PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 016, 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 Timestamp:	05/30/2019 05:43:56 PM Eastern Daylight Time

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 Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare
Plan Name:	Humana Gold Plus SNP-DE H4007-016 (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):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	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):	40650 - San Lorenzo, PR

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	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
Contract Number:	H4007
Plan ID:	016
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/
Physician Website Address:	www.humana.com/members/tools
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number	(800)681-3625

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

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

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service	(711)-

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

SECTION A: SECTION A-6

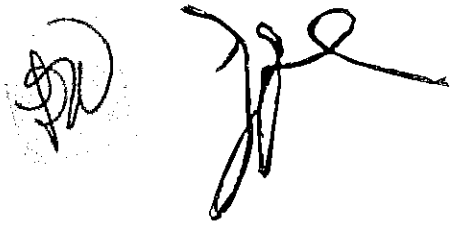
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No



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

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

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

Is there an enrollee Deductible?	No
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.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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?	No

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?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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 amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF	Original Medicare

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

benefit period?	
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

Services:	
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Care/Post-Stabilization Care cost sharing count towards any plan-level deductible?	No

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

Is there a service-specific Maximum	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	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 have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits per day:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	$0.00
Is authorization required?	Yes
Is a referral required for Partial	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Hospitalization?	

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which	: Medicare-covered Chiropractic Services

Chiropractic Services have a Copayment (Select all that apply):	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Select which Podiatry Services have a Copayment (Select all that apply):	: Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

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 Psychiatric Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Psychiatric Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered 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 : 9c1: Individual Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

Is there an enrollee Coinsurance?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

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

Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

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

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

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 Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

that apply):	
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Indicate Maximum	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Copayment amount per visit for Medicare-covered Observation Services:	
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
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 service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services	: Medicare-covered Ground Ambulance Services

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

have a Copayment (Select all that apply):	: Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	48
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

specific Maximum Plan Benefit Coverage amount?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
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?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	$0.00

SECTION B: #11A DME - BASE 2

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

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00

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

Is authorization required?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

Inserts:	
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
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?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

amount carry forward to the next period if it is unused?	
Is there a service-specific 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) 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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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

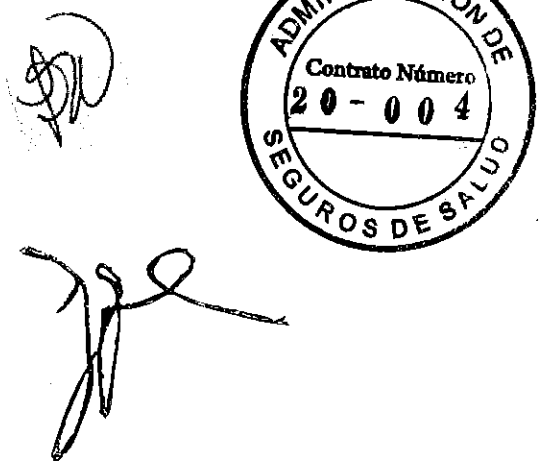
Notes:	The plan will provide $0 copayment for adult diapers box up to one (1) every month. Members who meet medical criteria. Brand according to exclusive contracted DME provider. Quantity varies by size. The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical 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 health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	20
What is the maximum number of meals the benefit provides?	40
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No



Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

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 Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
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?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

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

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
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 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 C?	Yes
Select enhanced benefit (Select all that apply):	: Additional Sessions of Smoking and Tobacco Cessation Counseling : Fitness Benefit* : 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:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Select type of benefit for Bathroom Safety Devices:	Mandatory

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

Select type of benefit for Medical Nutrition Therapy (MNT):	Mandatory
Do you offer Additional Sessions for Medicare-covered diseases?	Yes
Indicate the limit for Additional Sessions:	Hours
Indicate numerical limit on the services provided for Additional Sessions:	1
Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)	Yes
Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:	Visits
Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:	4
Select type of benefit for Wigs for Hair Loss Related to	Mandatory

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

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?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: Wigs for Hair Loss Related to Chemotherapy

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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
Is there an enrollee Copayment?	No

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
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

ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 20-00

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 Related to Chemotherapy Notes:	Authorization is required for this service.

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : 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:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum	$0

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

following Welcome Visit?	
Is authorization required for Other Medicare-covered Preventive Services?	No

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

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?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

	: Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	3
Select the Oral Exams periodicity:	Other, Describe
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
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 unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	2
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Preventive Dental Services have a Copayment (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Oral Exams:	$0.00
Indicate Maximum	$0.00

Copayment amount for Oral Exams:	
Indicate Minimum Copayment amount for Prophylaxis (Cleaning):	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning):	$0.00
Indicate Minimum Copayment amount for Dental X-Rays:	$0.00
Indicate Maximum Copayment amount for Dental X-Rays:	$0.00

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
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 comprchensive oral evaluation up to 1 every 3 years.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	2
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Copayment amount for Medicare-covered	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
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 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 under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory

ADMINISTRACIÓN
Contrato Número
20-004
SEGUROS DE SALUD

Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No

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?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	No, indicate number
Indicate quantity (number of pairs) for Contact lenses:	1
Select Contact lenses	Every year

periodicity:	
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	No, indicate number
Indicate quantity for Eyeglasses (lenses and frames):	1
Select Eyeglasses (lenses and frames) periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

Contact lenses:	
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum 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:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that	: In-Network Medicare-covered benefits

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard Benefit
Describe the components of your network (select all that apply):	: 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.	: 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 ceiling pricing?	Yes
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:	: In-Network Retail Pharmacy - one month supply : In-Network Retail Pharmacy - three month supply
Enter number of days for Standard Retail Cost-sharing one month supply:	30

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

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:	vyqd

PLAN SYSTEM INFORMATION

Last entry Date:	05/30/2019
PBP Software Version:	2020.01
Plan Ready for Upload Timestamp:	05/30/2019 05:50:44 PM Eastern Daylight Time

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 Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
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
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	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):	40650 - San Lorenzo, PR

	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	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
Contract Number:	H4007
Plan ID:	018
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/
Physician Website Address:	www.humana.com/members/tools
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number	(800)681-3625

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
H-0-0-4

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

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service	(711)-

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

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

SECTION A: SECTION A-6

Is your organization 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)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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?	No

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?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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 amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF	Original Medicare

benefit period?	
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Services:	
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Care/Post-Stabilization Care cost sharing count towards any plan-level deductible?	No

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

Is there a service-specific Maximum	No

Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	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 have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits per day:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	$0.00
Is authorization required?	Yes
Is a referral required for Partial	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Hospitalization?	

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which	: Medicare-covered Chiropractic Services

Chiropractic Services have a Copayment (Select all that apply):	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Select which Podiatry Services have a Copayment (Select all that apply):	: Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

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 Psychiatric Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Psychiatric Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered 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 : 9c1: Individual Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

Is there an enrollee Coinsurance?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
2 0 - 0 0 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

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

Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

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

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

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 Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

that apply):	
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Indicate Maximum	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Copayment amount per visit for Medicare-covered Observation Services:	
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
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 service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services	: Medicare-covered Ground Ambulance Services

have a Copayment (Select all that apply):	: Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	36
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: 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-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
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?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	$0.00

SECTION B: #11A DME - BASE 2

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

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00

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

Is authorization required?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

Inserts:	
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
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?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	30.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage	No

amount carry forward to the next period if it is unused?	
Is there a service-specific 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) 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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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 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 health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	20
What is the maximum number of meals the benefit provides?	40
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-009

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

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

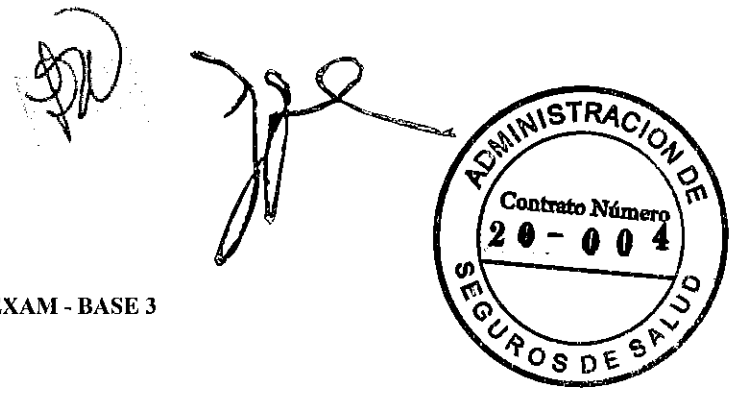
Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00



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

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
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

	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 C?	Yes
Select enhanced benefit (Select all that apply):	: Additional Sessions of Smoking and Tobacco Cessation Counseling : Fitness Benefit* : 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:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Select type of benefit for Bathroom Safety Devices:	Mandatory

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

Select type of benefit for Medical Nutrition Therapy (MNT):	Mandatory
Do you offer Additional Sessions for Medicare-covered diseases?	Yes
Indicate the limit for Additional Sessions:	Hours
Indicate numerical limit on the services provided for Additional Sessions:	1
Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)	Yes
Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:	Visits
Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:	4
Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: Wigs for Hair Loss Related to Chemotherapy

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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
Is there an enrollee Copayment?	No

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-00

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

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : 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:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-	$0

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

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

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

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

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

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?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	3
Select the Oral Exams periodicity:	Other, Describe
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
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 unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	2
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis	0%

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-005

(Cleaning):	
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
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 years.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of	1

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-001

visits for Periodontics:	
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	2
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	: Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance	25%

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

percentage for Restorative Services:	
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	25%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	25%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
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

Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?	No
Is a referral required for Eye Exams?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
H-0004

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	No, indicate number
Indicate quantity (number of pairs) for Contact lenses:	1
Select Contact lenses periodicity:	Every year
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	No, indicate number
Indicate quantity for Eyeglasses (lenses and frames):	1
Select Eyeglasses (lenses and frames) periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear	: Medicare-covered Benefits

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Benefits have a Copayment (Select all that apply):	: Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum 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:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for	2

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Hearing Aids (all types):	
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard Benefit
Describe the components of your network (select all that apply):	: 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.	: 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 ceiling pricing?	Yes
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:	: In-Network Retail Pharmacy - one month supply : In-Network Retail Pharmacy - three month supply
Enter number of days for Standard Retail Cost-sharing one month supply:	30
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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

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 Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare
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):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	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):	40650 - San Lorenzo, PR

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	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
Contract Number:	H4007
Plan ID:	019
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/
Physician Website Address:	www.humana.com/members/tools
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number	(800)681-3625

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

for Prospective Medicare Beneficiaries:	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service	(711)-

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

SECTION A: SECTION A-6

Is your organization 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)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

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

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

Is there an enrollee Deductible?	No
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.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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?	No

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?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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 amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

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

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

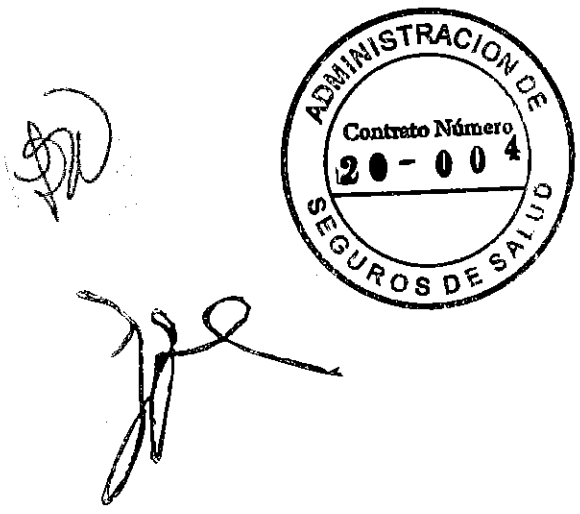
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF	Original Medicare



benefit period?	
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Services:	
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Care/Post-Stabilization Care cost sharing count towards any plan-level deductible?	No

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

Is there a service-specific Maximum	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	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 have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits per day:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	$0.00
Is authorization required?	Yes
Is a referral required for Partial	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Hospitalization?	

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which	: Medicare-covered Chiropractic Services

Chiropractic Services have a Copayment (Select all that apply):	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Select which Podiatry Services have a Copayment (Select all that apply):	: Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

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 Psychiatric Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Psychiatric Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered 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 : 9c1: Individual Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

Is there an enrollee Coinsurance?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

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

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

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 Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services

that apply):	
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Indicate Maximum	$0.00

Copayment amount per visit for Medicare-covered Observation Services:	
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
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 service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

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

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services	: Medicare-covered Ground Ambulance Services

have a Copayment (Select all that apply):	: Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	4
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

specific Maximum Plan Benefit Coverage amount?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
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?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

SECTION B: #11A DME - BASE 2

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00

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

Is authorization required?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or	$0.00

Inserts:	
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
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?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	15.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

amount carry forward to the next period if it is unused?	
Is there a service-specific 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) 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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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 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 health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	20
What is the maximum number of meals the benefit provides?	40
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

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

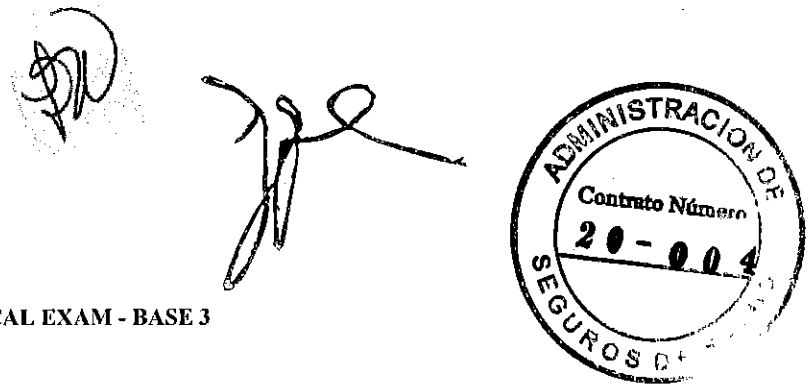
Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00



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

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
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

	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 C?	Yes
Select enhanced benefit (Select all that apply):	: Additional Sessions of Smoking and Tobacco Cessation Counseling : Fitness Benefit* : 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:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Select type of benefit for Bathroom Safety Devices:	Mandatory

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

Select type of benefit for Medical Nutrition Therapy (MNT):	Mandatory
Do you offer Additional Sessions for Medicare-covered diseases?	Yes
Indicate the limit for Additional Sessions:	Hours
Indicate numerical limit on the services provided for Additional Sessions:	1
Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)	Yes
Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:	Visits
Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:	4
Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: Wigs for Hair Loss Related to Chemotherapy

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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
Is there an enrollee Copayment?	No

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
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.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : 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:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-	$0

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

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

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

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

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

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

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?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 20-004

Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	3
Select the Oral Exams periodicity:	Other, Describe
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
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 unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	2
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis	0%

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

(Cleaning):	
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
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 years.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of	1

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

visits for Periodontics:	
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	2
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	: Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance	50%

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

percentage for Restorative Services:	
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	50%
Indicate Maximum Coinsurance percentage for Periodontics:	50%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	50%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	50%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
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 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?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?	No
Is a referral required for Eye Exams?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	No, indicate number
Indicate quantity (number of pairs) for Contact lenses:	1
Select Contact lenses periodicity:	Every year
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	No, indicate number
Indicate quantity for Eyeglasses (lenses and frames):	1
Select Eyeglasses (lenses and frames) periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	100.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear	: Medicare-covered Benefits

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20 - 004

Benefits have a Copayment (Select all that apply):	: Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum 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:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for	2

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Hearing Aids (all types):	
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	75.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard Benefit
Describe the components of your network (select all that apply):	: 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.	: 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 ceiling pricing?	Yes
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004

Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:	: In-Network Retail Pharmacy - one month supply : In-Network Retail Pharmacy - three month supply
Enter number of days for Standard Retail Cost-sharing one month supply:	30
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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
20-004