cost?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee

Yes

No

Copayment?

Select which Worldwide Services : Worldwide Emergency Coverage : Worldwide Urgent Coverage

have a Copayment (Select all that apply): : Worldwide Emergency Transportation





\$0.00 Indicate Minimum Copayment amount for Worldwide Emergency Coverage: Indicate Maximum \$0.00 Copayment amount for Worldwide Emergency Coverage: Is this Copayment Yes waived for Worldwide **Emergency Coverage** if admitted to hospital? \$0.00 Indicate Minimum Copayment amount for Worldwide Urgent Coverage: Indicate Maximum \$0.00 Copayment amount for Worldwide Urgent Coverage: Is this Copayment Yes waived for Worldwide Urgent Coverage if admitted to hospital? Indicate Minimum \$0.00 Copayment amount for Worldwide Emergency Transportation: \$0.00 Indicate Maximum Copayment amount for Worldwide Emergency Transportation: Is this Copayment Yes waived for Worldwide **Emergency** Transportation if admitted to hospital? Is there an enrollee No

## SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a servicespecific Maximum
Enrollee Out-of-Pocket
Cost?
Is there an enrollee
No

Coinsurance?

- 1

Is there an enrollee No

Deductible?

Deductible?

**SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2** 

Is there an enrollee Yes
Copayment?
Indicate Minimum \$0.00
Copayment amount for
Medicare-covered
Benefits per day:

Indicate Maximum \$0.00 Copayment amount for

Medicare-covered
Benefits per day:
Is authorization

Is authorization Yes required?

Is a referral required for Partial

No





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Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1 No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee Yes.

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization

required?

Yes

Is a referral required

No

No

for Home Health

Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment? Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?

No

Is there a servicespecific Maximum Enrollee Out-of-Pocket

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Yes

Coinsurance?

Is there an enrollee Copayment?

Select which

: Medicare-covered Chiropractic Services





Chiropractic Services have a Copayment (Select all that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Is there an enrollee

Deductible?

Is authorization

No

Yes

No

\$0.00

\$0.00

required?

Is a referral required

for Chiropractic

Services?

# SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

## SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization

Yes

required?

Is a referral required

Yes

for Occupational Therapy Services?

# SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a servicespecific Maximum No

Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?

Indicate Minimum Copayment amount per \$0.00

visit for Medicarecovered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:







SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization

required?

Is a referral required for Physician Specialist Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? Select which Mental

: Medicare-covered Individual Sessions

Health Specialty

: Medicare-covered Group Sessions

Services have a Copayment (Select all

that apply):

Indicate Minimum Copayment amount for Medicare-covered

Individual Sessions: Indicate Maximum

\$0.00

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for

Medicare-covered Group Sessions:

\$0.00

\$0.00

Indicate Maximum Copayment amount for Medicare-covered

Group Sessions:

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization

required?

Yes

Is a referral required

Yes

for Mental Health Specialty Services -Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Is there a service-No specific Maximum Enrollee Out-of-Pocket

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

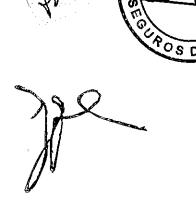
Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?



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Select which Podiatry

: Medicare-covered Podiatry Services

Services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization

No

required?

Is a referral required for Podiatrist Services? No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization

No

required?

Is a referral required

No

for Other Health Care Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible? Is there an enrollee

Yes

Copayment?

Select which Psychiatric Services : Medicare-covered Individual Sessions : Medicare-covered Group Sessions

have a Copayment (Select all that apply): Indicate Minimum

Copayment amount for Medicare-covered Individual Sessions:

\$0.00







Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions: Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Group Sessions:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered **Group Sessions:** 

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required

No

for Psychiatric Services?

SECTION B: #71 PT AND SP SERVICES - BASE 1

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization

Yes

required?

Is a referral required No for Physical Therapy

and Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?

Yes

Select the Medicarccovered benefits that will have Additional

Telehealth available:

: 4b: Urgently Needed Services

: 7a: Primary Care Physician Services : 7e1: Individual Sessions for Mental Health Specialty Services

: 7h1: Individual Sessions for Psychiatric Services

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost for Additional

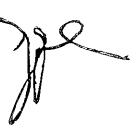
: 9c1: Individual Sessions for Outpatient Substance Abuse

Telehealth? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?





Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

#### SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization

required for Additional Telehealth Services?

No

Is a referral required for Additional

Telehealth Services?

# SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Yes

No

Copayment?

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

#### SECTION B: #7K OPIOID TREATMENT SERVICES - BASE 2

Is authorization

No

required?

Is a referral required

No

for Opioid Treatment

Services?

# SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

# SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

Yes

: Medicare-covered Diagnostic Procedures/Tests

Select which Outpatient Diag

: Medicare-covered Lab Services

Procs/Tests/Lab Services have a Copayment (Select all Contrato Número POSD

that apply):

Indicate Minimum

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum \$0.00

\$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Lab

Services:

If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

Is authorization

required?

Is a referral required

Yes

Yes

for Outpatient Diagnostic

Procedures/Test/Lab

Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

: Medicare-covered X-Ray Services

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

No

Select which Outpatient

: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services

Diag/Therapeutic Rad

Services have a Copayment (Select all

that apply):

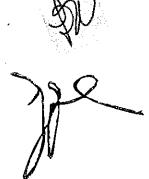
Indicate Minimum Copayment amount for

other Medicarecovered Diagnostic Radiological Services (e.g., CT, MRI, etc): Indicate Maximum

Copayment amount for other Medicarecovered Diagnostic Radiological Services (e.g., CT, MRI, etc):

\$0.00

\$0.00





Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Therapeutic

Radiological Services: Indicate Maximum

\$0.00

\$0.00

Copayment amount for Medicare-covered Therapeutic

Radiological Services:

Indicate Minimum

Copayment amount for Medicare-covered X-

Ray Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-

Ray Services:

If a member receives multiple services at the same location on the

same day, does only the maximum copay

apply?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization

Yes

No

Yes

required?

Is a referral required

for Outpatient

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollec

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Services

: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services

have a Copayment

(Select all that apply):

\$0.00

Indicate Minimum Copayment amount per visit for Medicarecovered Outpatient

Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

\$0.00 Indicate Maximum





Copayment amount per visit for Medicarecovered Observation Services:

Is authorization required for Medicare-

covered Outpatient Hospital Services?

Is authorization required for Medicarecovered Observation

Services?

Is a referral required Yes for Medicare-covered

Outpatient Hospital

Services?

Is a referral required

Yes for Medicare-covered

Observation Services?

# SECTION B: #9B ASC SERVICES - BASE 1

Yes

Yes

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollec

No

Coinsurance?

### SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Is authorization

Yes

required?

Is a referral required

No

for Ambulatory Surgical Center

Services?

# SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

# SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee

Copayment?

Yes

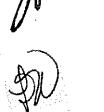
Select which

: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

Outpatient Substance Abuse services have a Copayment (Select all

that apply):







Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Individual Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Indicate Minimum

Individual Sessions:

\$0.00

Copayment amount for Medicare-covered

Group Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Group Sessions:

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization

No

required?

Is a referral required

No

for Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide

Yes

Outpatient Blood Services as a

supplemental benefit

under Part C? Select enhanced

; Three (3) Pint Deductible Waived

benefit:

Select type of benefit

Mandatory

for Three (3) Pint Deductible Waived:

Is there a service-

No specific Maximum

Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment? Is authorization No

required?

for Outpatient Blood

Is a referral required No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE I

Is there a servicespecific Maximum No

Enrollec Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

**SECTION B: #10A AMBULANCE SERVICES - BASE 2** 

Is there an enrollee

No

Deductible?

Copayment?

Is there an enrollee

Yes

Select which Services

: Medicare-covered Ground Ambulance Services



have a Copayment

: Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum

\$0.00

\$0.00

\$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for

Medicare-covered Air Ambulance Services:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3 Yes

Yes

Is authorization required for non-

emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Mandatory

No

Plan Approved Health-related Location

Does the plan provide

Transportation Services as a

supplemental benefit

under Part C?

Select enhanced benefit:

Select type of benefit for Plan Approved

Health-related Location:

Is this benefit

unlimited for number of trips for Plan Approved Healthrelated Location?

Indicate number of trips for Plan Approved Healthrelated Location:

Select Plan Approved

Health-related Location Trips periodicity:

Select Type of

Transportation for Plan Approved Healthrelated Location:

Select Mode of

Transportation for Plan

Approved Healthrelated Location:

Every year

One-way

: Van

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-

No





specific Maximum Plan Benefit Coverage

amount?

Is there a service- No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?
Is there an enrollee

No

Deductible?

#### SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per

trip:

Indicate Maximum

\$0.00

Copayment amount per

trip:

Is authorization

Yes

required?

Is a referral required

No

for Transportation

Services?

Notes:

Services arranged by the plan's transportation provider to approved locations by means of car, van, or

wheelchair access vehicle that provide members access to health benefits.

### SECTION B: #11A DME - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

To d'acte Minimum

Indicate Minimum

\$0.00

Copayment amount per item for Medicare-covered Benefits:

Indicate Maximum

\$0.00

Copayment amount per item for Medicare-covered Benefits:

SECTION B: #11A DME - BASE 2

Are there preferred No vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization

Yes

No

required?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2



Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Prosthetics/Medical : Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

Supplies have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount per item for Medicarecovered Prosthetic

\$0.00

\$0.00

\$0.00

Devices:

Indicate Maximum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum

Copayment amount per item for Medicarecovered Medical

Supplies:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Medical

Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization

Yes

required?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee

Copayment?

Yes

Select which Diabetic

Supplies and Services

: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapcutic Shoes or Inserts

have a Copayment

(Select all that apply):

Indicate Minimum

Copayment amount per

item for Medicarecovered Diabetes

Supplies:

Indicate Maximum

\$0.00

\$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Minimum

\$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or







Inserts:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Do you limit Diabetic Yes Supplies and Services to those from specified manufacturers?

Is authorization

No

required?

#### SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-No specific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Yes

Is there an enrollee Copayment?

Indicate Minimum

\$0.00

Copayment amount per session for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per session for Medicarecovered Benefits:

# SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

No

required?

Is a referral required for Dialysis Services?

No

## SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?

## **SECTION B: #13B OTC ITEMS - BASE 1**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Select type of benefit

for OTC Items:

Mandatory

Is there a service-

Yes

specific Maximum Plan Benefit Coverage

amount? Indicate Maximum

Plan Benefit Coverage

15.00

amount:

Select Maximum Plan

Every three months

Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage No



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amount carry forward to the next period if it

is unused?

Is there a servicespecific Maximum Enrollee Out-of-Pocket

·Cost?

Are you offering

Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement

Therapy (NRT)

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or

formulary drugs.

Attestation:

# SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

No

Yes

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

No No

Does this cover all of

the OTC list which may be found in Chapter 4 of the

Medicare Managed

Care Manual?

#### **SECTION B: #13B OTC ITEMS - BASE 3**

Notes:

The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

### **SECTION B: #13C MEAL BENEFIT - BASE 1**

Does the plan provide

a limited duration Meal

Benefit as a supplemental benefit under Part C? Note: Only primarily healthrelated meals offered in accordance with Chapter 4 of the MMCM should be

entered in this section.

Select type of benefit

for Meals:

Mandatory

How many days does your Meal Benefit last?

20

What is the maximum number of meals the

40

benefit provides? Is there a service-

No

specific Maximum Plan Benefit Coverage

amount?

No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

# SECTION B: #13C MEAL BENEFIT - BASE 2

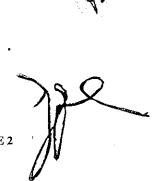
Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?





Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required

No

for the Meal Benefit?

#### SECTION B: #13C MEAL BENEFIT - BASE 3

Up to 10 meals over 5 days after an overnight stay in a hospital or nursing facility, limited to 4 times per

# SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero **Dollar Preventive** 

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Services Attestation

Is authorization

No

required?

Is a referral required? No

## SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide

the Annual Physical

Exam as a

supplemental benefit

under Part C? Select type of benefit

Mandatory

for the Annual

Physical Exam:

Is there a service-

No

specific Maximum

Plan Benefit Coverage

amount?

No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

### SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

\$0.00

Copayment?

Indicate Minimum Copayment amount for

each Annual Physical

Exam:

Exam:

Notes:

Indicate Maximum

Copayment amount for

each Annual Physical

\$0.00

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization

required?

No

Is a referral required for the Annual

No

Physical Exam?

An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the

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following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide

Other Defined

Supplemental Benefits

as a benefit under Part

Select enhanced

: Additional Sessions of Smoking and Tobacco Cessation Counseling : Fitness Benefit\*

Mandatory

benefit (Select all that

apply):

: Bathroom Safety Devices\*

: Medical Nutrition Therapy (MNT)

: Wigs for Hair Loss Related to Chemotherapy

Select type of benefit

for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in

addition to Medicare:

for Fitness Benefit:

Select type of benefit Mandatory

Select type of benefit

Mandatory

Yes

Hours

Yes

Visits

Mandatory

for Bathroom Safety

Devices:

# SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit

for Medical Nutrition Therapy (MNT):

Do you offer

Additional Sessions for

Medicare-covered

diseases?

Indicate the limit for

Additional Sessions:

Indicate numerical limit on the services

provided for

Additional Sessions:

Do you offer Coverage

for Non-Medicarecovered diseases? (Specify the diseases and describe the coverage in the notes

field)

Indicate units a limit will be provided in for

Coverage for Non-Medicare covered

diseases:

Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:

Select type of benefit for Wigs for Hair Loss

Related to Chemotherapy: Mandatory





SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

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Is there a service-

Yes

specific Maximum Plan Benefit Coverage amount for Other

Defined Supplemental

Benefits?

Select which Other

: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Indicate Maximum

500.00

Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:

Select Maximum Plan

Every year

Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a servicespecific Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization

Yes

required?

Is a referral required for Other Defined Supplemental Benefits?

No

Additional Sessions of

No authorization required for this service.

Smoking and Tobacco Cessation Counseling Notes:

> SilverSneakers is a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. Partner clubs provide access to an orientation to the facility and equipment along with access to club amenities. In addition, this program includes a specialized at-home package to support fitness and exercise at home for those unable to take a class at the

fitness center. The at home package includes information and tools for the member to exercise in their own home. No authorization required for this service.

Fitness Benefit Notes:\*

The plan will provide 1 bath chair every 5 years. Authorization is required for this service.

Devices Notes:\* Medical Nutrition Therapy (MNT) Notes:

Bathroom Safety

Members with ESRD or Diabetes will receive 1 one-hour session in addition to the Medicare-covered benefit every 12 months. Other conditions may be covered as directed by the physician's discretion and member will receive 4 one-hour sessions every 12 months as medically necessary. No authorization

required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14



SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Wigs for Hair Loss

Authorization is required for this service.

Related to

Chemotherapy Notes:

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization

No

No

required?

Is a referral required No

for Kidney Disease Education Services?

Is there a service-

specific Maximum Enrollee Out-of-Pocket Cost for Other

Medicare-covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there an enrollce

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee

Copayment?

Yes

\$0

\$0

\$0

Select which Services

: Medicare-covered Glaucoma Screening

have a Copayment

: Medicare-covered Diabetes Self-Management Training

(Select all that apply):

: Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams

: Medicare-covered EKG following Welcome Visit

: Other Medicare-covered Preventive Services

Indicate Minimum Copayment amount for Medicare-covered

Glaucoma Screening: Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-





Management Training:	
Indicate Maximum	\$0
Copayment amount for	
Medicare-covered Diabetes Self-	
Management Training:	
Indicate Minimum	\$0
Copayment amount for	Ψυ
Medicare-covered	
Barium Enemas:	_
Indicate Maximum	\$0
Copayment amount for Medicare-covered	
Barium Enemas:	
Indicate Minimum	\$0
Copayment amount for	
Medicare-covered	
Digital Rectal Exams: Indicate Maximum	¢Δ
Copayment amount for	\$0
Medicare-covered	
Digital Rectal Exams:	
Indicate Minimum	\$0
Copayment amount for	
Medicare-covered EKG following	
Welcome Visit:	
Indicate Maximum	\$0
Copayment amount for	
Medicare-covered	
EKG following Welcome Visit:	
Indicate Minimum	\$0
Copayment amount for	•-
Other Medicare-	
covered Preventive Services:	
Indicate Maximum	\$0
Copayment amount for	Ju
Other Medicare-	
covered Preventive	
Services:	NI
Is authorization required for Medicare-	No
covered Glaucoma	
Screening?	
Is authorization	No
required for Medicare-	
covered Diabetes Self- Management Training?	
Is authorization	No
required for Medicare-	
covered Barium	
Enemas?	
Is authorization required for Medicare-	No
covered Digital Rectal	
Exams?	
Is authorization	No
required for Medicare-	
covered EKG following Welcome	
Visit?	
In outhorization	No

No

Is authorization



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required for Other Medicare-covered Preventive Services?

### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required

No

for any Services?

#### SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum

INC

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Coinsurance?

# SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee

Yes

Copayment?

Select which Medicare

: Medicare Part B Chemotherapy Drugs

Part B Rx Drugs have

: Other Medicare Part B Drugs

a Copayment (Select

all that apply):

Indicate Minimum \$0.00

Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum

\$0.00

Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum

\$0.00

Copayment Amount for other Medicare Part

B Drugs:

Indicate Maximum

\$0.00

Copayment Amount for other Medicare Part

B Drugs:

Is there an enrollee

No

Deductible?

Is Authorization

Yes

Yes

Required?

Does the plan offer

step therapy?

Does the benefit step

: Part B to Part B?

from (select all that

apply):

# SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide

Part D home infusion drugs as part of a

bundled service as a

mandatory

supplemental benefit?

# SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

Preventive Dental

Items as a

supplemental benefit under Part C?

Select enhanced

: Oral Exams

benefits:

: Prophylaxis (Cleaning)

Select type of benefit

for Oral Exams:

: Dental X-Rays Mandatory



Is this benefit unlimited for Oral No, indicate number

Exams?

Indicate number of

visits for Oral Exams: Select the Oral Exams

Other, Describe

periodicity:

Select type of benefit for Prophylaxis

Mandatory

3

(Cleaning): Is this benefit

No, indicate number

unlimited for Prophylaxis (Cleaning)?

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Every year

2

2

# SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit

No, indicate number

unlimited for Dental

X-Rays?

Indicate number of

visits for Dental X-

Rays:

Select the Dental X-

Other, Describe

Rays periodicity: Is there a service-

No

specific Maximum Plan Benefit Coverage

amount?

# SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a servicespecific Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Yes

Coinsurance?

: Oral Exams

Select which Preventive Dental

: Prophylaxis (Cleaning) : Dental X-Rays

Services have a Coinsurance (Select all

that apply):

Is there a combination of services included in a single cost per Office

Visit?

Indicate Minimum Coinsurance

percentage for Oral

Exams:

Indicate Maximum Coinsurance

percentage for Oral

Prophylaxis

Exams:

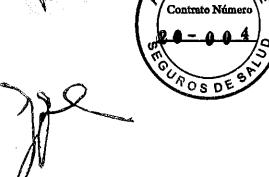
Indicate Minimum Coinsurance percentage for

No



0%

0%



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(Cleaning):

Indicate Maximum

0%

Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum

0%

Coinsurance

percentage for Dental

X-Rays:

Indicate Maximum

0%

Coinsurance

percentage for Dental

X-Rays:

**SECTION B: #16A PREVENTIVE DENTAL - BASE 4** 

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization

No

required?

Is a referral required No

for Preventive Dental

Services?

Notes:

Dental X-Rays include bitewing x-rays up to 1 set(s) every 2 years, panoramic film up to 1 every 3 years.

Oral exams include periodic oral exam up to 2 per year and comprehensive oral evaluation up to 1 every 3

Contrato Número

years.

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Comprehensive Dental

Items as a

benefits:

supplemental benefit under Part C?

Select enhanced

: Restorative Services

: Endodontics

Mandatory

: Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit

for Restorative

Services:

Is this benefit

No, indicate number

unlimited for Restorative Services?

Indicate number of

visits for Restorative

Services:

Other, Describe

Select the Restorative Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit

for Endodontics: Is this benefit

Yes

2

unlimited for **Endodontics?** 

Select type of benefit

Mandatory

Mandatory

for Periodontics: Is this benefit

No, indicate number

unlimited for Periodontics?

Indicate number of





visits for Periodontics:

Select the Periodontics

periodicity:

Every year

Select type of benefit

Mandatory

Mandatory

for Extractions:

Is this benefit unlimited for

Yes

Extractions? Select type of benefit

for Prosthodontics,

Other

Oral/Maxillofacial Surgery, Other Services:

2

Is this benefit unlimited for

No. indicate number

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?

Indicate number of

visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the

Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Plan-specified amount per period

Is there a service-

specific Maximum Plan Benefit Coverage

amount?

Select the Maximum

Plan Benefit Coverage

type:

Indicate Maximum

Plan Benefit Coverage

amount:

500.00

Select the Maximum

Plan Benefit Coverage

periodicity:

Every year

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

No

Coinsurance?

Select which

: Restorative Services

Comprehensive Dental Services have a

: Endodontics : Periodontics : Extractions

Coinsurance (Select all

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

that apply):

0%

Coinsurance percentage for Restorative Services:

Indicate Maximum

Indicate Minimum

Coinsurance

about:blank

50%



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percentage for Restorative Services:

Indicate Minimum

0%

Coinsurance percentage for **Endodontics:** 

Indicate Maximum

0%

Coinsurance percentage for Endodontics:

Indicate Minimum

50%

Coinsurance percentage for Periodontics:

Indicate Maximum Coinsurance

50%

percentage for Periodontics: Indicate Minimum

0%

Coinsurance percentage for Extractions:

Indicate Maximum Coinsurance percentage for

0%

Extractions: Indicate Minimum

50%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum

50%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is there an enrollee

No

Deductible?

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee

Copayment?

Select which

: Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

\$0.00

Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered

Benefits:

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required

No

for Comprehensive

Contrato Número



Dental Services?

Notes:

Endodontics includes root canal up to unlimited per year. Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year. Partial dentures and complete dentures up to 1 set(s) every 5 years. Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 50% up to 1 per tooth every 5 years.

### SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide

Eye Exams as a supplemental benefit under Part C?

Select enhanced

: Routine Eye Exams

benefit:

Select type of benefit for Routine Eye

Mandatory

Yes

Exams:

Is this benefit

No, indicate number

unlimited for Routine

Eye Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye

Every year

t

No

No

Exams periodicity:

Is there a servicespecific Maximum Plan Benefit Coverage

amount? Is there a service-

specific Maximum Enrollee Out-of-Pocket

Cost?

### SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

No Yes

\$0.00

\$0.00

Copayment?

Select which Eye

: Medicare-covered Benefits : Routine Eye Exams

Exams have a

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for

Routine Eye Exams:

Indicate Maximum Copayment amount for

Routine Eye Exams:

Is there an enrollee

\$0.00

\$0.00

No

Deductible?

# SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

No

Is a referral required for Eye Exams?

No







### SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Eyewear as a

supplemental benefit under Part C?

Select enhanced

: Contact lenses benefits: : Eyeglasses (lenses and frames)

Select type of benefit

Mandatory

Every year

Mandatory

Every year

1

No, indicate number

Plan-specified amount per period

No, indicate number

for Contact lenses:

Is this benefit

unlimited for Contact

lenses?

Indicate quantity (number of pairs) for

Contact lenses:

Select Contact lenses

periodicity:

Select type of benefit

for Eyeglasses (lenses

and frames):

Is this benefit

unlimited for Eyeglasses (lenses and

frames)?

Indicate quantity for Eyeglasses (lenses and

frames):

Select Eyeglasses

(lenses and frames)

periodicity:

**SECTION B: #17B EYEWEAR - BASE 3** 

Is there a servicespecific Maximum

Plan Benefit Coverage

amount?

Select the Maximum

Plan Benefit Coverage

type:

Do you offer a

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined

100.00

Every year

Yes

Maximum Plan Benefit Coverage amount:

Select the Combined

Maximum Plan Benefit

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a servicespecific Maximum Énrollee Out-of-Pocket

Is there an enrollee

No

No

Coinsurance?

Cost?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Eyewear

: Medicare-covered Benefits



Benefits have a

: Contact lenses

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

Copayment (Select all

; Eyeglasses (lenses and frames)

that apply):

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for

Contact lenses:

Indicate Maximum Copayment amount for

Contact lenses:

Indicate Minimum

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization

required?

Is a referral required

for Eyewear?

No No

Yes

SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide

Hearing Exams as a supplemental benefit

under Part C?

Select enhanced

: Routine Hearing Exams

No, indicate number

benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing

Exams:

Is this benefit

unlimited for Routine Hearing Exams?

Indicate number for Routine Hearing

Exams:

Select Routine Hearing Exams periodicity:

Select type of benefit for Fitting/Evaluation

for Hearing Aid: Is this benefit

unlimited for

Fitting/Evaluation for Hearing Aid?

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for

Hearing Aid periodicity:

Every year

1

Mandatory

Mandatory

No, indicate number

Every year



# SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-

specific Maximum Plan Benefit Coverage

amount?

Is there an enrollee

No

Deductible?

No

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

Yes

Coinsurance?

# SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Select which Hearing Exam Benefits have a : Medicare-covered Benefits : Routine Hearing Exams

Copayment (Select all

: Fitting/Evaluation for Hearing Aid

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

\$0.00

\$0.00

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

\$0.00

Indicate Minimum Copayment amount for

Routine Hearing

Exams:

Indicate Maximum \$0.00

Copayment amount for

Routine Hearing

Exams:

\$0.00

Indicate Minimum Copayment amount for Fitting/Evaluation for

Hearing Aid:

\$0.00

Indicate Maximum Copayment amount for

Fitting/Evaluation for

Hearing Aid:

No

Is authorization required?

Is a referral required

No

for Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1.

Does the plan provide

Hearing Aids as a supplemental benefit under Part C?

: Hearing Aids (all types)

Select enhanced benefits:

Select type of benefit for Hearing Aids (all

Mandatory

types):

Is this benefit

unlimited for Hearing Aids (all types)?

No, indicate number

Indicate quantity for

2



Hearing Aids (all

types):

Select Hearing Aids

Every year

(all types) periodicity:

**SECTION B: #18B HEARING AIDS - BASE 2** 

Is there a servicespecific Maximum

Ye

Plan Benefit Coverage amount?

Does the Maximum

Both ears combined

Plan Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum

75.00

Plan Benefit Coverage

amount:

Indicate Maximum

Every year

Plan Benefit Coverage

periodicity:

**SECTION B: #18B HEARING AIDS - BASE 3** 

Is there a servicespecific Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

Y

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

Hearing Aid (all

types):

\$0.00

Indicate Maximum Copayment amount per

Hearing Aid (all

types):

Is there an enrollee

No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization

required?

No

Is a referral required

No

for Hearing Aids?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBC1

Does your plan include

MA Uniformity
Flexibility with

reductions in cost or additional benefits?

Do you offer Special No Supplemental Benefits

for the Chronically III?
SECTION C: V/T - GENERAL - US

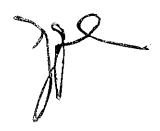
Do you offer a US Visitor/Travel No

Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)







Is there an In-Network

No

Plan Deductible?

### SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network

Maximum Enrollee Out-of-Pocket Cost?

Is your In-Network

Voluntary

Maximum Enrollee Out-of-Pocket

(MOOP) Cost at the Voluntary or Mandatory Level?

3400.00

Indicate In-Network Maximum Enrollee Out-of-Pocket Cost

Amount:

Select the benefits that

: In-Network Medicare-covered benefits

apply to the In-Network Maximum Enrollee Out-of-Pocket

cost:

Does the In-Network

Medicare-covered plan

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network

services?

#### SECTION D: MAX PLAN BENEFIT COVERAGE

Yes

Is there a Maximum

No

Plan Benefit Coverage

Amount?

### SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug (Part D) benefit? Select the type of drug

Defined Standard Benefit

benefit:

Describe the components of your : Standard Retail Cost-Sharing : Out-of-Network Pharmacy : Standard Mail Order Cost-Sharing

network (select all that apply):

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42

: Sponsor attests that it will comply with 42 CFR 423.154.

CFR 423.154.

# SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor

Yes

pricing?

Does plan utilize

Yes

ceiling pricing? Are there quantity

Yes

limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Yes

Will your plan be coverage of drugs to

No

limiting on-formulary certain indications (i.e., are you implementing indication-based formulary design)?





Do any drugs in your

Yes

formulary require a step therapy plan?

Do you pay for Over-

No

the-Counter medications (OTCs)

under the Utilization Management Program?

#### SECTION RX; DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard

: In-Network Retail Pharmacy - one month supply : In-Network Retail Pharmacy - three month supply

Retail Cost-sharing

Location/supply

amount(s) that apply:

Enter number of days for Standard Retail Cost-sharing one

30

month supply: Enter number of days

for Standard Retail Cost-sharing three

90

month supply: Select all Out-of-

: Out-of-Network Pharmacy - one month supply

Network Pharmacy Location/supply amount(s) that apply:

30

Enter number of days for Out-of-Network Pharmacy one month

supply:

Select all Standard Mail Order Cost: Standard Mail Order - one month supply : Standard Mail Order - three month supply

Sharing Location/supply

amount(s) that apply: Enter number of days

30

for Standard Mail Order Cost-Sharing one month supply: Enter number of days

90

for Standard Mail Order Cost-Sharing three month supply:

31

No

No

Select the Long Term Care Pharmacy one

: Long Term Care Pharmacy - one month supply

month Location/supply amount(s) that apply:

Enter number of days for Long Term Care Pharmacy one month supply:

Are all of the drugs on your formulary available with an extended day supply? Are any of the drugs

available at an extended day supply limited to a 1-month supply for the first fill?



