MEDICARE PLATINO 2021

APPENDIX C (1) (21)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFIT

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 016, SEGMENT 0

Module:	PBP
Requested By:	h6j9

PLAN SYSTEM INFORMATION

Last entry Date:	05/28/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/28/2020 08:55:14 PM Eastern Daylight Time
MA BPT Timestamp:	05/14/2020 09:41:01 AM Eastern Daylight Time
PD BPT Timestamp:	05/08/2020 08:43:14 AM Eastern Daylight Time
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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):	

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	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	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:	2021
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	(800)681-3625

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Contact Phone Number 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 Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-

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	No

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Section C of the PBP?	

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	Zero (No Copayment per Day)

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Lifetime Reserve Days:	

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 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: #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	No

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sharing on the day of discharge?	
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 benefit period?	Original Medicare
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	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Service

Rehabilitation Services have a Copayment (Select all that apply):	: 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 Services:	$0.00
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/POST-STABILIZATION SERVICES - BASE 1

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

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

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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/Post-Stabilization Services cost sharing count towards any plan-level deductible?	No

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

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

Coverage:	
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

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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 Hospitalization?	No

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	$0.00

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visit for Medicare-covered Benefits:	

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a 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 Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
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	No

Coinsurance?	
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: #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

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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
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

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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
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 may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse

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	: 9c2: Group 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
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 PROGRAM 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 PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program 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	Yes

Copayment?	
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
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

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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 Copayment amount per visit for Medicare-covered Observation	$0.00

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

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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 have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : 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	$0.00

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Services:	
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?	Yes
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-specific Maximum Plan Benefit Coverage amount?	No
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

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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

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

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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 Inserts:	$0.00
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

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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 amount carry forward to the next period if it is unused?	No
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

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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. 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	Yes

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.	
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	28
What is the maximum number of meals the benefit provides?	56
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 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Care Package
Select type of benefit for Other 2:	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: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

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SECTION B: #13E OTHER 2 - BASE 3

Notes:	No cost share for respiratory care kit (limit one per year), 14 days of meals (28 meals) for members with

	COVID-19 diagnosis, and COVID related treatment. Treatment will include 1a Inpatient Hospital Acute, 1b Inpatient Hospital Psychiatric, 2 SNF, 3 Cardiac and Pulmonary Rehabilitation Services, 4a Emergency/Post-Stabilization Services, 4b urgently Needed Services, 4c Worldwide Emergency/Urgent Coverage, 5 Partial Hospitalization, 6 Home Health Services, 7a Primary Care Physician Services, 7b Chiropractic Services, 7c Occupational Therapy Services, 7d Physician specialist Services, 7e Mental Health Specialty, 7f Podiatry Services, 7g Other Health Care Professional, 7h Psychiatric Services, 7i PT and SP Services, 7k Opioid Treatment Program Services, 8a Outpatient Diagnostic Procs/Tests/Lab Services, 8b Outpatient Diag/Therapeutic Rad Services, 9a Outpatient Hospital Services, 9b ASC Services, 9c Outpatient Substance Abuse, 10a Ambulance Services, 11a DME, 11b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX Drugs, Part D Prescription Drugs

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	Yes

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a benefit under Part C?	
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: 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
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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):	: 14c15: 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

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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:*	Fitness benefit includes 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. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is 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	: Medicare-covered Glaucoma Screening

have a Copayment (Select all that apply):	: 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-Management Training:	$0
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 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/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation 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	No

benefit?

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
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:	8
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%

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(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 visits for Periodontics:	1
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	Mandatory

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Oral/Maxillofacial Surgery, Other Services:	
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:	3
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:	2500.00
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 percentage for Restorative Services:	0%
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:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
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 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 amalgam or composite filling 0% up to 1 every 3 years, crown 0% 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

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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 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	Yes

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Benefit Coverage Amount for all Eyewear?	
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 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

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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	Yes

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supplemental benefit under Part C?	
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?	Yes
Select what type of benefit your SSBCI	: Reduced Cost Sharing : Additional Benefits

includes:	
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Other Program
Specify Other Program:	Advance Care Planning
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	4572

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost sharing for this package?	Yes

Which prerequisites are required for this package?	: Participation in a Care Management Program
Select the benefits that apply to reduced cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Does your VBID/MA Uniformity Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist Services?	All specialists
Select the Non-Medicare-covered benefits that will receive reduced cost sharing:	: 18b1: Hearing Aids (all types)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?	Yes
Select the types of benefits that apply to the copayment cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select all the Medicare-covered benefits that will receive reduced Copayment:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Select all the Non-Medicare-covered benefits that will receive reduced Copayment:	: 18b1: Hearing Aids (all types)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 11 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for Pulmonary Rehabilitation Services	$0.00

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Indicate Maximum Copayment for Pulmonary Rehabilitation Services	$0.00
Indicate Minimum Copayment for SET for PAD Services	$0.00
Indicate Maximum Copayment for SET for PAD Services	$0.00
Indicate Minimum Copayment for Urgently Needed Services	$0.00
Indicate Maximum Copayment for Urgently Needed Services	$0.00
Indicate Minimum Copayment for Chiropractic Services	$0.00
Indicate Maximum Copayment for Chiropractic Services	$0.00
Indicate Minimum Copayment for Occupational Therapy Services	$0.00
Indicate Maximum Copayment for Occupational Therapy Services	$0.00
Indicate Minimum Copayment for Physician Specialist Services	$0.00
Indicate Maximum Copayment for Physician Specialist Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum Copayment for Individual Sessions for Mental Health Specialty Services	$0.00
Indicate Minimum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Minimum Copayment for Podiatry Services	$0.00
Indicate Maximum Copayment for Podiatry Services	$0.00
Indicate Minimum Copayment for	$0.00

Individual Sessions for Psychiatric Services	
Indicate Maximum Copayment for Individual Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Maximum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Maximum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Minimum Copayment for Opioid Treatment Program Services	$0.00
Indicate Maximum Copayment for Opioid Treatment Program Services	$0.00
Indicate Minimum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Maximum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Minimum Copayment for Lab Services	$0.00
Indicate Maximum Copayment for Lab Services	$0.00
Indicate Minimum Copayment for Diagnostic Radiological Services	$0.00
Indicate Maximum Copayment for Diagnostic Radiological Services	$0.00
Indicate Minimum Copayment for Therapeutic Radiological Services	$0.00
Indicate Maximum Copayment for Therapeutic Radiological Services	$0.00
Indicate Minimum Copayment for	$0.00

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Outpatient X-Ray Services	
Indicate Maximum Copayment for Outpatient X-Ray Services	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 12 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Outpatient Hospital Services	$0.00
Indicate Maximum Copayment for Outpatient Hospital Services	$0.00
Indicate Minimum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Maximum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum Copayment for Durable Medical Equipment (DME)	$0.00
Indicate Maximum Copayment for Durable Medical Equipment (DME)	$0.00
Indicate Minimum Copayment for Prosthetic Devices	$0.00
Indicate Maximum Copayment for Prosthetic Devices	$0.00
Indicate Minimum Copayment for Medical Supplies	$0.00
Indicate Maximum Copayment for Medical Supplies	$0.00
Indicate Minimum Copayment for Diabetic Supplies	$0.00

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Indicate Maximum Copayment for Diabetic Supplies	$0.00
Indicate Minimum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Maximum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Minimum Copayment for Dialysis Services	$0.00
Indicate Maximum Copayment for Dialysis Services	$0.00
Indicate Minimum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Maximum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Minimum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Maximum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Minimum Copayment for Comprehensive Dental	$0.00
Indicate Maximum Copayment for Comprehensive Dental	$0.00
Indicate Minimum Copayment for Eye Exams	$0.00
Indicate Maximum Copayment for Eye Exams	$0.00
Indicate Minimum Copayment for Eyewear	$0.00
Indicate Maximum Copayment for Eyewear	$0.00
Indicate Minimum Copayment for Hearing Exams	$0.00
Indicate Maximum Copayment for Hearing Exams	$0.00

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 14 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Hearing Aids (all types)	$0.00
Indicate Maximum Copayment for Hearing Aids (all types)	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (RETROACTIVE REIMBURSEMENT):

PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum aggregate amount of reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	500.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situations. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: LIS Level 1 : LIS Level 2 : LIS Level 3 : LIS Level 4
Expected Number of Enrollees to be Targeted:	4572
Expected Number of Enrollees to be engaged and receive Model benefits:	3200

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No

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Is there a maximum benefit amount?	Yes
Specify the maximum benefit amount:	25.00

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Providing a restricted spend debit card to all LIS members to help bridge the gap between a member's fixed-income budget and what they need to afford adequate healthy food. Restricted items include: pet food, alcohol, tobacco or vaping products, household, cleaning or personal health items, over the counter health items, and lottery or any gaming tickets.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Foods Card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	25.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$25.00 per month loaded to a card for members to purchase healthy food.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 10b: Transportation Services : 13b: Over-the-Counter (OTC) Items : 13c: Meal Benefit : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 14c: Other Defined Supplemental Benefits : 16a: Preventive Dental : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18b: Hearing Aids

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE):

PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situation. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 1: PACKAGE #2

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?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 2: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 3: PACKAGE #2

Is there an enrollee Copayment?	No
Is authorization required?	Yes

Is a referral required for Transportation Services?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #2

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:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
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: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #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?	Yes

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as assistance with purchasing additional over-the-counter (OTC) items. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 1: PACKAGE #2

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?	84
What is the maximum number of meals the	168

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benefit provides?	
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: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 3: PACKAGE #2

Notes:	Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, who participate with Humana's Care Management Services, and who have had an inpatient hospital or skilled nursing facility stay within the last 30 days may receive 2 meals per day for 12 weeks, a total of 168 meals for each chronic condition. Additional 12 weeks of meals if member screens positive for food insecurity. Benefits are not included in the $500 Maximum Plan Benefit Coverage amount.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #2

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Transportation for Non-Medical Needs : Indoor Air Quality Equipment and Services : Social Needs Benefit : Complementary Therapies : Services Supporting Self-Direction : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

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

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Is authorization required?	Yes
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as food and produce. This may include, but is not limited to, produce and frozen meals delivered to the members home. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
How many days do your Meals (beyond limited basis) last?	50
What is the maximum number of meals the benefit provides?	150
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meals (beyond limited basis)?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as meals (beyond a limited basis). This may include providing additional home-delivered meals, beyond primarily health-related plan benefits, to chronically ill members screening positively for food insecurity. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit	Yes

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

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as pest control services for those members whose living environment has become unhealthy and jeopardizes the welfare and safety of member due to pest investation. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #2

Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan-approved Location
Select type of benefit for Plan-approved Location:	Mandatory
Is this benefit unlimited for number of trips for Plan-approved Location?	Yes
Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	One-way
Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee	No

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Coinsurance?	
Is there an enrollee Deductible?	No

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation for Non-Medical Needs?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as non-medically related transportation to locations such as the grocery store, bank, or other non-medical locations. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 1: PACKAGE #2

Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
Select type of benefit for Indoor Air Quality Equipment and Services:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Indoor Air Quality Equipment and Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as indoor air quality equipment and services. This may include, but is not limited to, providing humidifiers, dehumidifiers, or portable air conditioning units to help improve members living environment and overall health. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific	Yes

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

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as social needs benefits. This may include, but is not limited to, connecting members to available community resources and programs to address member isolation and improve mental and emotional health. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 1: PACKAGE #2

Does the plan provide Complementary Therapies as a supplemental benefit under Part C?	Yes
Select type of benefit for Complementary Therapies:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Complementary Therapies?	No

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as complimentary therapies offered inconjunction with traditional medical treatment. Services would be provided by licensed or certified practitioners. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #131 SERVICES SUPPORTING SELF-DIRECTION - BASE 1: PACKAGE #2

Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?	Yes
Select type of benefit for Services Supporting Self-Direction:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #131 SERVICES SUPPORTING SELF-DIRECTION - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Services Supporting Self-Direction?	No

SECTION B: VBID/UF/SSBCI 19B #131 SERVICES SUPPORTING SELF-DIRECTION - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as services supporting self-direction. This may include, but is not limited to, services that would assist members with managing his/her healthcare decisions and decision-making process. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-	No

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of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as general supports for living. This may include, but is not limited to, long term care services to assist member back to home. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #2

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):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	500.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every year

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #2

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #2

Home and Bathroom Safety Devices and Modifications Notes:*	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as fall prevention and safety equipment. This may include, but is not limited to, grab bars, bathtub and toilet safety rails or handles. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 1: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 2: PACKAGE #2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 3: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 4: PACKAGE #2

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

Copayment?	

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 5: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Preventive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for preventive dental services under SSBCI. This includes preventtive services such as oral exams, cleaning, fluoride treatment and dental x-rays. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 1: PACKAGE #2

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 2: PACKAGE #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?	Yes
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?	Yes

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SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 3: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum	Plan-specified amount per period

Plan Benefit Coverage type:	
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: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 5: PACKAGE #2

Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 6: PACKAGE #2

Is authorization required?.	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for comprehensive dental services under SSBCI. This includes, but is not limited to, non-reoutine services, diagnostic and restorative services, and extractions. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 1: PACKAGE #2

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?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
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

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SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 2: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 3: PACKAGE #2

Is authorization required?	Yes

Is a referral required for Eye Exams?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for routine eye exams under SSBCI. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 1: PACKAGE #2

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 2: PACKAGE #2

Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 3: PACKAGE #2

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: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 5: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 6: PACKAGE #2

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Is authorization required?	Yes
Is a referral required for Eyewear?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for eyewear under SSBCI. This includes contact lenses, eyeglasses (lenses and frames). Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 1: PACKAGE #2

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)?	Yes

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 2: PACKAGE #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:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 3: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 5: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Hearing Aids?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for hearing aids through SSBCI. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

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)

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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 D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	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
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
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	No

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formulary design)?	
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:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-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 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount (s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-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

SECTION RX: MEDICARE RX - NOTES

Notes:	$0 cost sharing on Part D covered drugs for the treatment of COVID 19 for members with a COVID 19 diagnosis for the full contract year.

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the	No

model?

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 018, SEGMENT 0

Module:	PBP
Requested By:	h6j9

PLAN SYSTEM INFORMATION

Last entry Date:	05/28/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/28/2020 08:56:16 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
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	

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	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:	2021
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 for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone	(800)681-3625

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Number for Prospective Medicare Beneficiaries:	
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 Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-

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

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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 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: #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	No

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Hospital Services?	

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 benefit period?	Original Medicare
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-	$0.00

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covered Cardiac Rehabilitation Services:	
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 Services:	$0.00
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/POST-STABILIZATION SERVICES - BASE 1

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

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

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

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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/Post-Stabilization Services cost sharing count towards any plan-level deductible?	No

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

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

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Transportation:	
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

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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 Hospitalization?	No

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	No

a supplemental benefit under Part C?	
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 Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
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

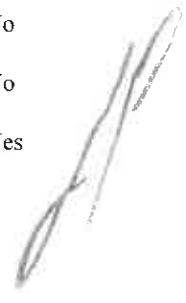
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit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

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	No

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Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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	$0.00

Copayment amount for Medicare-covered Individual Sessions:	
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 may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abus : 9c2: Group Sessions for Outpatient Substance Abus
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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: #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 PROGRAM 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 PROGRAM SERVICES - BASE 2

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

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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
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 Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes

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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
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	$0.00

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Copayment amount for Medicare-covered Group Sessions:	

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 have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : 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

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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-specific Maximum Plan Benefit Coverage amount?	No
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

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

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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 Inserts:	$0.00
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-	$0.00

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covered Benefits:

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 amount carry forward to the next period if it is unused?	No
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

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

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a	Yes

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.	
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	28
What is the maximum number of meals the benefit provides?	56
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 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Care Package
Select type of benefit for Other 2:	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: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

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SECTION B: #13E OTHER 2 - BASE 3

Notes:	No cost share for respiratory care kit (limit one per year), 14 days of meals (28 meals) for members with COVID-19 diagnosis, and COVID related treatment. Treatment will include 1a Inpatient Hospital Acute, 1b Inpatient Hospital Psychiatric, 2 SNF, 3 Cardiac and Pulmonary Rehabilitation Services, 4a Emergency/Post-Stabilization Services, 4b urgently Needed Services, 4c Worldwide Emergency/Urgent Coverage, 5 Partial Hospitalization, 6 Home Health Services, 7a Primary Care Physician Services, 7b Chiropractic Services, 7c Occupational Therapy Services, 7d Physician specialist Services, 7e Mental Health Specialty, 7f Podiatry Services, 7g Other Health Care Professional, 7h Psychiatric Services, 7i PT and SP Services, 7k Opioid Treatment Program Services, 8a Outpatient Diagnostic Procs/Tests/Lab Services, 8b Outpatient Diag/Therapeutic Rad Services, 9a Outpatient Hospital Services, 9b ASC Services, 9c Outpatient Substance Abuse, 10a Ambulance Services, 11a DME, 11b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX Drugs, Part D Prescription Drugs

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

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

Does the plan provide	Yes

Other Defined Supplemental Benefits as a benefit under Part C?	
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: 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
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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):	: 14c15: 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:*	Fitness benefit includes 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. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is 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	Yes

Copayment?	
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-Management Training:	$0
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	No

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Diabetes Self-Management Training?	
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 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/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation 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	No

bundled service as a mandatory supplemental benefit?	

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : 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:	8
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	0%

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Coinsurance percentage for Prophylaxis (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 and intraoral x-rays up to 6 per year. 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 visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes

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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:	3
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 percentage for Restorative Services:	25%
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	0%

Coinsurance percentage for Extractions:	
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 Dental Services?	No
Notes:	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, and bridges up to 1 every 5 years. Restorative services include amalgam or composite filling 0% up to 1 per tooth every 3 years, and 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	No

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Coinsurance?	
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 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	Yes

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Combined Max Plan Benefit Coverage Amount for all Eyewear?	
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 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 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	Yes

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supplemental benefit under Part C?	
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:	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?	Yes
Select what type of benefit your SSBCI	: Reduced Cost Sharing : Additional Benefits

includes:

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost sharing for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select the benefits that apply to reduced cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Does your VBID/MA	All specialists

Uniformity Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist Services?	
Select the Non-Medicare-covered benefits that will receive reduced cost sharing:	: 18b1: Hearing Aids (all types)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?	Yes
Select the types of benefits that apply to the copayment cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select all the Medicare-covered benefits that will receive reduced Copayment:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Select all the Non-	: 18b1: Hearing Aids (all types)

Medicare-covered benefits that will receive reduced Copayment:	

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 11 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for Pulmonary Rehabilitation Services	$0.00
Indicate Maximum Copayment for Pulmonary Rehabilitation Services	$0.00
Indicate Minimum Copayment for SET for PAD Services	$0.00
Indicate Maximum Copayment for SET for PAD Services	$0.00
Indicate Minimum Copayment for Urgently Needed Services	$0.00
Indicate Maximum Copayment for Urgently Needed Services	$0.00
Indicate Minimum Copayment for Chiropractic Services	$0.00
Indicate Maximum Copayment for Chiropractic Services	$0.00
Indicate Minimum Copayment for Occupational Therapy Services	$0.00
Indicate Maximum Copayment for Occupational Therapy Services	$0.00
Indicate Minimum Copayment for Physician Specialist Services	$0.00
Indicate Maximum Copayment for Physician Specialist Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum	$0.00

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Copayment for Individual Sessions for Mental Health Specialty Services	
Indicate Minimum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Minimum Copayment for Podiatry Services	$0.00
Indicate Maximum Copayment for Podiatry Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Psychiatric Services	$0.00
Indicate Maximum Copayment for Individual Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Maximum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Maximum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Minimum Copayment for Opioid Treatment Program Services	$0.00
Indicate Maximum Copayment for Opioid Treatment Program Services	$0.00
Indicate Minimum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Maximum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Minimum Copayment for Lab	$0.00

Services	
Indicate Maximum Copayment for Lab Services	$0.00
Indicate Minimum Copayment for Diagnostic Radiological Services	$0.00
Indicate Maximum Copayment for Diagnostic Radiological Services	$0.00
Indicate Minimum Copayment for Therapeutic Radiological Services	$0.00
Indicate Maximum Copayment for Therapeutic Radiological Services	$0.00
Indicate Minimum Copayment for Outpatient X-Ray Services	$0.00
Indicate Maximum Copayment for Outpatient X-Ray Services	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 12 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Outpatient Hospital Services	$0.00
Indicate Maximum Copayment for Outpatient Hospital Services	$0.00
Indicate Minimum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Maximum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum	$0.00

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Copayment for Durable Medical Equipment (DME)	
Indicate Maximum Copayment for Durable Medical Equipment (DME)	$0.00
Indicate Minimum Copayment for Prosthetic Devices	$0.00
Indicate Maximum Copayment for Prosthetic Devices	$0.00
Indicate Minimum Copayment for Medical Supplies	$0.00
Indicate Maximum Copayment for Medical Supplies	$0.00
Indicate Minimum Copayment for Diabetic Supplies	$0.00
Indicate Maximum Copayment for Diabetic Supplies	$0.00
Indicate Minimum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Maximum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Minimum Copayment for Dialysis Services	$0.00
Indicate Maximum Copayment for Dialysis Services	$0.00
Indicate Minimum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Maximum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Minimum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Maximum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Minimum Copayment for Comprehensive Dental	$0.00
Indicate Maximum Copayment for Comprehensive Dental	$0.00
Indicate Minimum Copayment for Eye Exams	$0.00

Indicate Maximum Copayment for Eye Exams	$0.00
Indicate Minimum Copayment for Eyewear	$0.00
Indicate Maximum Copayment for Eyewear	$0.00
Indicate Minimum Copayment for Hearing Exams	$0.00
Indicate Maximum Copayment for Hearing Exams	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 14 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Hearing Aids (all types)	$0.00
Indicate Maximum Copayment for Hearing Aids (all types)	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum aggregate amount of reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	500.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situations. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 10b: Transportation Services : 13b: Over-the-Counter (OTC) Items : 13c: Meal Benefit : 13i: Non-Primarily Health Related Benefits for the Chronically Ill

: 14c: Other Defined Supplemental Benefits
: 16a: Preventive Dental
: 16b: Comprehensive Dental
: 17a: Eye Exams
: 17b: Eyewear
: 18b: Hearing Aids

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situation. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 1: PACKAGE #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?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 2: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee	No

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Deductible?	

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 3: PACKAGE #1

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #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:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
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: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

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?	Yes

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as assistance with purchasing additional over-the-counter (OTC) items. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 1: PACKAGE #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

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Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	84
What is the maximum number of meals the benefit provides?	168
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: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 3: PACKAGE #1

Notes:	Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, who participate with Humana's Care Management Services, and who have had an inpatient hospital or skilled nursing facility stay within the last 30 days may receive 2 meals per day for 12 weeks, a total of 168 meals for each chronic condition. Additional 12 weeks of meals if member screens positive for food insecurity. This benefit does not apply to the $1,000 Maximum Plan Benefit Coverage amount.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Transportation for Non-Medical Needs : Indoor Air Quality Equipment and Services : Social Needs Benefit : Complementary Therapies : Services Supporting Self-Direction : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee	No

Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as food and produce. This may include, but is not limited to, produce and frozen meals delivered to the members home. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization. Eligible members will receive a $40 monthly debit card allowance for purchase of healthy food.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
How many days do your Meals (beyond limited basis) last?	50
What is the maximum number of meals the benefit provides?	150
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meals (beyond limited basis)?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as meals (beyond a limited basis). This may include providing additional home-delivered meals, beyond primarily health-related plan benefits, to chronically ill members screening positively for food insecurity. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a	Yes

supplemental benefit under Part C?	
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as pest control services for those members whose living environment has become unhealthy and jeopardizes the welfare and safety of member due to pest investation. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan-approved Location
Select type of benefit for Plan-approved Location:	Mandatory
Is this benefit unlimited for number of trips for Plan-approved Location?	Yes
Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	One-way
Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

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SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan	Every year

Benefit Coverage periodicity:	
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: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation for Non-Medical Needs?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as non-medically related transportation to locations such as the grocery store, bank, or other non-medical locations. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization. Eligible members may receive non-medical related transportation 36 one-way trips. For locations such as the bank, supermarket, church, pharmacy not limited to a same day appointment. This benefit is not included in the $1,000 Maximum Plan Benefit Coverage Amount.

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 1: PACKAGE #1

Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
Select type of benefit for Indoor Air Quality Equipment and Services:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Indoor Air Quality Equipment and Services?	No

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SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as indoor air quality equipment and services. This may include, but is not limited to, providing humidifiers, dehumidifiers, or portable air conditioning units to help improve members living environment and overall health. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as social needs benefits. This may include, but is not limited to, connecting members to available community resources and programs to address member isolation and improve mental and emotional health. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 1: PACKAGE #1

Does the plan provide Complementary Therapies as a supplemental benefit under Part C?	Yes
Select type of benefit for Complementary Therapies:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 2: PACKAGE #1

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

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Complementary Therapies?	No

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as complimentary therapies offered inconjunction with traditional medical treatment. Services would be provided by licensed or certified practitioners. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 1: PACKAGE #1

Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?	Yes
Select type of benefit for Services Supporting Self-Direction:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Services Supporting Self-Direction?	No

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as services supporting self-direction. This may include, but is not limited to, services that would assist members with managing his/her healthcare decisions and decision-making process. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #1

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit	Yes

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Coverage amount?	
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as general supports for living. This may include, but is not limited to, long term care services to assist member back to home. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization. Eligible members will receive a $40 monthly debit card allowance to help make utility payments (electricity, water, telephone, high speed internet, and/or cable).

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

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):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	1000.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety	Every year

Devices and Modifications:	

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as fall prevention and safety equipment. This may include, but is not limited to, grab bars, bathtub and toilet safety rails or handles. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 1: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 2: PACKAGE #1

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage	Every year

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periodicity:

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 3: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 4: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 5: PACKAGE #1

Is authorization required?	Yes
Is a referral required for Preventive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for preventive dental services under SSBCI. This includes preventtive services such as oral exams, cleaning, fluoride treatment and dental x-rays. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 1: PACKAGE #1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 2: PACKAGE #1

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?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other	Mandatory

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

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 3: PACKAGE #1

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:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 4: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 5: PACKAGE #1

Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 6: PACKAGE #1

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for comprehensive dental services under SSBCI. This includes, but is not limited to, non-reoutine services, diagnostic and restorative services, and extractions. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 1: PACKAGE #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?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
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-	No

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of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 2: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 3: PACKAGE #1

Is authorization required?	Yes
Is a referral required for Eye Exams?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for routine eye exams under SSBCI. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 1: PACKAGE #1

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 2: PACKAGE #1

Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 3: PACKAGE #1

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

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SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 4: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 5: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 6: PACKAGE #1

Is authorization required?	Yes
Is a referral required for Eyewear?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for eyewear under SSBCI. This includes contact lenses, eyeglasses (lenses and frames). Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 1: PACKAGE #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)?	Yes

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 2: PACKAGE #1

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:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

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SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 3: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 4: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 5: PACKAGE #1

Is authorization required?	Yes
Is a referral required for	No

Hearing Aids?	
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for hearing aids through SSBCI. Benefits are limited to $1,000 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

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 D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	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
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
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

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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:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-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 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount (s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No

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Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: MEDICARE RX - NOTES

Notes:	$0 cost sharing on Part D covered drugs for the treatment of COVID 19 for members with a COVID 19 diagnosis for the full contract year.

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 019, SEGMENT 0

Module:	PBP
Requested By:	h6j9

PLAN SYSTEM INFORMATION

Last entry Date:	05/28/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/28/2020 08:57:01 PM Eastern Daylight Time
MA BPT Timestamp:	05/14/2020 09:42:41 AM Eastern Daylight Time
PD BPT Timestamp:	05/08/2020 08:43:36 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	05/18/2020 12:11:49 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):	

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	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	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:	2021
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	(800)681-3625

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Contact Phone Number 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 Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-

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	No

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Section C of the PBP?	

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	Zero (No Copayment per Day)

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Lifetime Reserve Days:	

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 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: #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	No

sharing on the day of discharge?	
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 benefit period?	Original Medicare
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	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services have a Copayment (Select all that apply):	: 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 Services:	$0.00
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/POST-STABILIZATION SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY/POST-STABILIZATION 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
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/Post-Stabilization Services cost sharing count towards any plan-level deductible?	No

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

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

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Coverage:	
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

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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 Hospitalization?	No

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	$0.00

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visit for Medicare-covered Benefits:	

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a 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 Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
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	No

Coinsurance?	
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: #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
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
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 may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse

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	: 9c2: Group 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
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 PROGRAM 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 PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program 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	Yes

Copayment?	
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
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

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 Copayment amount per visit for Medicare-covered Observation	$0.00

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

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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 have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : 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	$0.00

Services:	
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:	24
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-specific Maximum Plan Benefit Coverage amount?	No
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

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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

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	$0.00

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Copayment amount per item for Medicare-covered Medical Supplies:	

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 Inserts:	$0.00
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-	$0.00

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covered Benefits:	
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 amount carry forward to the next period if it is unused?	No
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

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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?	28
What is the maximum number of meals the benefit provides?	56
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 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Care Package
Select type of benefit for Other 2:	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: #13E OTHER 2 - BASE 2

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

Is a referral required for Other Services?	No

SECTION B: #13E OTHER 2 - BASE 3

Notes:	No cost share for respiratory care kit (limit one per year), 14 days of meals (28 meals) for members with COVID-19 diagnosis, and COVID related treatment. Treatment will include 1a Inpatient Hospital Acute, 1b Inpatient Hospital Psychiatric, 2 SNF, 3 Cardiac and Pulmonary Rehabilitation Services, 4a Emergency/Post-Stabilization Services, 4b urgently Needed Services, 4c Worldwide Emergency/Urgent Coverage, 5 Partial Hospitalization, 6 Home Health Services, 7a Primary Care Physician Services, 7b Chiropractic Services, 7c Occupational Therapy Services, 7d Physician specialist Services, 7e Mental Health Specialty, 7f Podiatry Services, 7g Other Health Care Professional, 7h Psychiatric Services, 7i PT and SP Services, 7k Opioid Treatment Program Services, 8a Outpatient Diagnostic Procs/Tests/Lab Services, 8b Outpatient Diag/Therapeutic Rad Services, 9a Outpatient Hospital Services, 9b ASC Services, 9c Outpatient Substance Abuse, 10a Ambulance Services, 11a DME, 11b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX Drugs, Part D Prescription Drugs

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):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: 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
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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):	: 14c15: 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:*	Fitness benefit includes 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. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is 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

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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-Management Training:	$0
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

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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 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/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation 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	No

Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : 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:	8
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	0%

for Oral Exams:	
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
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 visits for Periodontics:	1
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:	3
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 percentage for Restorative Services:	50%
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	0%

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for Extractions:	
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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	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, bridges up to 1 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

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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 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	Plan-specified amount per period

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type:	
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	400.00
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 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 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?	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	Yes

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for the Chronically Ill?	
Select what type of benefit your SSBCI includes:	: Reduced Cost Sharing : Additional Benefits
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Other Program
Specify Other Program:	Advance Care Planning
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	4572

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost sharing for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select the benefits that apply to reduced cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Does your VBID/MA Uniformity Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist Services?	All specialists
Select the Non-Medicare-covered benefits that will receive reduced cost sharing:	: 18b1: Hearing Aids (all types)

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?	Yes
Select the types of benefits that apply to the copayment cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select all the Medicare-covered benefits that will receive reduced Copayment:	: 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services : 3-4: SET for PAD Services : 4b: Urgently Needed Services : 7b: Chiropractic Services : 7c: Occupational Therapy Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7f: Podiatry Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 7i: Physical Therapy and Speech-Language Pathology Services : 7k: Opioid Treatment Program Services : 8a1: Diagnostic Procedures/Tests : 8a2: Lab Services : 8b1: Diagnostic Radiological Services : 8b2: Therapeutic Radiological Services : 8b3: Outpatient X-Ray Services : 9a1: Outpatient Hospital Services : 9b: Ambulatory Surgical Center (ASC) Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies : 11c1: Diabetic Supplies : 11c2: Diabetic Therapeutic Shoes/Inserts : 12: Dialysis Services : 15-1: Medicare Part B Chemotherapy/Radiation Drugs : 15-2: Other Medicare Part B Drugs : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams
Select all the Non-Medicare-covered benefits that will receive reduced Copayment:	: 18b1: Hearing Aids (all types)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 11 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Maximum Copayment for Intensive Cardiac Rehabilitation Services	$0.00
Indicate Minimum Copayment for	$0.00

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Pulmonary Rehabilitation Services	
Indicate Maximum Copayment for Pulmonary Rehabilitation Services	$0.00
Indicate Minimum Copayment for SET for PAD Services	$0.00
Indicate Maximum Copayment for SET for PAD Services	$0.00
Indicate Minimum Copayment for Urgently Needed Services	$0.00
Indicate Maximum Copayment for Urgently Needed Services	$0.00
Indicate Minimum Copayment for Chiropractic Services	$0.00
Indicate Maximum Copayment for Chiropractic Services	$0.00
Indicate Minimum Copayment for Occupational Therapy Services	$0.00
Indicate Maximum Copayment for Occupational Therapy Services	$0.00
Indicate Minimum Copayment for Physician Specialist Services	$0.00
Indicate Maximum Copayment for Physician Specialist Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum Copayment for Individual Sessions for Mental Health Specialty Services	$0.00
Indicate Minimum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Maximum Copayment for Group Sessions for Mental Health Specialty Services	$0.00
Indicate Minimum Copayment for Podiatry Services	$0.00
Indicate Maximum Copayment for Podiatry Services	$0.00

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Indicate Minimum Copayment for Individual Sessions for Psychiatric Services	$0.00
Indicate Maximum Copayment for Individual Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Maximum Copayment for Group Sessions for Psychiatric Services	$0.00
Indicate Minimum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Maximum Copayment for Physical Therapy and Speech-Language Pathology Services	$0.00
Indicate Minimum Copayment for Opioid Treatment Program Services	$0.00
Indicate Maximum Copayment for Opioid Treatment Program Services	$0.00
Indicate Minimum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Maximum Copayment for Diagnostic Procedures/Tests	$0.00
Indicate Minimum Copayment for Lab Services	$0.00
Indicate Maximum Copayment for Lab Services	$0.00
Indicate Minimum Copayment for Diagnostic Radiological Services	$0.00
Indicate Maximum Copayment for Diagnostic Radiological Services	$0.00
Indicate Minimum Copayment for Therapeutic Radiological Services	$0.00
Indicate Maximum Copayment for Therapeutic Radiological Services	$0.00

Indicate Minimum Copayment for Outpatient X-Ray Services	$0.00
Indicate Maximum Copayment for Outpatient X-Ray Services	$0.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 12 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Outpatient Hospital Services	$0.00
Indicate Maximum Copayment for Outpatient Hospital Services	$0.00
Indicate Minimum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Maximum Copayment for Ambulatory Surgical Center (ASC) Services	$0.00
Indicate Minimum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Individual Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Maximum Copayment for Group Sessions for Outpatient Substance Abuse	$0.00
Indicate Minimum Copayment for Durable Medical Equipment (DME)	$0.00
Indicate Maximum Copayment for Durable Medical Equipment (DME)	$0.00
Indicate Minimum Copayment for Prosthetic Devices	$0.00
Indicate Maximum Copayment for Prosthetic Devices	$0.00
Indicate Minimum Copayment for Medical Supplies	$0.00
Indicate Maximum Copayment for Medical Supplies	$0.00
Indicate Minimum	$0.00

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Copayment for Diabetic Supplies	
Indicate Maximum Copayment for Diabetic Supplies	$0.00
Indicate Minimum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Maximum Copayment for Diabetic Therapeutic Shoes/Inserts	$0.00
Indicate Minimum Copayment for Dialysis Services	$0.00
Indicate Maximum Copayment for Dialysis Services	$0.00
Indicate Minimum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Maximum Copayment for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Indicate Minimum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Maximum Copayment for Other Medicare Part B Drugs	$0.00
Indicate Minimum Copayment for Comprehensive Dental	$0.00
Indicate Maximum Copayment for Comprehensive Dental	$0.00
Indicate Minimum Copayment for Eye Exams	$0.00
Indicate Maximum Copayment for Eye Exams	$0.00
Indicate Minimum Copayment for Eyewear	$0.00
Indicate Maximum Copayment for Eyewear	$0.00
Indicate Minimum Copayment for Hearing Exams	$0.00
Indicate Maximum Copayment for Hearing Exams	$0.00

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 14 (REDUCED COPAYMENT): PACKAGE #1

Indicate Minimum Copayment for Hearing Aids (all types)	$0.00
Indicate Maximum Copayment for Hearing	$0.00

Aids (all types)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum aggregate amount of reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	500.00

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situations. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: LIS Level 1 : LIS Level 2 : LIS Level 3 : LIS Level 4
Expected Number of Enrollees to be Targeted:	4572
Expected Number of Enrollees to be engaged and receive Model benefits:	3200

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering	No

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retroactive reimbursement?	
Is there a maximum benefit amount?	Yes
Specify the maximum benefit amount:	25.00

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Providing a restricted spend debit card to all LIS members to help bridge the gap between a member's fixed-income budget and what they need to afford adequate healthy food. Restricted items include: pet food, alcohol, tobacco or vaping products, household, cleaning or personal health items, over the counter health items, and lottery or any gaming tickets.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Foods Card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	25.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$25.00 per month loaded to a card for members to purchase healthy food.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 10b: Transportation Services : 13b: Over-the-Counter (OTC) Items : 13c: Meal Benefit : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 14c: Other Defined Supplemental Benefits : 16a: Preventive Dental : 16b: Comprehensive Dental : 17a: Eye Exams : 17b: Eyewear

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: 18b: Hearing Aids

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits to address specific needs based on the individual's unique situation. Benefits may include but are not limited to, fall prevention equipment, housekeeping services, dental care, meal prep/delivery, transportation for medical and non-medical needs. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 1: PACKAGE #2

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?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 2: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 3: PACKAGE #2

Is there an enrollee Copayment?	No

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

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #2

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:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
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: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #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?	Yes

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as assistance with purchasing additional over-the-counter (OTC) items. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 1: PACKAGE #2

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?	84

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What is the maximum number of meals the benefit provides?	168
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: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 3: PACKAGE #2

Notes:	Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, who participate with Humana's Care Management Services, and who have had an inpatient hospital or skilled nursing facility stay within the last 30 days may receive 2 meals per day for 12 weeks, a total of 168 meals for each chronic condition. Additional 12 weeks of meals if member screens positive for food insecurity. Benefits are not included in the $500 Maximum Plan Benefit Coverage amount.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #2

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Transportation for Non-Medical Needs : Indoor Air Quality Equipment and Services : Social Needs Benefit : Complementary Therapies : Services Supporting Self-Direction : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

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

Copayment?	
Is authorization required?	Yes
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as food and produce. This may include, but is not limited to, produce and frozen meals delivered to the members home. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
How many days do your Meals (beyond limited basis) last?	50
What is the maximum number of meals the benefit provides?	150
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meals (beyond limited basis)?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as meals (beyond a limited basis). This may include providing additional home-delivered meals, beyond primarily health-related plan benefits, to chronically ill members screening positively for food insecurity. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific	Yes

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

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as pest control services for those members whose living environment has become unhealthy and jeopardizes the welfare and safety of member due to pest investation. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #2

Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan-approved Location
Select type of benefit for Plan-approved Location:	Mandatory
Is this benefit unlimited for number of trips for Plan-approved Location?	Yes
Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	One-way
Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	: Taxi : Rideshare Services : Bus/Subway : Van : Medical Transport

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #2

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

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

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation for Non-Medical Needs?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as non-medically related transportation to locations such as the grocery store, bank, or other non-medical locations. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 1: PACKAGE #2

Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
Select type of benefit for Indoor Air Quality Equipment and Services:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Indoor Air Quality Equipment and Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I INDOOR AIR QUALITY EQUIPMENT AND SERVICES - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as indoor air quality equipment and services. This may include, but is not limited to, providing humidifiers, dehumidifiers, or portable air conditioning units to help improve members living environment and overall health. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory

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

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as social needs benefits. This may include, but is not limited to, connecting members to available community resources and programs to address member isolation and improve mental and emotional health. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 1: PACKAGE #2

Does the plan provide Complementary Therapies as a supplemental benefit under Part C?	Yes
Select type of benefit for Complementary Therapies:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Complementary Therapies?	No

SECTION B: VBID/UF/SSBCI 19B #13I COMPLEMENTARY THERAPIES - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as complimentary therapies offered inconjunction with traditional medical treatment. Services would be provided by licensed or certified practitioners. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 1: PACKAGE #2

Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?	Yes
Select type of benefit for Services Supporting Self-Direction:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Services Supporting Self-Direction?	No

SECTION B: VBID/UF/SSBCI 19B #13I SERVICES SUPPORTING SELF-DIRECTION - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as services supporting self-direction. This may include, but is not limited to, services that would assist members with managing his/her healthcare decisions and decision-making process. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific	No

Maximum Enrollee Out-of-Pocket Cost?	

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as general supports for living. This may include, but is not limited to, long term care services to assist member back to home. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #2

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):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	500.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every year

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #2

Is there an enrollee	No

Coinsurance?	

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #2

Home and Bathroom Safety Devices and Modifications Notes:*	Chronically ill members who participate with Humana's Care Management services can receive non-primarily health related benefits such as fall prevention and safety equipment. This may include, but is not limited to, grab bars, bathtub and toilet safety rails or handles. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 1: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 2: PACKAGE #2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year

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SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 3: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 4: PACKAGE #2

Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #16A PREVENTIVE DENTAL - BASE 5: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Preventive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for preventive dental services under SSBCI. This includes preventtive services such as oral exams, cleaning, fluoride treatment and dental x-rays. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 1: PACKAGE #2

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 2: PACKAGE #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?	Yes
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?	Yes

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SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 3: PACKAGE #2

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: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 5: PACKAGE #2

Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #16B COMPREHENSIVE DENTAL - BASE 6: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for comprehensive dental services under SSBCI. This includes, but is not limited to, non-reoutine services, diagnostic and restorative services, and extractions. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 1: PACKAGE #2

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?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
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

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SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 2: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #17A EYE EXAMS - BASE 3: PACKAGE #2

Is authorization	Yes

required?	
Is a referral required for Eye Exams?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for routine eye exams under SSBCI. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 1: PACKAGE #2

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 2: PACKAGE #2

Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 3: PACKAGE #2

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: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 5: PACKAGE #2

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

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SECTION B: VBID/UF/SSBCI 19B #17B EYEWEAR - BASE 6: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Eyewear?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for eyewear under SSBCI. This includes contact lenses, eyeglasses (lenses and frames). Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization.

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 1: PACKAGE #2

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)?	Yes

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 2: PACKAGE #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:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 3: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 4: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #18B HEARING AIDS - BASE 5: PACKAGE #2

Is authorization required?	Yes
Is a referral required for Hearing Aids?	No
Notes:	Chronically ill members who participate with Humana's Care Management services can receive additional supplemental benefits for hearing aids through SSBCI. Benefits are limited to $500 per year and must be coordinated by Humana Care Manager based on Care Manager assessment and authorization

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

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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 D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	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
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
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	No

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indication-based formulary design)?	
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:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-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 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount (s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-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

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SECTION RX: MEDICARE RX - NOTES

Notes:	$0 cost sharing on Part D covered drugs for the treatment of COVID 19 for members with a COVID 19 diagnosis for the full contract year.

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives	No

programs through the model?

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 022, SEGMENT 0

Module:	PBP
Requested By:	h6j9

PLAN SYSTEM INFORMATION

Last entry Date:	05/28/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/28/2020 09:00:08 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 H4007-022 (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
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	

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	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:	022
Segment ID:	0
Contract Period:	2021
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 for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone	(800)681-3625

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Number for Prospective Medicare Beneficiaries:	
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 Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-

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

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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 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: #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	No

Hospital Services?	

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 benefit period?	Original Medicare
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-	$0.00

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covered Cardiac Rehabilitation Services:	
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 Services:	$0.00
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/POST-STABILIZATION SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY/POST-STABILIZATION 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
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/Post-Stabilization Services cost sharing count towards any plan-level deductible?	No

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

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

Transportation:	
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

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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 Hospitalization?	No

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	No

a supplemental benefit under Part C?	
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 Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
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

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	No

Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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	$0.00

Copayment amount for Medicare-covered Individual Sessions:	
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 may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group 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
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 PROGRAM 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 PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program 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
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 Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes

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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
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	$0.00

Copayment amount for Medicare-covered Group Sessions:	

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 have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : 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

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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:	12
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-specific Maximum Plan Benefit Coverage amount?	No
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?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%

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 Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per	$0.00

item for Medicare-covered Medical Supplies:	

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 Inserts:	$0.00
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

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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 amount carry forward to the next period if it is unused?	No
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

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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?	28
What is the maximum number of meals the benefit provides?	56
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 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Care Package
Select type of benefit for Other 2:	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: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for	No

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Other Services?

SECTION B: #13E OTHER 2 - BASE 3

Notes:	No cost share for respiratory care kit (limit one per year), 14 days of meals (28 meals) for members with COVID-19 diagnosis, and COVID related treatment. Treatment will include 1a Inpatient Hospital Acute, 1b Inpatient Hospital Psychiatric, 2 SNF, 3 Cardiac and Pulmonary Rehabilitation Services, 4a Emergency/Post-Stabilization Services, 4b urgently Needed Services, 4c Worldwide Emergency/Urgent Coverage, 5 Partial Hospitalization, 6 Home Health Services, 7a Primary Care Physician Services, 7b Chiropractic Services, 7c Occupational Therapy Services, 7d Physician specialist Services, 7e Mental Health Specialty, 7f Podiatry Services, 7g Other Health Care Professional, 7h Psychiatric Services, 7i PT and SP Services, 7k Opioid Treatment Program Services, 8a Outpatient Diagnostic Procs/Tests/Lab Services, 8b Outpatient Diag/Therapeutic Rad Services, 9a Outpatient Hospital Services, 9b ASC Services, 9c Outpatient Substance Abuse, 10a Ambulance Services, 11a DME, 11b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX Drugs, Part D Prescription Drugs

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):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: 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
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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):	: 14c15: 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	No

Deductible?	
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:*	Fitness benefit includes 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. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is 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 Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
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	No

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for Medicare-covered Diabetes Self-Management Training?	
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 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/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation 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	No

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drugs as part of a bundled service as a mandatory supplemental benefit?	

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : 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:	8
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%

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Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
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 visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited	Yes

for Extractions?	
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:	3
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 percentage for Restorative Services:	50%
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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	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, bridges up to 1 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

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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 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

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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 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 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	No, indicate number

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Exams?	
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

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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?	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

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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 D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	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
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
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	Yes

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required for certain prescription drugs?	
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	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:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-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 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount (s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-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	No

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first fill?

SECTION RX: MEDICARE RX - NOTES

Notes:	$0 cost sharing on Part D covered drugs for the treatment of COVID 19 for members with a COVID 19 diagnosis for the full contract year.

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 023, SEGMENT 0

Module:	PBP
Requested By:	h6j9

PLAN SYSTEM INFORMATION

Last entry Date:	05/28/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/28/2020 09:00:47 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 H4007-023 (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
Service Area(s):	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:	023
Segment ID:	0
Contract Period:	2021
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 for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone	(800)681-3625

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Number for Prospective Medicare Beneficiaries:	
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 Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(711)-

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

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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 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: #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	No

Hospital Services?	

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 benefit period?	Original Medicare
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-	$0.00

covered Cardiac Rehabilitation Services:	
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 Services:	$0.00
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/POST-STABILIZATION SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY/POST-STABILIZATION 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
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/Post-Stabilization Services cost sharing count towards any plan-level deductible?	No

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

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

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Transportation:	
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

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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 Hospitalization?	No

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	No

a supplemental benefit under Part C?	
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 Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
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

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	No

Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
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	$0.00

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Copayment amount for Medicare-covered Individual Sessions:	
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 may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group 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
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 PROGRAM 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 PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program 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
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00

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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 Copayment amount per visit for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes

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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
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	$0.00

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Copayment amount for Medicare-covered Group Sessions:	

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 have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : 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

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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-specific Maximum Plan Benefit Coverage amount?	No
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

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 Inserts:	$0.00
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-	$0.00

covered Benefits:

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:	45.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
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	Yes

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.	
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	28
What is the maximum number of meals the benefit provides?	56
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 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Care Package
Select type of benefit for Other 2:	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: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

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SECTION B: #13E OTHER 2 - BASE 3

Notes:	No cost share for respiratory care kit (limit one per year), 14 days of meals (28 meals) for members with

	COVID-19 diagnosis, and COVID related treatment. Treatment will include 1a Inpatient Hospital Acute, 1b Inpatient Hospital Psychiatric, 2 SNF, 3 Cardiac and Pulmonary Rehabilitation Services, 4a Emergency/Post-Stabilization Services, 4b urgently Needed Services, 4c Worldwide Emergency/Urgent Coverage, 5 Partial Hospitalization, 6 Home Health Services, 7a Primary Care Physician Services, 7b Chiropractic Services, 7c Occupational Therapy Services, 7d Physician specialist Services, 7e Mental Health Specialty, 7f Podiatry Services, 7g Other Health Care Professional, 7h Psychiatric Services, 7i PT and SP Services, 7k Opioid Treatment Program Services, 8a Outpatient Diagnostic Procs/Tests/Lab Services, 8b Outpatient Diag/Therapeutic Rad Services, 9a Outpatient Hospital Services, 9b ASC Services, 9c Outpatient Substance Abuse, 10a Ambulance Services, 11a DME, 11b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX Drugs, Part D Prescription Drugs

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

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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	Yes

a benefit under Part C?	
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: 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
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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):	: 14c15: 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

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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:*	Fitness benefit includes 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. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is 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	: Medicare-covered Glaucoma Screening

have a Copayment (Select all that apply):	: 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-Management Training:	$0
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 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/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation 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	No

benefit?

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
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:	8
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%

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(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 visits for Periodontics:	1
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	Mandatory

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Oral/Maxillofacial Surgery, Other Services:	
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:	3
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:	2000.00
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 percentage for Restorative Services:	0%
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:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
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 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 amalgam or composite filling 0% up to 1 every 3 years, crown 0% 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

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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 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	Yes

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Benefit Coverage Amount for all Eyewear?	
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 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 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

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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	Yes

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supplemental benefit under Part C?	
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?	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?	Yes
Select what type of benefit your SSBCI	: Additional Benefits

includes:	
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Other Program
Specify Other Program:	Advance Care Planning
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	4572

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: LIS Level 1 : LIS Level 2 : LIS Level 3 : LIS Level 4
Expected Number of Enrollees to be Targeted:	4572
Expected Number of Enrollees to be engaged and receive Model benefits:	3200

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	Yes
Specify the maximum benefit amount:	25.00

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Providing a restricted spend debit card to all LIS members to help bridge the gap between a member's fixed-income budget and what they need to afford adequate healthy food. Restricted items include: pet food, alcohol, tobacco or vaping products, household, cleaning or personal health items, over the counter health items, and lottery or any gaming tickets.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Foods Card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	25.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

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

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

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$25.00 per month loaded to a card for members to purchase healthy food.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13c: Meal Benefit : 13i: Non-Primarily Health Related Benefits for the Chronically Ill

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, who participate with Humana's Care Management Services, and who have had an inpatient hospital or skilled nursing facility stay within the last 30 days may receive 2 meals per day for 12 weeks, a total of 168 meals for each chronic condition. Additional 12 weeks of meals if member screens positive for food insecurity. Eligible members will receive a monthly debit card to be used toward utilities payments (electricity, water, telephone, high speed internet, and/or cable), and/or healthy food purchase. Eligible members may receive non-medical related transportation for locations such as the bank, supermarket, church, pharmacy not limited to a same day appointment.

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 1: PACKAGE #2

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?	84
What is the maximum	168

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number of meals the benefit provides?	
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: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 3: PACKAGE #2

Notes:	Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), or Depression, who participate with Humana's Care Management Services, and who have had an inpatient hospital or skilled nursing facility stay within the last 30 days may receive 2 meals per day for 12 weeks, a total of 168 meals for each chronic condition. Additional 12 weeks of meals if member screens positive for food insecurity.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #2

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Transportation for Non-Medical Needs : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	60.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Food and Produce?	No

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SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:	Eligible members will receive a $60 monthly debit card allowance for purchase of healthy food.

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #2

Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan-approved Location
Select type of benefit for Plan-approved Location:	Mandatory
Is this benefit unlimited for number of trips for Plan-approved Location?	No
Indicate number of trips for Plan-approved Location:	24
Select Plan-approved Location Trips periodicity:	Every year
Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	One-way
Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	: Taxi : Van : Medical Transport : Other, Describe

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
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: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation for Non-Medical Needs?	No
Notes:	Eligible members may receive non-medical related transportation to locations such as the bank, supermarket, church, pharmacy not limited to a same day appointment.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage	60.00

amount:	
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:	Eligible members will receive a $60 monthly debit card allowance to help make utility payments (electricity, water, telephone, high speed internet, and/or cable).

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 D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	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
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
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:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-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 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount (s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for	30

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Standard Mail-Order Cost Sharing 1-month supply:	
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-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

SECTION RX: MEDICARE RX - NOTES

Notes:	$0 cost sharing on Part D covered drugs for the treatment of COVID 19 for members with a COVID 19 diagnosis for the full contract year.

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No