# MEDICARE PLATINO 2021

APPENDIX C (1) (21)
MEDICARE ADVANTAGE
PRODUCT PLAN BENEFIT

EDE Data Keputi Lago LOLOT

# 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

05/28/2020 Last entry Date: 2021.01 PBP Software Version:

Plan Ready for Upload

05/28/2020 08:55:14 PM Eastern Daylight Time

Timestamp:

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 05/18/2020 12:11:49 PM Eastern Daylight Time Last Upload File

Creation Timestamp:

PLAN STATUS

Plan Ready for Upload Section A Status

Section B1 Status Completed Section B2 Status Completed Completed Section B3 Status 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 Completed Section B11 Status Section B12 Status Completed Section B13 Status Completed Completed Section B14 Status Section B15 Status Completed Completed Section B16 Status Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed Section C Status Completed Section D Status Completed

SECTION A: SECTION A-1

Section Mrx Status

HUMANA HEALTH PLANS OF PUERTO RICO, INC. Organization Legal

Name:

Organization Marketing Humana

Name:

www.humana.com/medicare Organization Web Site:

Completed

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 40010 - Adjuntas, PR Service Area(s): Service Area(s): 40020 - Aguada, PR 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): Service Area(s): 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR





5/28/2020 about-blank

FDF Data Report

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):	TOOLO Gainias, I K
Solvico Alica(S).	. 3





about-blank 5/28/2020

LDI Data Veholt Take 2 of 64

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 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): Service Area(s): 40700 - Trujillo Alto, PR 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR Service Area(s): Service Area(s): 40730 - Vega Baja, PR Service Area(s): 40740 - Vieques, PR Service Area(s): 40750 - Villalba, PR 40760 - Yabucoa, PR Service Area(s): 40770 - Yauco, PR Service Area(s):

 Contract Number:
 H4007

 Plan ID:
 016

 Segment ID:
 0

 Contract Period:
 2021

Plan Geographic Name: Puerto Rico Island Wide

No

Yes

Yes

No

No

Dual-Eligible

Is this an Employer-Only

plan?

#### **SECTION A: SECTION A-2**

Does this Plan have a No CMS-approved Continuation Area?

Do you intend to

participate in the PLATINO program?

Is this a Special Needs

Plan?

Special Needs Plan

Type:

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-

SNP?

# SECTION A: SECTION A-3

Participating Pharmacy Website Address:

https://www.humana.com/pharmacy/

Formulary Website

http://www.humana.com/medicare/medicare\_prescription\_drugs/medicare\_drug\_tools/medicare\_drug\_list/

Address:

Physician Website www.humana.com/members/tools

(866)773-5959

Address:

Customer Service (866)773-5959

Contact Phone Number for Current Medicare

Beneficiaries:

Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service (800)681-3625

J.





shout-blank 5/28/2020

гог раца кероп I ago y oi oy

Contact Phone Number for Prospective Medicare

Beneficiaries:

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part D Medicare

Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Medicare

Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Current Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare

Beneficiaries:

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

Current Part D Medicare Beneficiaries:

Customer Service

(711)-Contact Local TTY/TDD

for Current Part D Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

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

**SECTION A: SECTION A-5** 

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

Is your organization No filing a standard bid for



about-blank 5/20/2020 DI Data Report

1 1180 2 01 0 1

Section C of the PBP?

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

Is your organization N filing a standard bid for Section D of the PBP?

Do any of your No

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

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

Does the plan provide

Yes

Inpatient Hospital-Acute

Services as a

supplemental benefit

under Part C?

Select enhanced benefits: : Additional Days

Select type of benefit for

Mandatory

Additional Days:

Is this benefit unlimited

Yes

for Additional Days?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Does this plan's No

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

Is there an enrollee No

Coinsurance?

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

Does this plan's No

Additional Days cost sharing vary by hospital (s) in which an enrollee

obtains care?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered







гог рана кероп I age U UI UT

Lifetime Reserve Days:

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

Indicate the number of

Zero (No Copayment per Day)

Per Admission or Per Stay

day intervals for Additional Days:

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

What is your Inpatient

Hospital-Acute benefit

period?

Do you charge cost No

sharing on the day of

discharge?

Is authorization Yes

required?

Is a referral required for No Inpatient Hospital-Acute

Services?

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's No

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Do you charge the

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment

\$0.00

No

Yes

No

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

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

Indicate the number of day intervals for the Medicare-covered

Zero (No Copayment per Day)

Lifetime Reserve Days: SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost No







ahaut-hlank 5/28/2020 The Data Report

sharing on the day of

discharge?

Is authorization Yes

required?

d for No

Zero

Is a referral required for Inpatient Psychiatric Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide No

Skilled Nursing Facility

Services as a

supplemental benefit

under Part C?

Do you allow less than 3 Yes

day inpatient hospital stay prior to SNF

admission?

Indicate the Number of

Hospital Days Required Prior to SNF Admission

(0-2):

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's No

Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an

enrollee obtains care?

Is there an enrollee No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF Original Medicare

No

benefit period?

Is authorization Yes

required?

Is a referral required for No

SNF Services?

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

Does the plan provide No

Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific N Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Cardiac and : Medicare-covered Cardiac Rehabilitation Services

Pulmonary : Medicare-covered Intensive Cardiac Rehabilitation Services

Contrato Número

21 - 0 0 9

OF POSDESA



about-blank

The Dam Rebott Tugo o or of

Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services

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

(Select all that apply): (PAD) Services

Indicate Minimum Copayment amount per service for Medicarecovered Cardiac

\$0.00

Rehabilitation Services:

Indicate Maximum

Copayment amount per service for Medicarecovered Cardiac Rehabilitation Services: \$0.00

\$0.00

\$0.00

Indicate Minimum Copayment amount per

service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Services:

Indicate Maximum Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Minimum \$0.00

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

Disease (PAD) Services:

Indicate Maximum \$0.00

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

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

Is authorization Yes

required?

Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

OMINISTRACION ON THE PROPERTY OF THE PROPERTY Contrato Número CUROSDE

5/20/2020 ahaut-hlank

The hard vehice and a second of the second o

Is there an enrollee

Yes

Copayment?

Indicate Minimum

imum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is the Copayment for Yes

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for

waiver:

Enter number of Days or 24

Hours:

Does the No

Emergency/Post-Stabilization Services cost sharing count towards any plan-level

deductible?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

In these on somelles

Is there an enrollee No

Coinsurance?

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

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Does the Urgently No Needed Services cost

sharing count towards any plan-level deductible?

Is the Copayment for No

Medicare-covered Benefits waived if admitted to hospital?

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

Does the plan provide

Yes

Worldwide

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

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Emergency Transportation

: Worldwide Urgent Coverage

Select type of benefit for

Worldwide Emergency

Mandatory





I DI Data Keport

Coverage:

Select type of benefit for

Mandatory

Mandatory

Worldwide Urgent

Coverage:

Select type of benefit for

Worldwide Emergency

Transportation:

Is there a Maximum Plan No

Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Yes

Copayment?

Select which Worldwide : Worldwide Emergency Coverage Services have a : Worldwide Urgent Coverage : Worldwide Emergency Transportation

Copayment (Select all that apply):

\$0.00

Yes

Indicate Minimum

Copayment amount for

Worldwide Emergency

Coverage:

\$0.00 Indicate Maximum

Copayment amount for Worldwide Emergency

Coverage:

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

Indicate Minimum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

Is this Copayment Yes waived for Worldwide Urgent Coverage if

admitted to hospital?

Indicate Minimum \$0.00

Copayment amount for Worldwide Emergency

Transportation:

\$0.00 Indicate Maximum

Copayment amount for Worldwide Emergency Transportation:

Is this Copayment

waived for Worldwide

Emergency Transportation if admitted to hospital?

Is there an enrollee

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

No

Yes





TDI Data Report 1 450 11 01 01

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Is authorization

Yes

required?

Is a referral required for No

Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2 No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required for No

Home Health Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

\$0.00

Copayment amount per





I DI Data Nepoli 1 age 12 of of

visit for Medicarecovered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide No Chiropractic Services as a supplemental benefit

under Part C?

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

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee Yes

Copayment?

Select which : Medicare-covered Chiropractic Services

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

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is there an enrollee No

Deductible?

Is authorization No

required?

Is a referral required for Yes

Chiropractic Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization Yes

required?

Is a referral required for Yes

Occupational Therapy

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No





I DI Data IXPUIT Tage ID OF OT

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

No

required?

Is a referral required for

Yes

Physician Specialist

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

Select which Mental : Medicare-covered Individual Sessions Health Specialty : Medicare-covered Group Sessions

Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization Yes

required?

Is a referral required for Yes

Mental Health Specialty

Services - Non-Physician?

**SECTION B: #7F PODIATRY SERVICES - BASE 1** 

Does the plan provide No Podiatry Services as a supplemental benefit under Part C?





5/28/2020 ahaut-hlank

LDL Data Vehori Lago IT ULUT

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

# **SECTION B: #7F PODIATRY SERVICES - BASE 2**

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

Select which Podiatry

: Medicare-covered Podiatry Services

Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

#### **SECTION B: #7F PODIATRY SERVICES - BASE 3**

Is authorization

No

No

required?

Is a referral required for No

Podiatrist Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Is a referral required for No

Other Health Care Professional Services?

# SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

# SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 No

Is there an enrollee

Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?





5/20/2020 ahout-blank

IDI Data Keport Luge 15 of Of

Select which Psychiatric

Services have a

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

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

required?

Yes

Is a referral required for

No

Psychiatric Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount per visit for Medicare-

covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization Yes

required?

Is a referral required for

No

Physical Therapy and Speech-Language Pathology Services?

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

Do you offer an Yes

Additional Telehealth benefit for Part B

services?

Select the Medicare-: 4b: Urgently Needed Services : 7a: Primary Care Physician Services covered benefits that may have Additional : 7d: Physician Specialist Services

Telehealth Benefits : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services available:

: 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services

: 9c1: Individual Sessions for Outpatient Substance Abuse

Contrato Número QUAOS DE



ahout-blank

5/28/2020

1 DI Data Nepoti 1 ago 10 Ot Ot

: 9c2: Group Sessions for Outpatient Substance Abuse

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization required No

for Additional Telehealth

Services?

Is a referral required for No

Additional Telehealth

Services?

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

No

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization No

required?

Is a referral required for No

Opioid Treatment Program Services?

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

Is there a service-specific N Maximum Enrollee Outof-Pocket Cost?

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes



The Date Report

: Medicare-covered Diagnostic Procedures/Tests

: Medicare-covered Lab Services

\$0.00

\$0.00

Yes

Yes

Yes

Copayment?

Select which Outpatient

Diag Procs/Tests/Lab

Services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Lab

Services:

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

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

Is authorization

required?

Is a referral required for

Outpatient Diagnostic Procedures/Test/Lab

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

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

: Medicare-covered X-Ray Services

: Medicare-covered Diagnostic Radiological Services

: Medicare-covered Therapeutic Radiological Services

Is there an enrollee

Deductible?

No Yes

Is there an enrollee

Copayment?

Select which Outpatient Diag/Therapeutic Rad

Services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

\$0.00

\$0.00







5/28/2020 ahaut-hlank

TOT Data Meport

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

If a member receives Yes

multiple services at the same location on the same day, does only the maximum copay apply?

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

Is authorization

required?

Is a referral required for

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Yes

No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Select which Services

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

have a Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Observation

Services:

Indicate Maximum
Copayment amount per
visit for Medicarecovered Observation

----

\$0.00







shout-blank 5/28/2020

IDI Data Keport I não 17 ot o

Services:

Is authorization required Yes for Medicare-covered

Outpatient Hospital

Services?

Is authorization required Yes for Medicare-covered

Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient Hospital

Services?

Is a referral required for

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Yes

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Is authorization Yes

required?

Is a referral required for No

Ambulatory Surgical Center Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

No

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Yes Is there an enrollee

Copayment?

Select which Outpatient : Medicare-covered Individual Sessions Substance Abuse : Medicare-covered Group Sessions

services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for

Medicare-covered Individual Sessions: \$0.00

\$0.00







тыг раш кероп 1 450 40 01 01

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

No

Is authorization

required?

Is a referral required for No Outpatient Substance

Abuse?

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

Does the plan provide

Outpatient Blood Services as a supplemental benefit under Part C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

No

No

No

Mandatory

Yes

Select type of benefit for

Three (3) Pint Deductible Waived:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization No

required?

Is a referral required for

Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2 No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Services : Medicare-covered Ground Ambulance Services have a Copayment : Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum Copayment amount for Medicare-covered

Ground Ambulance

Services:

Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance

\$0.00

\$0.00







5/20/2020 ahout-blank

TDI Data Report

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment No waived if admitted to

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required Yes

for non-emergency Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for

Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited Yes

for number of trips for Plan Approved Healthrelated Location?

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of ; Van

Transportation for Plan : Other, Describe

Approved Health-related

Location:

**SECTION B: #10B TRANSPORTATION SERVICES - BASE 2** 

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Yes Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per

trip:

\$0.00 Indicate Maximum

Copayment amount per

trip:

Notes:

Is authorization required?

Is a referral required for Transportation Services? Yes

No

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





I DI Data Keputi 1 450 44 01 0T

wheelchair access vehicle that provide members access to health benefits.

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Benefits:

\$0.00 Indicate Maximum

Copayment amount per item for Medicarecovered Benefits:

# SECTION B: #11A DME - BASE 2

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

Is authorization Yes

required?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee Copayment?

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

No

Yes

Supplies have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

\$0.00 Indicate Maximum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

\$0.00 Indicate Minimum Copayment amount per

item for Medicarecovered Medical Supplies:

Indicate Maximum

Copayment amount per

item for Medicarecovered Medical Supplies:

\$0.00







5/28/2020 ahout-blank

LDI Data Keport 1 age 23 of ot

Is authorization

required?

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

Yes

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

: Medicare-covered Diabetes Supplies

Select which Diabetic Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment (Select all that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

\$0.00 Indicate Maximum

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

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

Is authorization No

required?

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

\$0.00

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per session for Medicarecovered Benefits:

Indicate Maximum Copayment amount per session for Medicarecovered Benefits:







5/28/2020 ahout-blank

LDL Data Report I age 2 OI OF

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

Is authorization

No

required?

Is a referral required for No

Dialysis Services?

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

Does the plan provide Acupuncture as a supplemental benefit

No

Yes

Mandatory

50.00

No

No

Yes

No

No

No

No

Every three months

under Part C?

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

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

under Part C?

Select type of benefit for

OTC Items:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to

the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering

Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement

Therapy (NRT) Attestation:

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

formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

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

Manual?

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

The plan will provide \$0 copayment for adult diapers box up to one (1) every month. Members who meet Notes:

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.

Yes

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

Does the plan provide a limited duration Meal

Benefit as a







5/28/2020

IDI Data Keport 1 450 22 OI O

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

Select type of benefit for

Meals:

Mandatory

How many days does your Meal Benefit last?

28

What is the maximum number of meals the

56

benefit provides?

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount:

Indicate Maximum \$0.00

Copayment amount:

Is authorization

required?

Yes

Is a referral required for the Meal Benefit?

No

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

Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per Notes:

year.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

(Optional):

COVID-19 Care Package

Select type of benefit for

Other 2:

No

Mandatory

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible? Is there an enrollee

No

Copayment?

Is authorization

Yes

required?

Is a referral required for

No

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

5/28/2020 about blank

RIMINISTRACIO

Contrato Número

OSDE

IDI Data Keport

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?

Nο

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical

Mandatory

Exam:

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

No

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Indicate Minimum Copayment amount for

each Annual Physical

\$0.00

Exam:

\$0.00

Indicate Maximum Copayment amount for each Annual Physical

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

Is authorization

No

required?

Is a referral required for the Annual Physical

No

Exam?

Notes:

An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive

examination than an annual wellness visit. Services in a Routine Physical Exam will include the 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 hospill SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide

Other Defined

Supplemental Benefits as

Yes

PONINISTRACION Contrato Número

I DI Data Keputi I ago 21 OI OT

a benefit under Part C?

Select enhanced benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling

: 14c4: Fitness Benefit\* (Select all that apply):

: 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: Select type of benefit for

Mandatory

4

Fitness Benefit:

Indicate type of Fitness

: Physical Fitness

Benefit offered (Select

all that apply):

Select type of benefit for Mandatory

Home and Bathroom Safety Devices and Modifications:

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

Select type of benefit for Mandatory

Wigs for Hair Loss Related to Chemotherapy:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other : 14c15: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select

all that apply):

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

500.00 Indicate Maximum Plan

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

Select Maximum Plan Every year

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

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

Benefits?

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee Is there an enrollee

Deductible?

No

Copayment?

No



about blank 5/28/2020 тыг рака кероп 1 450 20 01 0T

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

Is authorization

required?

Yes

Is a referral required for

Other Defined

No

Supplemental Benefits?

Additional Sessions of

Smoking and Tobacco Cessation Counseling

Notes:

Fitness Benefit Notes:\*

No authorization required for this service.

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

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

Safety Devices and Modifications Notes:\*

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

Wigs for Hair Loss

Related to

Authorization is required for this service.

Chemotherapy Notes:

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

Is there a service-specific Nο

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

No

No

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Is authorization

required?

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?

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

Is there an enrollee

Coinsurance?

Νo

Is there an enrollee

No

Yes

Deductible?

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

Is there an enrollee

Copayment?

Select which Services

: Medicare-covered Glaucoma Screening

POMINISTRAC Contrato Número POSDE



1D1 Dam 10por

have a Copayment : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas (Select all that apply): : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit : Other Medicare-covered Preventive Services \$0 Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: Indicate Maximum \$0 Copayment amount for Medicare-covered Glaucoma Screening: Indicate Minimum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Maximum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Minimum \$0 Copayment amount for Medicare-covered Barium Enemas: Indicate Maximum \$0 Copayment amount for Medicare-covered Barium Enemas: \$0 Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Minimum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Maximum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: \$0 Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: Indicate Maximum \$0 Copayment amount for Other Medicare-covered Preventive Services: PONINISTRACION PONINISTRACION Is authorization required No for Medicare-covered Glaucoma Screening? Is authorization required No Contrato Número for Medicare-covered Diabetes Self-Management Training?



TDI Data Keport I age DV OI OT

Is authorization required No

for Medicare-covered Barium Enemas?

Is authorization required No for Medicare-covered

Digital Rectal Exams?

Is authorization required No

for Medicare-covered EKG following

Is authorization required No

for Other Medicarecovered Preventive Services?

Welcome Visit?

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

Is a referral required for

any Services?

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

Is there a Maximum No Enrollee Out-of-Pocket

Cost?

Is there an enrollee No

Coinsurance?

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

Yes

Is there an enrollee

Copayment?

Select which Medicare

: Medicare Part B Chemotherapy/Radiation Drugs Part B Rx Drugs have a : Other Medicare Part B Drugs

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment Amount for Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Maximum \$0.00

Copayment Amount for Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Minimum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee No

Deductible?

Is Authorization

Yes

Required? Does the plan offer step

Yes

therapy?

Does the benefit step from (select all that

: Part B to Part B?

apply):

**SECTION B: #15 HOME INFUSION BUNDLED SERVICES** 

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





5/20/2020 ahout-blank

LDI Data Keport I USO DI OLO I

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Yes Preventive Dental Items as a supplemental benefit

under Part C?

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:

Select the Oral Exams

periodicity:

Other, Describe

Select type of benefit for

Prophylaxis (Cleaning):

Mandatory

Is this benefit unlimited

No, indicate number

for Prophylaxis

(Cleaning)?

Indicate number of visits

for Prophylaxis

2

(Cleaning): Select the Prophylaxis

Every year

(Cleaning) periodicity:

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

8

Select type of benefit for

Dental X-Rays:

Mandatory

Is this benefit unlimited

No, indicate number

for Dental X-Rays?

Indicate number of visits

for Dental X-Rays:

Other, Describe

Select the Dental X-Rays periodicity:

Is there a service-specific

Maximum Plan Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

No

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

Coinsurance?

Yes

Select which Preventive

: Oral Exams

Dental Services have a

: Prophylaxis (Cleaning) : Dental X-Rays

Coinsurance (Select all

that apply):

No

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

Visit?

Indicate Minimum 0%

Coinsurance percentage

for Oral Exams:

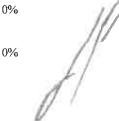
Indicate Maximum

Coinsurance percentage

for Oral Exams: Indicate Minimum

Coinsurance percentage for Prophylaxis

0%







5/20/2020 ahout-blank

гот рака куроп

(Cleaning):

Indicate Maximum 0%

Coinsurance percentage for Prophylaxis

(Cleaning):

0% Indicate Minimum

Coinsurance percentage for Dental X-Rays:

Indicate Maximum 0%

Coinsurance percentage for Dental X-Rays:

**SECTION B: #16A PREVENTIVE DENTAL - BASE 4** No

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5 No

Is authorization

required?

Is a referral required for

Preventive Dental Services?

No

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

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Endodontics : Periodontics Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for

Restorative Services:

No, indicate number

No, indicate number

Mandatory

Is this benefit unlimited

for Restorative Services? Indicate number of visits

for Restorative Services: Select the Restorative

Other, Describe

Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Endodontics:

Mandatory

Is this benefit unlimited

Yes

for Endodontics?

Select type of benefit for Mandatory

Periodontics:

Is this benefit unlimited

for Periodontics?

Indicate number of visits

for Periodontics:

Select the Periodontics

periodicity:

Every year

Select type of benefit for

Extractions:

Mandatory

Is this benefit unlimited

for Extractions?

Yes

Select type of benefit for

Prosthodontics, Other

Mandatory







The Data Meport 1 450 22 01 0T

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial

No, indicate number

Surgery, Other Services? Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

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

type:

Indicate Maximum Plan

2500.00

Benefit Coverage

amount:

Every year

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Yes

: Restorative Services Select which Comprehensive Dental : Endodontics

: Periodontics Services have a Coinsurance (Select all : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services that apply):

Indicate Minimum

Coinsurance percentage for Restorative Services:

0% Indicate Maximum

Coinsurance percentage for Restorative Services:

0%

0%

Indicate Minimum Coinsurance percentage

for Endodontics:

0% Indicate Maximum

Coinsurance percentage for Endodontics:

Indicate Minimum 0%

Coinsurance percentage for Periodontics:

Indicate Maximum 0%

Coinsurance percentage for Periodontics:

Indicate Minimum 0%

Coinsurance percentage for Extractions:

Indicate Maximum Coinsurance percentage for Extractions:





5/28/2020 ahant-hlank

LDI Dara Mchori I ago ot ot ot

Indicate Minimum 0% Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum 0%

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

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

Yes

Select which

: Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

\$0.00

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

No

\$0.00

Is authorization Yes

required?

Is a referral required for

Comprehensive Dental

Services?

Notes:

Endodontics includes root canal up to unlimited per year. Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year. Partial dentures and complete dentures

up to 1 set(s) every 5 years. Restorative services include 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?

Select enhanced benefit:

Yes

: Routine Eye Exams

Select type of benefit for

Routine Eye Exams:

Mandatory

1

Is this benefit unlimited

No, indicate number

for Routine Eye Exams?

Indicate number of

exams for Routine Eye

Exams:

Select the Routine Eye

Every year

Exams periodicity:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

Maximum Enrollee Out-

No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?







IDI Data Keport

Is there an enrollee

Yes

Copayment?

Select which Eye Exams

have a Copayment

: Medicare-covered Benefits : Routine Eye Exams

(Select all that apply):

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

\$0.00

\$0.00

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

\$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

No

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

Is authorization

No

No

Yes

required?

Is a referral required for

Eye Exams?

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

Does the plan provide

Eyewear as a

supplemental benefit under Part C?

Select enhanced benefits:

: Contact lenses

No, indicate number

No, indicate number

Plan-specified amount per period

: Eyeglasses (lenses and frames)

Select type of benefit for

Contact lenses:

Mandatory

Is this benefit unlimited

for Contact lenses?

Indicate quantity (number of pairs) for Contact lenses:

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)?

Indicate quantity for 1

Eyeglasses (lenses and frames):

Every year

Select Eyeglasses (lenses and frames) periodicity:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Do you offer a Combined Max Plan

Yes





5/28/2020 ahout-blank

LDI Data Keport 1 450 JU UI UT

Benefit Coverage

Amount for all Eyewear?

Indicate Combined

600.00

Maximum Plan Benefit Coverage amount:

Select the Combined

Every year

Maximum Plan Benefit Coverage periodicity:

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

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Eyewear

: Medicare-covered Benefits

Benefits have a

: Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

\$0.00

Copayment amount for

Contact lenses:

Indicate Maximum

\$0.00

Copayment amount for

Contact lenses:

\$0.00

Indicate Minimum Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization

No

No

required?

Is a referral required for

Eyewear?

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



5/20/2020

ahout-blank

The Date Mehore

1 Indicate number for

Routine Hearing Exams:

Select Routine Hearing

Every year

Exams periodicity:

Select type of benefit for

Mandatory

No, indicate number

Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited

for Fitting/Evaluation for

Hearing Aid? Indicate number for

Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation

for Hearing Aid periodicity:

Every year

1

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

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

Is there an enrollee

Deductible?

No No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

: Fitting/Evaluation for Hearing Aid

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Yes

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

Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Minimum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Is authorization No

required?

Is a referral required for No

Hearing Exams?

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

Does the plan provide Hearing Aids as a

Yes







5/28/2020

I DI Data Kepon I ago Jo ol ot

supplemental benefit

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited for Hearing Aids (all

No, indicate number

Mandatory

types)?

Indicate quantity for 2 Hearing Aids (all types):

Select Hearing Aids (all Every year

types) periodicity:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan Per ear

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

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

Yes

type:

Indicate Maximum Plan

1000.00

Benefit Coverage

amount:

Indicate Maximum Plan Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

**SECTION B: #18B HEARING AIDS - BASE 4** 

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per Hearing Aid (all types):

Indicate Maximum \$0.00

Copayment amount per Hearing Aid (all types):

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization No

required?

Is a referral required for No

Hearing Aids?

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

Does your plan include

MA Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special Yes

Supplemental Benefits for the Chronically III?

Select what type of : Reduced Cost Sharing benefit your SSBCI : Additional Benefits

OMINISTRACION ON Contrato Número

5/20/2020 ahout-hlank

1 DI Data Report

includes:

Are you offering a VBID No

Hospice Benefit?

Are you offering Part C Yes

benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)

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

Volue Posed Insuran

Value-Based Insurance : I attest that

Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type

: Other Program

No

No

(choose one or more):

Specify Other Program: Advance Care Planning

WHP Mode of : Telephonic
Engagement (choose one : In-Person
or more): : Web-Based

Does your organization

offer Part C Rewards or

Incentives for

beneficiaries for the offer

of WHP Services?

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP

activities?

Program Connectedness: : Electronic Health Records/Electronic Medical Records

Please check the way that advance care plans : Health Information Exchanges

: Other

and/or advance : Data Warehouses

directives are connected from your program to

from your program to access points of care.

Expected Number of 4572

Beneficiaries to be Engaged Annually:

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

Does your VBID/MA Yes

Uniformity
Flexibility/SSBCI
benefit offer Part C
reductions in cost?
How many packages
does your 19a Reduction

does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI

benefit contain? (1-15)

VBID/UF/SSBCI

Contrato Número

Contrato Número

Contrato Número

Contrato Número

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

Is this package SSBCI

applicable to VBID, MA Uniformity Flexibility or SSBCI?

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

Is there a prerequisite for Yes reduction of cost sharing

for this package?

ahout-blank 5/28/2020

гог рана кероп 1 age 70 01 07

Which prerequisites are

required for this package?

: Participation in a Care Management Program

Select the benefits that apply to reduced cost

sharing:

sharing:

: Medicare-covered benefits : Non-Medicare-covered benefits

Select the Medicarecovered benefits that will

receive reduced cost

: 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

All specialists

Does your VBID/MA Uniformity

Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist

Services?

deductible?

Select the Non-: 18b1; Hearing Aids (all types)

Medicare-covered benefits that will receive reduced cost sharing:

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

Are any benefits exempt No from the plan-level

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

Do you offer reduced

No

Coinsurance?

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

Do you offer a reduced deductible amount?



about blook 5/28/2020 rdr Data Neputi Lago +1 UI U+

# 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 Medicarecovered 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

Indicate Maximum \$0.00

Copayment for Cardiac Rehabilitation Services

Indicate Minimum

\$0.00

Copayment for Intensive Cardiac Rehabilitation

Services

Indicate Maximum Copayment for Intensive \$0.00

Cardiac Rehabilitation

Services

Indicate Minimum \$0.00

Copayment for Pulmonary

Rehabilitation Services





ahout-blank 5/20/2020 בא באר און באר באר און באר און

Indicate Maximum Copayment for	\$0.00
Pulmonary Rehabilitation Services 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	\$0.00
Chiropractic Services Indicate Maximum Copayment for	\$0.00
Chiropractic Services Indicate Minimum Copayment for Occupational Therapy	\$0.00
Services Indicate Maximum Copayment for Occupational Therapy	\$0.00
Services Indicate Minimum Copayment for Physician	\$0.00
Specialist Services 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	\$0.00
Services Indicate Maximum Copayment for Group Sessions for Mental Health Specialty	\$0.00
Services Indicate Minimum Copayment for Podiatry	\$0.00
Services Indicate Maximum Copayment for Podiatry Services	\$0.00
Indicate Minimum Copayment for	\$0.00







about-blank 5/28/2020

I DI Data Kepuli

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





\$W

about-blank 5/28/2020

Outpatient X-Ray

Services

Indicate Maximum

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

Copayment for Outpatient X-Ray

Services

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

Indicate Minimum

Copayment for

Outpatient Hospital

Services

Indicate Maximum

Copayment for

Outpatient Hospital

Services

Indicate Minimum

Copayment for Ambulatory Surgical

Ambulatory Surgical Center (ASC) Services

Indicate Maximum
Copayment for

Ambulatory Surgical Center (ASC) Services

Indicate Minimum \$0.00

Copayment for Individual Sessions for Outpatient Substance

Abuse

Indicate Maximum \$0.00

Copayment for Individual Sessions for Outpatient Substance

Abuse

Indicate Minimum \$0.00

Copayment for Group Sessions for Outpatient Substance Abuse

Indicate Maximum \$0.00

Copayment for Group Sessions for Outpatient Substance Abuse

Indicate Minimum \$0.00

Copayment for Durable Medical Equipment

(DME)

Indicate Maximum \$0.00

Copayment for Durable Medical Equipment

(DME)

Indicate Minimum \$0.00

Copayment for Prosthetic Devices

Indicate Maximum \$0.00

Copayment for Prosthetic Devices

Indicate Minimum \$0.00

Copayment for Medical

Supplies

Indicate Maximum \$0.00

Copayment for Medical Supplies

Supplies

Indicate Minimum \$0.00 Copayment for Diabetic

Supplies

J.





about-blank 5/29/2020

LDI Dara Vehore I age TO UL UT

	te Maximum ment for Diabetic es	\$0.00					
Indica Copay Thera	te Minimum ment for Diabetic	\$0.00					
Copay Therap	te Maximum ment for Diabetic peutic Tnserts	\$0.00					
	te Minimum ment for Dialysis es	\$0.00					
	te Maximum ment for Dialysis es	\$0.00					
Copay Part B	te Minimum ment for Medicare otherapy/Radiation	\$0.00					
Copay Part B	te Maximum ment for Medicare otherapy/Radiation	\$0.00					
Indica Copay	te Minimum ment for Other are Part B Drugs	\$0.00					
Indica Copay	te Maximum ment for Other are Part B Drugs	\$0.00					
Copay	te Minimum ment for rehensive Dental	\$0.00					
Indica Copay	te Maximum ment for rehensive Dental	\$0.00					
Indica	te Minimum ment for Eye	\$0.00					
	te Maximum ment for Eye	\$0.00		10	, N	ISTRAC	
	te Minimum ment for Eyewear	\$0.00		///	R.Dhyl.	NSTRACION ON ONTRACTOR NAME OF THE PARTY OF	
Indica	te Maximum ment for Eyewear	\$0.00	1	1	(Cor	ntrato Número m	
Indica	te Minimum ment for Hearing	\$0.00			SE S		
	te Maximum ment for Hearing	\$0.00			A	SDESA	
SECT	ION B: #19A REDI	ICED COST S	SHARING FOR	VRID/LIF/SSBCI	- BASE 14 (REI	DUCED COPAYME	NT): I

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

\$0.00 Indicate Minimum Copayment for Hearing

Aids (all types)

Indicate Maximum

Copayment for Hearing

Aids (all types)

\$0.00

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

5/20/2020 ahout-blank

TDI Data Kepuli LABO TO OL OT

PACKAGE #1

Are you offering retroactive

No

reimbursement?

Is there a maximum

Yes

aggregate amount of reduced cost sharing?

500.00

Specify the maximum aggregate amount of reduced cost sharing:

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 nonprimarily 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

Yes

2

Uniformity

Flexibility/SSBCI benefit offer additional

Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

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

Is this package **VBID** 

applicable to VBID or MA Uniformity Flexibility or SSBCI?

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

Targeting Methodology -

Please choose one or

both:

Select LIS reduction level:

: LIS Level 1 : LIS Level 2 : LIS Level 3

: Socioeconomic Status

: LIS Level 4 4572

3200

No

Expected Number of Enrollees to be Targeted:

Expected Number of

Enrollees to be engaged and receive Model

benefits:

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?

Select all the Non-: 13d: Other 1

Medicare-covered additional benefits offered in this package:

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?

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

PACKAGE #1

Are you offering No

retroactive reimbursement? PDMI Contrato Número POSDE



ミ/クタ/クハクハ ahout-blank

гог рана кероп rage 4/ OI O4

Is there a maximum

Specify the maximum

Yes

benefit amount?

25.00

benefit amount:

# 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

Mandatory

Other 1:

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount?

Indicate Maximum Plan

25.00

Benefit Coverage

amount:

Select Maximum Plan

Other, Describe

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization

No

No

Yes

required?

Is a referral required for

Other Services?

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

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

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

Is this package

applicable to VBID or MA Uniformity

Flexibility or SSBCI?

POMINISTRAC 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?

Which prerequisites are

: Participation in a Care Management Program

required for this

package?

Select all the Non-: 10b: Transportation Services Medicare-covered : 13b: Over-the-Counter (OTC) Items

additional benefits : 13c: Meal Benefit

: 13i: Non-Primarily Health Related Benefits for the Chronically III offered in this package:

: 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):

about blook 5/28/2020

Contrato Número

CROSDE

TOT Data Neport I age to or ot

#### PACKAGE #2

Are any benefits exempt No from the plan-level

deductible?

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

Are you offering

No

retroactive reimbursement?

No

Is there a maximum benefit amount?

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

> 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?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for

Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited Yes

for number of trips for Plan Approved Healthrelated Location?

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Taxi

Transportation for Plan : Rideshare Services Approved Health-related : Bus/Subway : Van

Location:

: 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?

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

No

Is authorization

Yes

required?





ahoutehlank 5/28/2020 FDF Data Report 1 age 47 Or O4

Is a referral required for No Transportation Services?

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

Does the plan provide Yes

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

Select type of benefit for

OTC Items:

Mandatory

Yes

500.00

Yes

Every year

ore nems.

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

Indicate Maximum Plan

Benefit Coverage

amount:

amount: Select Maximum Plan

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

Are you offering

Are you offering

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

Nicotine Replacement

Therapy (NRT)

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

formulary drugs.

Attestation:

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No No

Is there an enrollee

Copayment?

Yes

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

Manual?

#### 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 Y

limited duration Meal

Benefit as a

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

be entered in this section. Select type of benefit for

Meals:

How many days does your Meal Benefit last?

What is the maximum number of meals the

Mandatory

84

168





tho

about-blank 5/28/2020

LDL Data Ecport 1 age 20 01 07

benefit provides?

Is there a service-specific No Maximum Plan Benefit Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

No

Is there an enrollee

Deductible? Is there an enrollee No

Copayment?

Is authorization Yes

required?

Is a referral required for No

the Meal Benefit?

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

Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Notes:

> 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 : Food and Produce

benefit your Non-: Meals (beyond limited basis)

Primarily Health Related : Pest Control

: Transportation for Non-Medical Needs Benefits for the : Indoor Air Quality Equipment and Services Chronically Ill includes:

: 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?

Select type of benefit for

Mandatory

Yes

Food and Produce:

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

No

No

Deductible? Is there an enrollee

No

Copayment?





ahout-hlank 5/20/2020 FDF Data Report Fage 51 Or OF

Is authorization

Yes

Yes

50

150

500.00

No

No

Yes

No

Every year

Mandatory

required?

Is a referral required for No

Food and Produce?

#### 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 #131 MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide

Meals (beyond limited basis) as a supplemental benefit under Part C?

Select type of benefit for Meals (beyond limited

basis):

How many days do your Meals (beyond limited

basis) last?

What is the maximum number of meals the benefit provides?

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage periodicity:

Is there a service-specific No
Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for the Meals (beyond

limited basis)?

# 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?

Select type of benefit for

Pest Control:

Is there a service-specific Yes Maximum Plan Benefit

Yes

Mandatory







ahout-blank 5/28/2020

rbr Data Keport rage 32 01 04

Coverage amount?

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Nο

Copayment?

Is authorization Yes

required?

Is a referral required for No

Pest Control?

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?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Mandatory

Plan-approved Location:

Is this benefit unlimited Yes

for number of trips for Plan-approved Location?

Select Type of One-way

Transportation for Non-Medical Needs for Planapproved Location:

Select Mode of · Taxi

: Rideshare Services Transportation for Non-Medical Need for Plan-: Bus/Subway

: Van approved Location:

: Medical Transport

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

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

500.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Nο Contrato Número

ahaut-hlank 5/20/2020 FDF Data Report rage 33 Ot 04

Coinsurance?

Is there an enrollee

No

Deductible?

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

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

Is there an enrollee

No

Copayment?

Is authorization

Yes

No

Mandatory

required?

Is a referral required for Transportation for Non-

Medical Needs?

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.

Does the plan provide Yes

Indoor Air Quality
Equipment and Services
as a supplemental benefit

under Part C?

Select type of benefit for

Indoor Air Quality
Equipment and Services:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

Copayment?

Is authorization

required?

Is a referral required for No.

Is a referral required for Indoor Air Quality

Equipment and Services?

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?

Select type of benefit for

Social Needs Benefit:

Is there a service-specific

Yes

No

No

Yes

Mandatory Yes







about blank 5/28/2020

гог рага кероп rage of or of

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select Maximum Plan

Every year

Benefit Coverage

periodicity: Is there a service-specific

No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

No

No

No

Copayment? Is authorization

Yes

required?

Is a referral required for No

Social Needs Benefit?

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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

OMINISTRACIO

Contrato Número

1

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

Select type of benefit for

Mandatory

Yes

Complementary

under Part C?

Therapies:

Is there a service-specific

Maximum Plan Benefit

Yes

Coverage amount?

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

No

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

No

Is there an enrollee Copayment?

Is authorization

Yes

required?

Is a referral required for

No

Complementary

Therapies?

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

ahout-blank 5/28/2020 гог раца кероп I age JJ UI UT

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

> 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

Mandatory

500.00

No

No

No

Every year

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?

Select type of benefit for

Services Supporting Self-Direction:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for

Services Supporting Self-Direction?

Yes

No

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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 decisionmaking 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?

Select type of benefit for

General Supports for

Living:

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

Is there a service-specific Maximum Enrollee OutYes

Mandatory





Every year

periodicity:

No





about-blank 5/28/2020 PBP Data Report rage 30 of 04

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

No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes

required?

quireur

Is a referral required for General Supports for

No

Yes

Living?

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?

Select enhanced benefit : 14c8: Home and Bathroom Safety Devices and Modifications\*

(Select all that apply):

Select type of benefit for Mandatory

Home and Bathroom Safety Devices and Modifications:

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

Is there a service-specific Yes

Maximum Plan Benefit
Coverage amount for
Other Defined

Supplemental Benefits?

Select which Other : 14c8: Home and Bathroom Safety Devices and Modifications

Defined Supplemental Benefits have a

Maximum Plan Benefit Coverage amount (Select

all that apply):

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:

Select Maximum Plan Every year

Benefit Coverage
periodicity for Home and
Bathroom Safety
Devices and
Modifications:

TOSDES

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other
Defined Supplemental

Benefits?

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

Is there an enrollee N

Coinsurance?

Nο

500.00

fer

POMINISTRACION

Contrato Número

shout-blank 5/28/2020

rage 37 of 04 гог рана кероп

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

Is there an enrollee

Deductible?

Is there an enrollee

No

Yes

Nο

Copayment?

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

Is authorization

required?

Is a referral required for

Other Defined

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

Yes

No

Home and Bathroom Safety Devices and Modifications Notes:\*

Chronically ill members who participate with Humana's Care Management services can receive nonprimarily 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?

Select enhanced benefits:

: Oral Exams

: Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

Select type of benefit for

Oral Exams:

Mandatory

Yes

Is this benefit unlimited

for Oral Exams?

Select type of benefit for

Mandatory

Prophylaxis (Cleaning):

Is this benefit unlimited

for Prophylaxis (Cleaning)?

Yes

Select type of benefit for

Fluoride Treatment:

Mandatory

Yes

Is this benefit unlimited

for Fluoride Treatment?

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

Select type of benefit for

Dental X-Rays:

Yes

Yes

Mandatory

Is this benefit unlimited

for Dental X-Rays?

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

500.00

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum

Every year

Plan Benefit Coverage

periodicity:

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

No

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

Is there an enrollee

Deductible?

Is there an enrollee

No No





5/28/2020 about-blank

rage 38 01 04 rbr Data Keport

Copayment?

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

Is authorization

required?

Is a referral required for No

Preventive Dental

Services?

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

Yes

Select enhanced benefits: : Non-routine Services

: Diagnostic Services : Restorative Services : Endodontics : Periodontics

: Extractions

Mandatory

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for

Non-routine Services:

Is this benefit unlimited for Non-routine

Services?

Yes

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited

for Diagnostic Services?

Select type of benefit for Restorative Services:

Mandatory

Yes

Yes

Is this benefit unlimited

for Restorative Services?

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

Yes

for Extractions?

Mandatory

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is this benefit unlimited

Yes

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

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

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount?

Select the Maximum Plan-specified amount per period





5/20/2020 ahaut-hlank

гог рана кероп rage of or ut

Plan Benefit Coverage

type:

Indicate Maximum Plan

Benefit Coverage

amount:

Every year

Select the Maximum Plan Benefit Coverage

periodicity:

No

No

500.00

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

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

Is authorization

required?

Yes

Is a referral required for

No

Comprehensive Dental

Services?

Chronically ill members who participate with Humana's Care Management services can receive additional Notes:

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?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for

Routine Eye Exams:

Yes

Mandatory

Yes

Is this benefit unlimited

for Routine Eye Exams?

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select the Maximum

Plan Benefit Coverage periodicity:

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

500.00

Every year

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

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

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

Is authorization

required?

Yes





about blook 5/20/2020 гог раца кероп rage ou or ot

Is a referral required for

Eye Exams?

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?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames Mandatory

Select type of benefit for

Contact lenses:

Is this benefit unlimited Yes

for Contact lenses?

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited

for Eyeglasses (lenses

and frames)?

Mandatory

Mandatory

Yes

Yes

Yes

500.00

Every year

No

Yes

Select type of benefit for

Eyeglass lenses:

Is this benefit unlimited

for Eyeglass lenses?

Select type of benefit for Mandatory

Eyeglass frames:

Is this benefit unlimited Yes

for Eyeglass frames?

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

Plan-specified amount per period

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Do you offer a Yes

Combined Max Plan Benefit Coverage

Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined

Maximum Plan Benefit

Coverage periodicity:

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

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





about-blank 5/28/2020

rage of of 04 ror Data Report

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?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited Yes

for Hearing Aids (all

types)?

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

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Both ears combined

Mandatory

Benefit Coverage Amount apply per ear or

for both ears combined?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

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?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Copayment?

Nο

Is there an enrollee

Deductible?

No

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

Is authorization

Yes

required? 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?

# SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

No

Is there an In-Network

Plan Deductible?

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





ahout blook 5/28/2020

rage oz or o4 гвт рана кероп

Is there an In-Network

Maximum Enrollee Outof-Pocket Cost?

Is your In-Network

Voluntary

Yes

Maximum Enrollee Outof-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Indicate In-Network 3400.00

Maximum Enrollee Outof-Pocket Cost Amount:

Select the benefits that apply to the In-Network Maximum Enrollee Out: In-Network Medicare-covered benefits

of-Pocket cost: Does the In-Network

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

Yes

# services?

#### SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan

Benefit Coverage

Amount?

#### SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions

in Cost Sharing?

#### SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?

# SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Yes

Medicare Prescription drug (Part D) benefit?

Defined Standard

Select the type of drug benefit:

Describe the components : Standard Retail of your pharmacy : Out-of-Network network (select all that : Standard Mail-Order : Long-Term Care apply):

Sponsor attests that it will comply with 42

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

#### SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor Yes

pricing?

CFR 423.154.

Does plan utilize ceiling Yes

pricing?

Are there quantity limits Yes

on certain prescription

drugs?

Is prior authorization

required for certain prescription drugs?

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

Yes







5/28/2020 ahout-hlank

rbr Data Keport rage oo oi o4

formulary design)?

Do any drugs in your formulary require a step Yes

therapy plan?

Do you pay for over-the-

No

counter medications (OTCs) under the

utilization management

program?

# SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail

Cost sharing

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

Location/supply amount

(s) that apply:

Enter number of days for Standard Retail Cost

30

Sharing 1-month supply: Enter number of days for

90

Standard Retail Cost Sharing 3-month supply: Select all Out-of-

; Out-of-Network Pharmacy - one month supply

Network Pharmacy Location/supply amount

(s) that apply:

Enter number of days for

Out-of-Network Pharmacy 1-month 30

supply:

Select all Standard Mail-

Order Cost Sharing

: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply

Location/supply amount

(s) that apply:

Enter number of days for Standard Mail-Order Cost Sharing 1-month

30

supply:

Enter number of days for Standard Mail-Order Cost Sharing 3-month

90

supply: Select the Long-Term

: Long-Term Care Pharmacy - 1-month supply

Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care Pharmacy 1-month

supply:

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

No

31

Are any of the drugs available at an extended day supply limited to a 1-month supply for the

No

first fill?

# SECTION RX: MEDICARE RX - NOTES

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

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

No

Do you offer Part D Rewards and Incentives programs through the



Centrate Número



rbr Data Keport rage 04 01 04

model?







shout-blank 5/09/0000

rage 1 01 02 гыг пана кероп

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

DATA REPORT FOR Contract H4007, PLAN 018, SEGMENT 0

Module: PBP h6j9 Requested By: PLAN SYSTEM INFORMATION Last entry Date: 05/28/2020 PBP Software Version: 2021.01

05/28/2020 08:56:16 PM Eastern Daylight Time Plan Ready for Upload

Timestamp:

**PLAN STATUS** 

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Completed Section B14 Status 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 A: SECTION A-1

Section Mrx Status

HUMANA HEALTH PLANS OF PUERTO RICO, INC. Organization Legal

Name:

Organization Marketing Humana

Organization Web Site:

Name:

Completed

www.humana.com/medicare Plan Name: Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)

Organization Type: Local CCP **HMO** Plan Type:

Enrollee Type: Part A and Part B 40010 - Adjuntas, PR Service Area(s): Service Area(s): 40020 - Aguada, PR 40030 - Aguadilla, PR Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): 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

40110 - Bayamon, PR Service Area(s):

40120 - Cabo Rojo, PR Service Area(s):

DAINISTRACION Contrato Número 21 ഗ POSDES



5/28/2020 ahaut-hlank

rbr Data Report rage 2 01 02

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):	





po

about-blank 5/28/2020

rage 3 of 02 гыг папа кероп

40670 - Santa Isabel, PR

Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s):

Service Area(s): 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR 40740 - Vieques, PR Service Area(s): Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR 40770 - Yauco, PR Service Area(s):

Contract Number: H4007 Plan ID: 018 Segment ID: 0 Contract Period: 2021

Plan Geographic Name: Puerto Rico Island Wide

No

No

No

Is this an Employer-Only

plan?

#### **SECTION A: SECTION A-2**

Does this Plan have a No

CMS-approved Continuation Area?

Do you intend to Yes

participate in the PLATINO program?

Is this a Special Needs Yes

Plan?

Special Needs Plan Dual-Eligible

Type:

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

#### **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

(866)773-5959

Contact Phone Number for Current Medicare

Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

(800)681-3625 Customer Service

Contact Phone Number for Prospective Medicare

Beneficiaries:

Customer Service Contact Local Phone

(800)681-3625





5/20/2020 ahaut-hlank

rbr Data Keport rage 4 01 02

Number for Prospective Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part

D Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

(800)681-3625 Customer Service

Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-Contact TTY/TDD for

Current Part D Medicare

Beneficiaries:

Customer Service (711)-

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

Customer Service (711)-

Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

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

**SECTION A: SECTION A-5** 

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

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

**SECTION A: SECTION A-6** 

Is your organization filing a standard bid for Section D of the PBP?







5/20/2020 ahout-blank

rbr Data Keport rage 3 01 02

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

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

Does the plan provide Yes

Inpatient Hospital-Acute

Services as a

supplemental benefit

under Part C?

Select enhanced benefits: : Additional Days

Select type of benefit for

Mandatory

Additional Days:

Is this benefit unlimited

Yes

for Additional Days?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Does this plan's No

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

Is there an enrollee

No

Coinsurance?

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

Does this plan's No Additional Days cost

sharing vary by hospital (s) in which an enrollee

obtains care?

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

No

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

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

Medicare-covered stay:

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

Indicate the number of day intervals for the Medicare-covered

Zero (No Copayment per Day)

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

Indicate the number of

Lifetime Reserve Days:

Zero (No Copayment per Day)

day intervals for Additional Days:

Contrato Número
21 - 0 0 4

OFF POS DE SAY



about-blank 5/28/2020

rage o or oz гыг папа кероп

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

No

Yes

What is your Inpatient

Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost

sharing on the day of

discharge?

Is authorization

required?

Is a referral required for No Inpatient Hospital-Acute

Services?

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

Does the plan provide

Inpatient Hospital Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

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

Does this plan's

Medicare-covered

benefit cost sharing vary by hospital(s) in which

an enrollee obtains care?

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Yes

No

No

No

No

Copayment?

Do you charge the

Medicare-defined cost shares? (These are the total charges for all services provided to the

enrollee in the inpatient

facility.)

Indicate Copayment amount for the

\$0.00

Medicare-covered stay:

Indicate the number of

day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of

Zero (No Copayment per Day)

Per Admission or Per Stay

day intervals for the Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

benefit period? Do you charge cost

sharing on the day of discharge?

Is authorization

Yes

No

required?

Is a referral required for Inpatient Psychiatric

No







rage / 01 02 гыг раца кероп

Hospital Services?

# SECTION B: #2 SNF - BASE 1

Does the plan provide No

Skilled Nursing Facility

Services as a

supplemental benefit

under Part C?

Do you allow less than 3 Yes

Zero

day inpatient hospital stay prior to SNF admission?

Indicate the Number of

Hospital Days Required

Prior to SNF Admission

(0-2):

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's

Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Copayment?

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

What is your SNF

Original Medicare

No

benefit period?

Is authorization Yes

required?

Is a referral required for No

SNF Services?

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

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

: Medicare-covered Cardiac Rehabilitation Services

Select which Cardiac and Pulmonary

: Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

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

(Select all that apply): (PAD) Services

Indicate Minimum

\$0.00

Copayment amount per service for Medicare-



5/28/2020 ahout-blank

rage o or oz гвг раца кероп

covered Cardiac

Rehabilitation Services:

Indicate Maximum \$0.00 Copayment amount per

service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

\$0.00 Indicate Minimum

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

Peripheral Artery Disease (PAD) Services:

Indicate Maximum \$0.00

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

Disease (PAD) Services:

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

Is authorization Yes

required?

Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

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

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:



rage 9 of 02 rbr Data Keport

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Is the Copayment for

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for waiver:

Enter number of Days or 24

Hours:

Does the No

Emergency/Post-Stabilization Services cost sharing count towards any plan-level

deductible?

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

\$0.00

Yes

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

deductible?

Is the Copayment for No

Medicare-covered Benefits waived if admitted to hospital?

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

Does the plan provide Yes

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

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for

Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Coverage:

Select type of benefit for Worldwide Emergency

Mandatory

Mandatory

Mandatory





гвг рана кероп rage to or oz

Transportation:

Is there a Maximum Plan No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Yes

Copayment?

Select which Worldwide : Worldwide Emergency Coverage Services have a : Worldwide Urgent Coverage : Worldwide Emergency Transportation

Copayment (Select all

that apply):

\$0.00

Yes

Yes

Indicate Minimum Copayment amount for Worldwide Emergency

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency

Coverage:

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

Indicate Minimum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

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

\$0.00

Indicate Minimum Copayment amount for Worldwide Emergency

Transportation:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency Transportation:

waived for Worldwide

Is this Copayment Yes

Emergency

Transportation if admitted to hospital?

Is there an enrollee No

Deductible?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No





5/20/2020 ahout-blank

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Is authorization

Yes

required?

Is a referral required for

No

Partial Hospitalization?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Yes

No

Is a referral required for

Home Health Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as No

OMINISTRACION Contrato Número -0.0GUROS DE



гог раца кероп rage 12 01 02

a supplemental benefit

under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2 No

Is there an enrollee

Coinsurance?

Yes

Is there an enrollee

Copayment?

Select which : Medicare-covered Chiropractic Services

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

Indicate Minimum . \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Benefits:

Is there an enrollee

No

Deductible?

Is authorization No required?

Is a referral required for

Chiropractic Services?

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

Yes

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

\$0.00 Indicate Maximum

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization Yes

required?

Is a referral required for

Yes

Occupational Therapy

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes







5/28/2020 ahout-blank

rage 15 of 02 rbr Data Keport

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

No

Yes

Is authorization required?

Is a referral required for Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No No

Is there an enrollee

Deductible?

Yes

Is there an enrollee Copayment?

Select which Mental : Medicare-covered Individual Sessions : Medicare-covered Group Sessions

Health Specialty Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization Yes

required?

Is a referral required for Yes

Mental Health Specialty

Services - Non-Physician?

**SECTION B: #7F PODIATRY SERVICES - BASE 1** 

Does the plan provide

Podiatry Services as a supplemental benefit under Part C?

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee No Contrato Número - 0 0 POSDE

ahaut-hlank 5/28/2020 гыг папа кероп rage 14 01 02

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

: Medicare-covered Podiatry Services

Copayment?

Select which Podiatry

Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00 Copayment amount per

visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

**SECTION B: #7F PODIATRY SERVICES - BASE 3** 

Is authorization

required?

No

Is a referral required for

No

Podiatrist Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

No

Is a referral required for

No

Other Health Care Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 No

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

No Yes

Copayment?

Is there an enrollee

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

Services have a

Copayment (Select all

Select which Psychiatric

that apply):

\$0.00 Indicate Minimum

PAINISTRACION PR Centrato Número POSDE



5/20/2020 ahout-blank

rage 13 01 02 гыг рана кероп

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Group

# SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required for No

Psychiatric Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Yes No

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Yes

Additional Telehealth benefit for Part B

services?

Select the Medicare-: 4b: Urgently Needed Services covered benefits that : 7a: Primary Care Physician Services may have Additional : 7d: Physician Specialist Services

Telehealth Benefits

: 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services

available:

: 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services

: 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abusini STRAC/O : 9c2: Group Sessions for Outpatient Substance Abusini STRAC/O

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost for Additional Telehealth?

Centrate Número



5/28/2020

ahaut-hlank

гог рана кероп rage 10 01 02

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

Is there an enrollee

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization required

for Additional Telehealth

Services?

Is a referral required for

Additional Telehealth

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee

Yes

No

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization required?

Is a referral required for No

Opioid Treatment Program Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Copayment?

No

Is there an enrollee

Yes

Select which Outpatient

Diag Procs/Tests/Lab

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

Services have a

Copayment (Select all





that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Diagnostic

Procedures/Tests:

Indicate Maximum

Copayment amount for

Medicare-covered

Diagnostic

Procedures/Tests:

Indicate Minimum

\$0.00

\$0.00

\$0.00

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum

Copayment amount for Medicare-covered Lab

Services:

If a member receives

Yes

multiple services at the same location on the same day, does only the maximum copay apply?

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

Is authorization

Yes

required?

Is a referral required for

Outpatient Diagnostic

Procedures/Test/Lab

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

: Medicare-covered X-Ray Services

: Medicare-covered Diagnostic Radiological Services

: Medicare-covered Therapeutic Radiological Services

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Outpatient

Diag/Therapeutic Rad

Services have a

Copayment (Select all

that apply):

Indicate Minimum Copayment amount for

other Medicare-covered

Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum

Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Minimum Copayment amount for Medicare-covered

Therapeutic Radiological

Services:

\$0.00

\$0.00







Indicate Maximum

Copayment amount for Medicare-covered

Therapeutic Radiological

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

If a member receives

Yes

\$0.00

multiple services at the same location on the same day, does only the maximum copay apply?

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

Is authorization

Yes

No

required?

Is a referral required for

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? Select which Services

have a Copayment

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

(Select all that apply):

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

\$0.00 Indicate Maximum

Copayment amount per visit for Medicarecovered Observation

Services:

Is authorization required for Medicare-covered Outpatient Hospital

Services?







rage 19 01 02 гыг Бага кероп

Is authorization required

for Medicare-covered Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient Hospital

Services?

Is a referral required for Yes

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Yes

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Is authorization Yes

required?

Is a referral required for No

Ambulatory Surgical Center Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Outpatient Substance Abuse

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

services have a Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00





rage zu or oz гог рана кероп

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization required?

No

Is a referral required for No

Outpatient Substance

Abuse?

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

Does the plan provide Yes

Outpatient Blood Services as a supplemental benefit under Part C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Mandatory

Three (3) Pint Deductible Waived:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

No

No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for No

Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment? : Medicare-covered Ground Ambulance Services

Select which Services

have a Copayment : Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum \$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum \$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:







5/20/2020 ahout-blank

rage ZI OI OZ гог раца кероп

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

hospital?

No

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

Is authorization required

Yes

No

for non-emergency Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Mandatory

Plan Approved Healthrelated Location:

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

Indicate number of trips 48

for Plan Approved Health-related Location:

Select Plan Approved

Health-related Location

Trips periodicity:

Select Type of Transportation for Plan Approved Health-related

Location:

Select Mode of

: Van : Other, Describe

Transportation for Plan Approved Health-related

Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Every year

One-way

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

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

trip:

Indicate Maximum

\$0.00

Copayment amount per

trip:

Is authorization

Yes

required?

Is a referral required for No

Transportation Services?





5/20/2020 about-blank

rage 22 01 02 ror Data Keport

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** 

No

No

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Benefits:

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

Are there preferred No

vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization Yes

required?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No Yes

Is there an enrollee

Copayment? Select which

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

Prosthetics/Medical Supplies have a Copayment (Select all

that apply):

\$0.00 Indicate Minimum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Medical

Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Medical Supplies:







5/20/2020 ahout-blank

rage 23 of 02 гог рана кероп

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

Is authorization

Yes

required?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

Yes

Select which Diabetic

: Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment

(Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

\$0.00 Indicate Maximum

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

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

Is authorization

No

Yes

required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Nο

Deductible?

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount per session for Medicare-

covered Benefits:

\$0.00

Copayment amount per session for Medicare-

Indicate Maximum







5/20/2020 about-blank

rdr Data Report rage 24 of 62

covered Benefits:

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

required?

Is a referral required for No

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

No

Acupuncture as a supplemental benefit under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide

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

Select type of benefit for

Mandatory

Yes

No

No

OTC Items:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 50.00

Benefit Coverage

amount:

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?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Yes

Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

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

formulary drugs.

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

Is there an enrollee

Coinsurance?

No No

Is there an enrollee Deductible?

Is there an enrollee

Copayment?

Does this cover all of the No OTC list which may be

found in Chapter 4 of the Medicare Managed Care

Manual?

No

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

Notes: The plan will provide \$0 copayment for adult diapers box up to one (1) every month. Members who meet

medical criteria. Brand according to exclusive contracted DME provider.

The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet do need cal

Contrato Número

POSDE

criteria.

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

Does the plan provide a

Yes



гвг рана кероп rage 23 of 62

limited duration Meal

Benefit as a

supplemental benefit under Part C? Note:

Only primarily healthrelated meals offered in

accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for

Mandatory

28

No

No

No

No

Meals:

How many days does your Meal Benefit last?

What is the maximum 56 number of meals the

benefit provides?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount:

\$0.00 Indicate Maximum

Copayment amount:

Is authorization Yes

required?

Is a referral required for

the Meal Benefit?

**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

No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

(Optional):

Mandatory

COVID-19 Care Package

Select type of benefit for

Other 2:

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

No

Is there an enrollee Copayment?

Is authorization

Yes

No

required?

Is a referral required for

Other Services?





5/28/2020 ahaut-hlank

гог рана кероп rage 20 01 02

#### SECTION B: #13E OTHER 2 - BASE 3

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

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

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

services that are offered at zero dollar cost sharing.

Services Attestation Is authorization

No

required?

Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical

Exam:

Mandatory

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes \$0.00

Indicate Minimum Copayment amount for each Annual Physical

Exam:

Indicate Maximum Copayment amount for each Annual Physical

Exam:

\$0.00

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

Is authorization

No

required?

Is a referral required for

the Annual Physical

No

Exam? Notes:

An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive

examination than an annual wellness visit. Services in a Routine Physical Exam will include the 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

Yes



rbr Daia Kepoti rage 27 01 02

Other Defined

Supplemental Benefits as a benefit under Part C?

Select enhanced benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling

(Select all that apply): : 14c4: Fitness Benefit\*

Mandatory

Mandatory

Mandatory

: Physical Fitness

4

: 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:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for

Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Select type of benefit for

Home and Bathroom Safety Devices and Modifications:

of benefit for Mandatory

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

Select type of benefit for

Wigs for Hair Loss

Related to Chemotherapy:

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other : 14c15: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply):

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

Indicate Maximum Plan 500.00

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

Select Maximum Plan Every year

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

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

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

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No



about:blank 5/28/2020

rage 20 of 02 гыг пана кероп

Is there an enrollee

No

Copayment?

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

Is authorization

required?

Is a referral required for

No

Other Defined

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco Cessation Counseling

No authorization required for this service.

Notes:

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

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

Modifications Notes:\*

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

Wigs for Hair Loss

Related to

Authorization is required for this service.

Chemotherapy Notes:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization No

required?

Is a referral required for No

Kidney Disease **Education Services?** 

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Medicare-covered Preventive Services?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

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

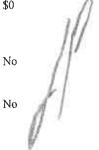
Is there an enrollee



5/20/2020 about blank

rage 29 Of OZ

Copayment? Select which Services : Medicare-covered Glaucoma Screening have a Copayment : Medicare-covered Diabetes Self-Management Training (Select all that apply): : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit : Other Medicare-covered Preventive Services Indicate Minimum \$0 Copayment amount for Medicare-covered Glaucoma Screening: Indicate Maximum \$0 Copayment amount for Medicare-covered Glaucoma Screening: Indicate Minimum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: \$0 Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Minimum \$0 Copayment amount for Medicare-covered Barium Enemas: Indicate Maximum \$0 Copayment amount for Medicare-covered Barium Enemas: **\$**0 Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Minimum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Maximum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: \$0 Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: POMINISTRACION Indicate Maximum \$0 Copayment amount for Other Medicare-covered Preventive Services: Is authorization required



for Medicare-covered Glaucoma Screening? Is authorization required

for Medicare-covered



\$w

rbr Data Report rage 30 of 02

Diabetes Self-

Management Training?

Is authorization required

for Medicare-covered

Barium Enemas?

Is authorization required No

for Medicare-covered Digital Rectal Exams?

Is authorization required

for Medicare-covered EKG following Welcome Visit?

Is authorization required No

for Other Medicarecovered Preventive

Services?

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

Is a referral required for

any Services?

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

Is there a Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Yes

\$0.00

No

No

No

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

Is there an enrollee

Copayment?

Select which Medicare

: Medicare Part B Chemotherapy/Radiation Drugs

: Other Medicare Part B Drugs

Part B Rx Drugs have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Maximum

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Minimum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee No

Deductible?

Is Authorization Yes

Required?

Yes

Does the plan offer step

therapy?

Does the benefit step

: Part B to Part B?

from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Part D home infusion drugs as part of a

No

Does the plan provide
Part D home infusion

Contrato Número

Contrato Número

CON CONTRACTOR DE SAVORO DE SAVO



about-blank 5/29/2020

гог раза кероп rage 31 01 02

bundled service as a mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit

under Part C?

Select enhanced 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:

Other, Describe

Select the Oral Exams periodicity:

Select type of benefit for

Mandatory

Prophylaxis (Cleaning):

Is this benefit unlimited

for Prophylaxis

No, indicate number

(Cleaning)?

Indicate number of visits

for Prophylaxis (Cleaning):

Select the Prophylaxis

(Cleaning) periodicity:

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

Select type of benefit for

Dental X-Rays:

Mandatory

Every year

Is this benefit unlimited

for Dental X-Rays?

No, indicate number

Indicate number of visits

for Dental X-Rays:

Select the Dental X-Rays

Other, Describe

periodicity:

Is there a service-specific No

Maximum Plan Benefit

Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Yes

Coinsurance?

Select which Preventive : Oral Exams

Dental Services have a

: Prophylaxis (Cleaning)

: Dental X-Rays

Coinsurance (Select all

that apply):

No

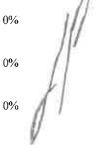
Is there a combination of services included in a single cost per Office

Visit?

Indicate Minimum Coinsurance percentage

for Oral Exams: Indicate Maximum Coinsurance percentage

for Oral Exams: Indicate Minimum 0%







5/20/2020 ahoutchlank

гог рана кероп rage oz or oz

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Maximum

Coinsurance percentage for Prophylaxis

(Cleaning):

Indicate Minimum

0%

0%

Coinsurance percentage for Dental X-Rays:

Indicate Maximum 0%

Coinsurance percentage for Dental X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization

No

required?

Is a referral required for

Preventive Dental

No

Services?

Notes:

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

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 Yes

Does the plan provide

Comprehensive Dental Items as a supplemental benefit under Part C?

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:

Select the Restorative

Other, Describe

Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Mandatory

Select type of benefit for

**Endodontics:** 

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:

Select the Periodontics

periodicity:

Every year

Select type of benefit for

Mandatory

Extractions:

Is this benefit unlimited

for Extractions?

Yes



5/28/2020 ahout-blank

гвг раца кероп rage 33 01 02

Select type of benefit for

Mandatory

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is this benefit unlimited

No, indicate number

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services? Indicate number of visits 3 for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services: Select the

Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Maximum Plan Benefit

Coverage amount? Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan

3000.00

Benefit Coverage

amount:

Select the Maximum

Every year

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Yes

0%

Is there an enrollee

Coinsurance?

Select which : Restorative Services Comprehensive Dental : Endodontics : Periodontics Services have a Coinsurance (Select all : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services that apply):

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum 25%

Coinsurance percentage for Restorative Services:

Indicate Minimum 0%

Coinsurance percentage

for Endodontics:

0% Indicate Maximum

Coinsurance percentage for Endodontics:

Indicate Minimum

Coinsurance percentage for Periodontics:

0%

0%

0%

Indicate Maximum Coinsurance percentage

for Periodontics:

Indicate Minimum Coinsurance percentage

for Extractions:

Indicate Maximum 0%



5/28/2020 ahout-blank

гог рана кероп rage 34 of 02

Coinsurance percentage

for Extractions:

Indicate Minimum 25%

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

Indicate Maximum 25%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

: Medicare-covered Benefits Select which

Comprehensive Dental Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization

required?

No

Is a referral required for

Comprehensive Dental

Services?

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?

: Routine Eye Exams

No, indicate number

Select enhanced benefit: Select type of benefit for

Routine Eye Exams:

Mandatory

Yes

Is this benefit unlimited

for Routine Eye Exams?

Indicate number of 1

exams for Routine Eye

Exams:

Select the Routine Eye

Exams periodicity:

Every year

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific

No Maximum Enrollee Outof-Pocket Cost?

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

Is there an enrollee





5/20/2020 ahout-hlank

тыт папа кероп rage 33 of 62

Coinsurance?

Is there an enrollee

Copayment?

Select which Eve Exams : Medicare-covered Benefits have a Copayment : Routine Eye Exams

Yes

\$0.00

\$0.00

No

No

No

(Select all that apply):

Indicate Minimum

Copayment amount for

Medicare-covered Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

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

Is authorization

required?

Is a referral required for

Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Eyewear as a

supplemental benefit

under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for

Contact lenses:

Is this benefit unlimited for Contact lenses?

Indicate quantity

(number of pairs) for Contact lenses:

Select Contact lenses

periodicity:

Every year

Mandatory

No, indicate number

No, indicate number

Select type of benefit for

Eyeglasses (lenses and

frames):

Mandatory

Is this benefit unlimited

for Eyeglasses (lenses

and frames)?

Indicate quantity for

Eyeglasses (lenses and

frames):

Select Eyeglasses (lenses

Every year

1

and frames) periodicity:

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Do you offer a Yes







5/20/2020 ahaut-hlank

rage 50 01 02 тыт папа кероп

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 500.00

Maximum Plan Benefit Coverage amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

Yes

Select which Eyewear : Medicare-covered Benefits

Benefits have a

: Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum \$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for

Contact lenses:

Indicate Maximum \$0.00

Copayment amount for

Contact lenses:

Indicate Minimum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization

required?

No

No

Is a referral required for

Eyewear?

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

Does the plan provide

Yes

Hearing Exams as a supplemental benefit

under Part C?

: Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Select enhanced benefits:

Mandatory

Is this benefit unlimited for Routine Hearing

No, indicate number

Exams?





5/28/2020 ahout-blank

rage 37 01 02 гвг рана кероп

Indicate number for Routine Hearing Exams:

Select Routine Hearing

Every year

Exams periodicity:

Select type of benefit for Mandatory Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for No, indicate number

Hearing Aid?

Indicate number for Fitting/Evaluation for Hearing Aid:

1

Select Fitting/Evaluation

Every year

for Hearing Aid periodicity:

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

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

Is there an enrollee Deductible?

No

Is there a service-specific

No

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Copayment?

Select which Hearing

: Medicare-covered Benefits : Routine Hearing Exams

Exam Benefits have a Copayment (Select all

: Fitting/Evaluation for Hearing Aid

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

\$0.00

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for

Routine Hearing Exams:

Indicate Maximum

Copayment amount for

\$0.00

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:

Is authorization No

required?

Is a referral required for

No

Hearing Exams?

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

Does the plan provide Hearing Aids as a







rage 30 of 02 rbr Data Keport

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Mandatory Hearing Aids (all types):

Is this benefit unlimited

No, indicate number

for Hearing Aids (all

types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all Every year

types) periodicity:

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

Yes

Is there a service-specific Maximum Plan Benefit

Coverage amount? Does the Maximum Plan

Per ear

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

Select the Maximum Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Indicate Maximum Plan

Every year

Benefit Coverage

periodicity:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

No

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per Hearing Aid (all types):

Indicate Maximum \$0.00

Copayment amount per Hearing Aid (all types):

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization No

required?

Is a referral required for No

Hearing Aids?

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

Does your plan include No

MA Uniformity Flexibility with reductions in cost or additional benefits? Do you offer Special

Yes

Supplemental Benefits for the Chronically III?

Select what type of : Reduced Cost Sharing benefit your SSBCI : Additional Benefits





5/20/2020 ahout-blank

rbr Data Report rage 39 01 02

includes:

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

Does your VBID/MA

Yes

1

Uniformity

Flexibility/SSBCI

benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

in Cost Sharing

VBID/MA Uniformity

Flexibility/SSBCI

benefit contain? (1-15)

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

Is this package

SSBCI

applicable to VBID, MA Uniformity Flexibility or

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?

Which prerequisites are

required for this package?

: Participation in a Care Management Program

Select the benefits that

: Medicare-covered benefits : Non-Medicare-covered benefits

apply to reduced cost sharing:

Select the Medicarecovered benefits that will : 3-1: Cardiac Rehabilitation Services: 3-2: Intensive Cardiac Rehabilitation Services: 3-3: Pulmonary Rehabilitation Services

receive reduced cost sharing:

: 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



2hout:blank 5/28/2020

гог рана кероп rage 40 of 62

Uniformity

Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist

Services?

Select the Non-: 18b1: Hearing Aids (all types)

Medicare-covered benefits that will receive reduced cost sharing:

# 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

No

Coinsurance?

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

Do you offer a reduced

deductible amount?

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

: Medicare-covered benefits : Non-Medicare-covered benefits

copayment cost sharing:

Select all the Medicare-

: 3-1: Cardiac Rehabilitation Services

covered benefits that will

: 3-2: Intensive Cardiac Rehabilitation Services

receive reduced Copayment:

: 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)





5/20/2020 about blank

PDF Data Report Fage 41 01 02

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

Mental Health Specialty

\$0.00

Indicate Maximum

Services







about-blank 5/28/2020

rage 42 of 02

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	\$0.00
Procedures/Tests Indicate Minimum Copayment for Lab	\$0.00







shout-blank 5/28/2020

rbr Data Report rage 45 01 02

Services

Indicate Maximum

Copayment for Lab

Services

Indicate Minimum \$0.00

\$0.00

\$0.00

Copayment for

Diagnostic Radiological

Services

Indicate Maximum \$0.00

Copayment for

Diagnostic Radiological

Services

Indicate Minimum \$0.00

Copayment for

Therapeutic Radiological

Services

Indicate Maximum \$0.00

Copayment for

Therapeutic Radiological

Services

Indicate Minimum

Copayment for Outpatient X-Ray

Services

Indicate Maximum \$0.00

Copayment for Outpatient X-Ray

Services

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

Indicate Minimum \$0.00

Copayment for

Outpatient Hospital

Services

Indicate Maximum \$0.00

Copayment for Outpatient Hospital

Services

Indicate Minimum \$0.00

Copayment for Ambulatory Surgical Center (ASC) Services

Indicate Maximum \$0.00

Copayment for Ambulatory Surgical Center (ASC) Services

Indicate Minimum \$0.00

Copayment for Individual Sessions for Outpatient Substance Abuse

Indicate Maximum \$0.00

Copayment for Individual Sessions for Outpatient Substance

Abuse

Indicate Minimum \$0.00 Copayment for Group

Sessions for Outpatient Substance Abuse

Substance Abuse

Indicate Maximum \$0.00 Copayment for Group Sessions for Outpatient

Indicate Minimum \$0.00







about-blank 5/28/2020

rbr Data Keport rage 44 01 02

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	\$0.00
Supplies Indicate Maximum Copayment for Medical	\$0.00
Supplies Indicate Minimum Copayment for Diabetic	\$0.00
Supplies Indicate Maximum Copayment for Diabetic	\$0.00
Supplies Indicate Minimum Copayment for Diabetic Therapeutic	\$0.00
Shoes/Inserts Indicate Maximum Copayment for Diabetic Therapeutic	\$0.00
Shoes/Inserts Indicate Minimum Copayment for Dialysis Services	\$0.00
Indicate Maximum Copayment for Dialysis Services	\$0.00
Indicate Minimum Copayment for Medicare Part B	\$0.00
Chemotherapy/Radiation Drugs	ድል ልል
Indicate Maximum Copayment for Medicare Part B Chamatherany/Radiation	\$0.00
Chemotherapy/Radiation Drugs Indicate Minimum	\$0.00
Copayment for Other Medicare Part B Drugs Indicate Maximum	\$0.00
Copayment for Other Medicare Part B Drugs Indicate Minimum	\$0.00
Copayment for Comprehensive Dental Indicate Maximum	\$0.00
Copayment for Comprehensive Dental Indicate Minimum	\$0.00
Copayment for Eye Exams	\$3.00







грг рана кероп rage 40 01 02

Indicate Maximum

\$0.00

Copayment for Eye

Exams

Indicate Minimum

\$0.00

\$0.00

\$0.00

\$0.00

Copayment for Eyewear

Indicate Maximum

Copayment for Eyewear

Indicate Minimum

\$0.00

Copayment for Hearing

Exams

Indicate Maximum

Copayment for Hearing

Exams

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

Indicate Minimum

Copayment for Hearing

Aids (all types)

Indicate Maximum

\$0.00

No

500.00

Copayment for Hearing

Aids (all types)

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

PACKAGE #1

Are you offering

retroactive

reimbursement?

Is there a maximum Yes

aggregate amount of reduced cost sharing?

Specify the maximum

aggregate amount of reduced cost sharing:

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 nonprimarily 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

Yes

1

Does your VBID/MA

Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

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

: Participation in a Care Management Program

Is this package SSBCI

applicable to VBID or MA Uniformity Flexibility or 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?

Which prerequisites are

required for this

package?

Select all the Non-: 10b: Transportation Services Medicare-covered : 13b: Over-the-Counter (OTC) Items

additional benefits : 13c: Meal Benefit

: 13i: Non-Primarily Health Related Benefits for the Chronically III offered in this package:

PANINISTRACION Contrato Número 0 0 co O POSDE

5/20/2020 ahout-blank

гог раза кероп rage 40 of 02

: 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?

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

Are you offering

No

No

retroactive reimbursement?

benefit amount?

Is there a maximum

No

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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 Yes Transportation Services

as a supplemental benefit

under Part C?

Plan Approved Health-related Location Select enhanced benefit: Mandatory

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited Yes

for number of trips for Plan Approved Healthrelated Location?

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Taxi

Transportation for Plan : Rideshare Services Approved Health-related : Bus/Subway Location: ; Van

: Medical Transport

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan 1000.00

Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee

Every year



No

No



5/28/2020 ahout-blank

rbr Data Report rage 47 01 02

Deductible?

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

Is there an enrollee

No

Copayment?

Is authorization

Yes

Yes

required?

Is a referral required for No

Transportation Services?

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?

Select type of benefit for

OTC Items:

Mandatory

- ·

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

1000.00

Yes

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

periodicity:

Every year

No

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Yes

Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement

Therapy (NRT)

Attestation:

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

formulary drugs.

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

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

140

No

Is there an enrollee

lee No

Copayment?

Does this cover all of the Yes

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

Manual?

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 healthrelated meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.









rage 48 01 02 гог рана кероп

Select type of benefit for

Mandatory

Meals:

How many days does

your Meal Benefit last?

What is the maximum 168

number of meals the benefit provides?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment? Is authorization

Yes

required?

Is a referral required for

No

the Meal Benefit?

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

Members who are diagnosed with Chronic Pulmonary Disease (COPD), Diabetes, Congestive Heart Notes:

> 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

: Food and Produce

benefit your Non-: Meals (beyond limited basis)

Primarily Health Related : Pest Control

Benefits for the : Transportation for Non-Medical Needs Chronically Ill includes: : 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

Yes

supplemental benefit under Part C?

Select type of benefit for

Mandatory

Food and Produce:

Yes

Is there a service-specific Maximum Plan Benefit

Coverage amount? Indicate Maximum Plan

1000.00

Benefit Coverage

amount:

Every year

Select Maximum Plan Benefit Coverage periodicity:

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 #1

Is there an enrollee

Νo





5/28/2020 ahoutchlank

PBP Data Report Page 49 01 02

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization

Yes

No

Mandatory

50

150

Yes

1000.00

Every year

required?

Is a referral required for

Food and Produce?

## 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?

Select type of benefit for Meals (beyond limited

basis):

How many days do your

Meals (beyond limited

basis) last?

What is the maximum

number of meals the benefit provides?

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee

Deductible?
Is there an enrollee

Copayment?
Is authorization

required?

Is a referral required for the Meals (beyond

the Meals (beyond limited basis)?

No No

No

No

Yes

No

Contrato Número

POS DE SAV

## 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

about-blank

5/28/2020

гог рана кероп rage ou or oz

supplemental benefit

under Part C?

Select type of benefit for Mandatory

Pest Control:

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Benefit Coverage

Indicate Maximum Plan

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

No

Yes

1000.00

Every year

Is there an enrollee

Deductible?

Is there an enrollee

No

No

Yes

Yes

One-way

1000.00

Copayment?

Yes

Is authorization required?

Is a referral required for

Pest Control?

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Mandatory

Plan-approved Location:

Is this benefit unlimited

for number of trips for

Plan-approved Location?

Select Type of

Transportation for Non-Medical Needs for Planapproved Location:

Select Mode of

: Taxi

Transportation for Non-: Rideshare Services Medical Need for Plan-: Bus/Subway : Van

approved Location:

: Medical Transport

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?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan Every year Contrato Número



5/28/2020 about-blank

грг раца кероп rage of or oz

Benefit Coverage periodicity:

Is there a service-specific

No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: VBJD/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment?

No

Is authorization

Yes

required?

Is a referral required for Transportation for NonNo

Medical Needs?

Notes:

Chronically ill members who participate with Humana's Care Management services can receive nonprimarily 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?

Select type of benefit for Mandatory

Indoor Air Ouality Equipment and Services:

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 1000.00

Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

Is there an enrollee

No

Copayment? Is authorization

Yes

required? Is a referral required for Indoor Air Quality

No

POSDE Equipment and Services?

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 nonprimarily 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.

OMINISTRACION

Contrato Número

-0.0

5/28/2020 about blank

гог раца кероп rage oz or oz

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

Does the plan provide Social Needs Benefit as Yes

a supplemental benefit

under Part C?

Select type of benefit for

Mandatory

Social Needs Benefit:

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount? Indicate Maximum Plan

Benefit Coverage

1000.00

amount:

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 SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

No

Is authorization

Yes

required?

No

Is a referral required for Social Needs Benefit?

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 nonprimarily 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

Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

1000.00

Benefit Coverage amount:

Select Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee

Nο

Deductible?





about blank 5/20/2020

rage 33 of 62 гог рана кероп

Is there an enrollee

No

Copayment? Is authorization

Yes

required?

Is a referral required for

No

Complementary Therapies?

## 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 nonprimarily 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?

Select type of benefit for Services Supporting

Self-Direction:

Mandatory

Yes

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Every year

1000.00

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization required?

Is a referral required for

Services Supporting

No

No

No

No

Yes

#### Self-Direction?

Notes:

Chronically ill members who participate with Humana's Care Management services can receive nonprimarily 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 decisionmaking 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?

Select type of benefit for Mandatory General Supports for

Living:

Is there a service-specific Yes Maximum Plan Benefit







5/28/2020 ahout-hlank

rdr Data Report rage 54 Ot 02

Coverage amount?

Indicate Maximum Plan 1

1000.00

Benefit Coverage

amount:

Select Maximum Plan

Every year

Benefit Coverage periodicity:

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 #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes

required?

Is a referral required for No

General Supports for

Living?

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

Yes

Other Defined Supplemental Benefits as

a benefit under Part C?

Select enhanced benefit : 14c8: Home and Bathroom Safety Devices and Modifications\*

(Select all that apply):

Select type of benefit for Mandatory

Home and Bathroom Safety Devices and Modifications:

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

Is there a service-specific Ye

Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other : 14c8: Home and Bathroom Safety Devices and Modifications

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select

all that apply):

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:

Select Maximum Plan Benefit Coverage

ahautihlank

periodicity for Home and Bathroom Safety 1000.00

Every year



Contrato Número

21 - 0 0 4

OFFICUROS DE SEV



5/28/2020

гог рана кероп rage 33 of 02

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 Outof-Pocket Cost for Other Defined Supplemental Benefits?

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

Is there an enrollee

Coinsurance?

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

Is there an enrollee

No

Yes

No

Yes

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization

required?

Is a referral required for

Other Defined

Supplemental Benefits?

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 nonprimarily 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?

Select enhanced benefits: : Oral Exams

> : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

Select type of benefit for

Oral Exams:

Mandatory

Is this benefit unlimited

Yes

for Oral Exams?

Select type of benefit for Mandatory

Prophylaxis (Cleaning):

Is this benefit unlimited

for Prophylaxis

(Cleaning)?

Yes

Mandatory

Select type of benefit for

Fluoride Treatment:

Is this benefit unlimited Yes

for Fluoride Treatment?

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

Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

1000.00

Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage Every year





5/28/2020 ahout-blank

гог раза кероп rage 30 of 02

periodicity:

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Nο

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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 preventive 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?

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

Yes

Services? Select type of benefit for

Mandatory

Yes

Diagnostic Services:

Is this benefit unlimited

for Diagnostic Services?

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited

Yes

for Restorative Services?

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

Mandatory

Periodontics:

Is this benefit unlimited

Yes

for Periodontics?

Select type of benefit for

Extractions:

Is this benefit unlimited for Extractions?

Select type of benefit for Prosthodontics, Other

Mandatory

Mandatory

MINISTRACION STRACION Contrato Número

5/28/2020 ahoutchlank

гвт раца кероп rage 37 of 62

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited Yes

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

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

Indicate Maximum Plan

1000.00

Benefit Coverage

amount:

Select the Maximum

Every year

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

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

Yes

Eye Exams as a supplemental benefit

under Part C?

Select enhanced benefit:

: Routine Eye Exams

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited

Yes

for Routine Eye Exams?

Yes

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

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select the Maximum

Plan Benefit Coverage periodicity:

Every year

Is there a service-specific Maximum Enrollee Out-







5/20/2020 ahout-blank

гвг раза кероп rage 38 of 62

of-Pocket Cost?

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

Is there an enrollee

Is there an enrollee

Coinsurance?

Copayment?

Is there an enrollee

No

No

No

Deductible?

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

Yes

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?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Mandatory

Is this benefit unlimited

for Contact lenses?

Yes

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited Yes

for Eyeglasses (lenses

and frames)?

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

Select type of benefit for Mandatory

Eyeglass lenses:

Is this benefit unlimited Yes

for Eyeglass lenses?

Select type of benefit for

Eyeglass frames:

Mandatory

Is this benefit unlimited Yes

for Eyeglass frames?

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

Plan-specified amount per period

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Do you offer a Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 500.00

Maximum Plan Benefit

Coverage amount:

Select the Combined

Maximum Plan Benefit Coverage periodicity:

Every year

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

SMINISTRACION Contrato Número -0.0CUROSDE



5/28/2020 ahout-blank

гыг пана кероп rage by of of

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization

required?

Yes No

No

Is a referral required for

Eyewear?

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?

Select enhanced benefits: : Hearing Aids (all types)

Mandatory

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited Yes

for Hearing Aids (all

types)?

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Both ears combined

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

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan 1000.00

Benefit Coverage

amount:

Indicate Maximum Plan

Benefit Coverage

periodicity:

Every year

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Copayment?

No

Is there an enrollee

No

Yes

Deductible?

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

Is authorization

required?

Is a referral required for No





5/20/2020 ahout-blank

rbr Data Keport rage ou or oz

Hearing Aids?

Chronically ill members who participate with Humana's Care Management services can receive additional Notes:

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 No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Yes

Is there an In-Network No

Plan Deductible?

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

Is there an In-Network

Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Voluntary

Maximum Enrollee Outof-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Indicate In-Network 3400.00

Maximum Enrollee Outof-Pocket Cost Amount:

Select the benefits that : In-Network Medicare-covered benefits

apply to the In-Network Maximum Enrollee Outof-Pocket cost:

Does the In-Network Yes

Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan

services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan No

Benefit Coverage

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions No

in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined No Supplemental Benefits with uniform cost

sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Yes

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

Defined Standard

benefit:

Describe the components : Standard Retail of your pharmacy : Out-of-Network network (select all that : Standard Mail-Order apply): : Long-Term Care

Sponsor attests that it will comply with 42

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

CFR 423.154.

**SECTION RX: MEDICARE RX GENERAL 2** 

Does plan utilize floor

pricing?

Yes

Does plan utilize ceiling

Yes

pricing?

Contrato Número POSDES



5/28/2020 ahout-blank

rage of of oz гвт раца кероп

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

Yes

therapy plan?

Do you pay for over-thecounter medications (OTCs) under the utilization management program?

No

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

Select all Standard Retail

Cost sharing

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

: Out-of-Network Pharmacy - one month supply

Location/supply amount

(s) that apply:

Enter number of days for 30

Standard Retail Cost

Sharing 1-month supply: Enter number of days for 90

Standard Retail Cost Sharing 3-month supply:

Select all Out-of-Network Pharmacy Location/supply amount

(s) that apply:

Enter number of days for

Out-of-Network Pharmacy 1-month supply:

30

30

90

Select all Standard Mail-Order Cost Sharing Location/supply amount

: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply

(s) that apply: Enter number of days for Standard Mail-Order Cost Sharing 1-month

supply:

Enter number of days for Standard Mail-Order Cost Sharing 3-month

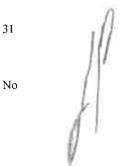
supply:

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

Enter number of days for Long-Term Care Pharmacy 1-month supply:

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

: Long-Term Care Pharmacy - 1-month supply







5/28/2020 about-blank

rage 02 01 02

Are any of the drugs available at an extended day supply limited to a 1-month supply for the 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.



rbr Data Report rage 1 01 04

### 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

ad

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 05/18/2020 12:11:49 PM Eastern Daylight Time

Creation Timestamp:

**PLAN STATUS** 

Timestamp:

Section A Status Plan Ready for Upload

Section B1 Status Completed Completed Section B2 Status Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Completed Section B9 Status Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Completed Section B13 Status 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 A: SECTION A-1** 

Organization Legal HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Section D Status Section Mrx Status

Organization Marketing Humana

Name:

Organization Web Site: www.humana.com/medicare

Completed

Completed

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 40030 - Aguadilla, PR Service Area(s): Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): 40050 - Aibonito, PR 40060 - Anasco, PR Service Area(s): 40070 - Arecibo, PR Service Area(s): Service Area(s): 40080 - Arroyo, PR





rar Data Report

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 40620 - Salinas, PR
Service Area(s): Service Area(s):	70020 - Baillias, FK
Bervice Area(8).	



\$V

rbr Data Keport rage 5 of 64

40630 - San German, PR

Service Area(s): 40640 - San Juan, PR Service Area(s): 40650 - San Lorenzo, PR 40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, 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 No

plan?

### **SECTION A: SECTION A-2**

Does this Plan have a No CMS-approved

Continuation Area?

Do you intend to Yes

participate in the PLATINO program?

Is this a Special Needs Yes

Plan?

Special Needs Plan

Type:

Is this D-SNP plan a No

Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

**SECTION A: SECTION A-3** 

Participating Pharmacy

Website Address:

https://www.humana.com/pharmacy/

Formulary Website

http://www.humana.com/medicare/medicare\_prescription\_drugs/medicare\_drug\_tools/medicare\_drug\_list/

Address:

Physician Website www.humana.com/members/tools

No

Dual-Eligible

Address:

Customer Service (866)773-5959

Contact Phone Number for Current Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service (800)681-3625







rbr Data Keport rage 4 of 04

Contact Phone Number for Prospective Medicare

Beneficiaries:

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part D Medicare

D Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare Beneficiaries:

Customer Service (711)Contact TTY/TDD for

Current Part D Medicare Beneficiaries:

Customer Service (711)-Contact Local TTY/TDD

for Current Part D Medicare Beneficiaries:

Customer Service (711)-Contact TTY/TDD for

Prospective Part D
Medicare Beneficiaries:

Customer Service (711)-

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

**SECTION A: SECTION A-5** 

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

Is your organization No filing a standard bid for







rbr Data Report rage 3 01 04

Section C of the PBP?

#### SECTION A: SECTION A-6

Is your organization N filing a standard bid for Section D of the PBP?

Do any of your No

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

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

Does the plan provide Yes

Inpatient Hospital-Acute

Services as a

supplemental benefit

under Part C?

Select enhanced benefits: : Additional Days

Select type of benefit for

Additional Days:

Is this benefit unlimited Yes

for Additional Days?

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

Mandatory

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Does this plan's No

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

Is there an enrollee No

Coinsurance?

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

Does this plan's No Additional Days cost

sharing vary by hospital (s) in which an enrollee

obtains care?

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

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

Indicate the number of Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

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

Indicate the number of Zero (No Copayment per Day)

day intervals for the Medicare-covered



гвг рака кероп rage o of 04

Lifetime Reserve Days:

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

Indicate the number of day intervals for

Zero (No Copayment per Day)

Per Admission or Per Stay

Additional Days:

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

No

Yes

No

No

No

What is your Inpatient

Hospital-Acute benefit

period?

Do you charge cost

sharing on the day of

discharge?

Is authorization required?

Is a referral required for Inpatient Hospital-Acute

Services?

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

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's No Medicare-covered

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

Indicate the number of Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

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

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

No

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

benefit period?

Do you charge cost

Per Admission or Per Stay



5/29/2020 about-blank

rage / or 04 гвг раца кероп

sharing on the day of

discharge?

Is authorization Yes

required?

Is a referral required for No

Inpatient Psychiatric Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide No

Skilled Nursing Facility

Services as a

supplemental benefit

under Part C?

Do you allow less than 3 Yes

day inpatient hospital stay prior to SNF admission?

Indicate the Number of

Hospital Days Required

Prior to SNF Admission

(0-2):

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's No

Medicare-covered

benefit cost sharing vary

by the Skilled Nursing

Facility in which an

enrollee obtains care?

Is there an enrollee

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Original Medicare

Is authorization

required?

No

Yes

No

Zero

Is a referral required for SNF Services?

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

Does the plan provide

Cardiac and Pulmonary

Rehabilitation Services

as a supplemental benefit

under Part C?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee Deductible?

No

Yes

Is there an enrollee

Copayment?

Select which Cardiac and : Medicare-covered Cardiac Rehabilitation Services

: Medicare-covered Intensive Cardiac Rehabilitation Services Pulmonary

OMINISTRACION POMINISTRACION Contrato Número 1 - 0.0

rbr Data Keport rage 8 01 04

Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

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

(Select all that apply): (PAD) Services

\$0.00

\$0.00

Indicate Minimum Copayment amount per service for Medicare-

service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Minimum \$0.00

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

Indicate Maximum \$0.00

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

Disease (PAD) Services:

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

Is authorization Yes

required?

Is a referral required for No Cardiac and Pulmonary

Rehabilitation Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Contrato Número

21 - 00 4

CO POS DE SAV



rage 9 of 04 rbr Data Keport

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Yes

24

Copayment amount for

Medicare-covered

Benefits:

Is the Copayment for Medicare-covered

Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for

waiver:

Enter number of Days or

Hours:

Does the No

Emergency/Post-Stabilization Services cost sharing count towards any plan-level

deductible?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Yes

Coinsurance?

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

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Does the Urgently No

Needed Services cost sharing count towards

any plan-level deductible?

Is the Copayment for No

Medicare-covered Benefits waived if admitted to hospital?

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

Does the plan provide

Worldwide

Yes

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

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for

Worldwide Emergency

Mandatory

POMINISTRACION POMINISTRACION Contrato Número - 0 0

гог рана кероп rage 10 01 04

Coverage:

Select type of benefit for

Worldwide Urgent

Coverage:

Mandatory

Select type of benefit for Worldwide Emergency

Mandatory

No

Transportation:

Is there a Maximum Plan

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Yes

\$0.00

Yes

\$0.00

\$0.00

Copayment?

Select which Worldwide

Services have a

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

Copayment (Select all

: Worldwide Emergency Transportation

that apply):

Indicate Minimum \$0.00

Copayment amount for Worldwide Emergency

Coverage:

Indicate Maximum

Copayment amount for Worldwide Emergency

Coverage:

Is this Copayment

waived for Worldwide Emergency Coverage if

admitted to hospital?

Indicate Minimum

Copayment amount for

Worldwide Urgent

Coverage:

Indicate Maximum

Copayment amount for Worldwide Urgent

Coverage:

Is this Copayment Yes

waived for Worldwide Urgent Coverage if admitted to hospital?

Indicate Minimum \$0.00

Copayment amount for Worldwide Emergency

Transportation:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency

Transportation:

Is this Copayment Yes

waived for Worldwide

Emergency Transportation if admitted to hospital?

Is there an enrollee No

Deductible?

ahout-blank

SECTION B: #5 PARTIAL HOSPITALIZATION = BASE 1

Contrato Número O

5/20/2020

rbr Data Keport rage 11 01 04

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Benefits per day:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Benefits per day:

Is authorization Yes

required?

Is a referral required for No Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Is a referral required for

Home Health Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per







5/28/2020 ahaut hlank

rage 12 01 04 грг раца кероп

visit for Medicarecovered Benefits:

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

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

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

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

Is there an enrollee Coinsurance?

No

Is there an enrollee

Yes

\$0.00

Copayment?

Select which Chiropractic Services have a Copayment (Select all that apply): : Medicare-covered Chiropractic Services

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for

Medicare-covered

Benefits:

Is there an enrollee

No

No

Yes

Deductible?

Is authorization

required?

Is a referral required for

Chiropractic Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

\$0.00

\$0.00

No

Copayment?

Indicate Minimum

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Yes

Yes

Is a referral required for

Occupational Therapy

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No





rbr Data Report rage 15 01 04

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization

No

No

required?

Is a referral required for Yes

Physician Specialist

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Select which Mental : Medicare-covered Individual Sessions Health Specialty : Medicare-covered Group Sessions

Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization Yes

required?

Is a referral required for

Mental Health Specialty

Services - Non-Physician?

**SECTION B: #7F PODIATRY SERVICES - BASE 1** 

Yes

Does the plan provide N Podiatry Services as a supplemental benefit

under Part C?





гог раца кероп rage 14 01 04

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

**SECTION B: #7F PODIATRY SERVICES - BASE 2** 

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Podiatry

: Medicare-covered Podiatry Services

Services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

**SECTION B: #7F PODIATRY SERVICES - BASE 3** 

Is authorization

No

required?

Is a referral required for

No

Podiatrist Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

Deductible?

No

Yes

Is there an enrollee

Copayment?

\$0.00

Indicate Minimum Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

No

required?

Is a referral required for

No

Other Health Care Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible? Is there an enrollee

Copayment?

Yes





5/28/2020 ahout-blank

гыг раца кероп rage 10 01 04

Select which Psychiatric

Services have a

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

Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Group

Sessions:

#### SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required for No

Psychiatric Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum

Copayment amount per

\$0.00

visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per visit for Medicare-

covered Benefits:

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

Is authorization

Yes

required?

Is a referral required for No

Physical Therapy and Speech-Language Pathology Services?

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

Do you offer an Yes

Additional Telehealth benefit for Part B

services?

available:

Select the Medicare-: 4b: Urgently Needed Services : 7a: Primary Care Physician Services covered benefits that may have Additional : 7d: Physician Specialist Services

Telehealth Benefits

: 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

POMINISTRACIO Contrato Número POSDES



5/20/2020 about-blank

rbr Data Keport rage 10 01 04

: 9c2: Group Sessions for Outpatient Substance Abuse

Is there a service-specific No Maximum Enrollee Outof-Pocket Cost for Additional Telehealth?

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

No

No

Yes

\$0.00

\$0.00

No

No

No

No

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Indicate Minimum

Copayment amount per

visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per

visit for Medicarecovered Benefits:

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

Is authorization required for Additional Telehealth

Services?

Is a referral required for

Additional Telehealth

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

lee No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization

required?

Is a referral required for No

Opioid Treatment Program Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

No Yes



гог рага кероп rage 17 01 04

Copayment?

Select which Outpatient

Diag Procs/Tests/Lab

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

Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Lab

Services:

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

Yes

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

Is authorization

required?

Is a referral required for Yes

Outpatient Diagnostic Procedures/Test/Lab

Services?

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

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

## 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

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

Services have a Copayment (Select all

: Medicare-covered X-Ray Services

that apply):

\$0.00

Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

\$0.00







5/28/2020

rage 18 01 04 грг раца кероп

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

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

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

Is authorization Yes

required?

No

Is a referral required for

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee No

Deductible?

Yes

Is there an enrollee Copayment?

Select which Services : Medicare-covered Outpatient Hospital Services have a Copayment : Medicare-covered Observation Services

(Select all that apply):

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Observation







5/28/2020 about:blank

rbr Data Kepoti rage 19 01 04

Services:

Is authorization required Yes

for Medicare-covered Outpatient Hospital

Services?

Is authorization required Yes

for Medicare-covered Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient Hospital Services?

Is a referral required for

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Yes

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

e No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

No

Yes

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Is authorization Yes

required?

Is a referral required for No

Ambulatory Surgical Center Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Select which Outpatient : Medicare-covered Individual Sessions
Substance Abuse : Medicare-covered Group Sessions

services have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:







about blank 5/28/2020

гог раца кероп rage 20 01 04

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization

required?

Is a referral required for No

Outpatient Substance

Abuse?

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

Does the plan provide Yes

Outpatient Blood Services as a supplemental benefit under Part C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Mandatory

Three (3) Pint Deductible Waived:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

Is authorization No

required?

Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum \$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for Medicare-covered

Ground Ambulance

\$0.00







5/28/2020 about blank

rage 21 01 04 гвт раца кероп

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment No

waived if admitted to

hospital?

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

Is authorization required

for non-emergency Medicare services?

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

Does the plan provide Yes Transportation Services as a supplemental benefit

under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved HealthMandatory

related Location: Is this benefit unlimited for number of trips for

No

Plan Approved Healthrelated Location? Indicate number of trips

24

for Plan Approved Health-related Location:

Every year

Select Plan Approved Health-related Location

Trips periodicity: Select Type of

One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Van

Transportation for Plan : Other, Describe

Approved Health-related

Location:

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

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

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee

Deductible?

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

Is there an enrollee Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

trip:

Indicate Maximum \$0.00

Copayment amount per

trip:





5/20/2020 ahaut hlank

rage 22 01 04 гог рана кероп

Is authorization

Yes

No

required?

Is a referral required for

Transportation Services?

Notes:

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

wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee

Deductible?

No

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Benefits:

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

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization Yes

required?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

Is there an enrollee

Deductible?

No

No

Is there an enrollee

Copayment?

Yes

Select which

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

Supplies have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

\$0.00 Indicate Minimum Copayment amount per item for Medicare-

covered Medical Supplies:

\$0.00 Indicate Maximum





5/28/2020 ahout-blank

гог рана кероп rage 23 01 04

Copayment amount per item for Medicarecovered Medical Supplies:

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

Is authorization

required?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

Select which Diabetic : Medicare-covered Diabetes Supplies

: Medicare-covered Diabetic Therapeutic Shoes or Inserts Supplies and Services

have a Copayment (Select all that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Do you limit Diabetic Yes Supplies and Services to

those from specified manufacturers?

Is authorization No

required?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No Coinsurance?

Is there an enrollee No

Deductible? Is there an enrollee Yes

Copayment? Indicate Minimum \$0.00

Copayment amount per session for Medicare-







5/28/2020 about blank

rage 24 of 04 гыг раца кероп

covered Benefits:

Indicate Maximum \$0.00

Copayment amount per session for Medicarecovered Benefits:

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

required?

Is a referral required for Dialysis Services?

No

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

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

No

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

Does the plan provide

Yes

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

under Part C?

Select type of benefit for

Yes

No

No

Yes

Mandatory

OTC Items:

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 30.00

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

Every three months

periodicity: Does your Maximum

Plan Benefit Coverage amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering

Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement

Therapy (NRT)

Attestation:

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

co

POMINISTRACIO

Contrate Número

formulary drugs.

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

Is there an enrollee

Coinsurance?

Is there an enrollee

No

Deductible?

No

Is there an enrollee Copayment?

No

No

Does this cover all of the OTC list which may be found in Chapter 4 of the

Medicare Managed Care

Manual?

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

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

criteria.

5/28/2020 about blook

гыг рага керогі rage 23 01 04

#### **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.

Select type of benefit for Mandatory

Meals:

How many days does your Meal Benefit last?

What is the maximum 56 number of meals the benefit provides?

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

No

No

28

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount:

Indicate Maximum \$0.00

Copayment amount:

Yes Is authorization

required?

Is a referral required for No

the Meal Benefit?

## **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

COVID-19 Care Package

(Optional):

Select type of benefit for Mandatory

Other 2:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment? Is authorization

Yes

required?







5/28/2020 ahout-blank

rage 20 01 04 гыг папа кероп

Is a referral required for

No

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?

Nο

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Select type of benefit for

Mandatory

the Annual Physical

Exam:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Nο

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for each Annual Physical

Exam:

Indicate Maximum

Copayment amount for each Annual Physical

Exam:

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

\$0.00

Is authorization

required?

Is a referral required for the Annual Physical

Exam?

Notes:

No

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

ADMINISTR4C

Contrate Número

5/28/2020 about blank

гыг раца кероп rage 27 01 04

#### 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 : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling

(Select all that apply): : 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:

Indicate number of visits 4

offered in addition to

Medicare:

Select type of benefit for

Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Select type of benefit for

Home and Bathroom Safety Devices and Modifications:

Mandatory

Mandatory

: Physical Fitness

Mandatory

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

Select type of benefit for Mandatory

Wigs for Hair Loss

Related to

Chemotherapy:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?

Select which Other : 14c15: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select

all that apply):

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

Indicate Maximum Plan 500.00

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

Select Maximum Plan Every year

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

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental Benefits?

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

Is there an enrollee

Coinsurance?

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

P.DMINISTRACIO POSDESP

5/28/2020

about:blook

rage 28 01 04 гог раца кероп

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization

required?

Yes No

Is a referral required for

Other Defined

Supplemental Benefits? Additional Sessions of

Smoking and Tobacco Cessation Counseling

No authorization required for this service.

Notes:

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

Authorization is required for this service.

Related to

Chemotherapy Notes:

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

Is there an enrollee

Deductible?

No

No

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

\$0.00

Indicate Maximum Copayment amount for

Medicare-covered

Benefits:

Is authorization

No

required?

Is a referral required for

No

Kidney Disease **Education Services?** 

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Medicare-covered Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

OMINIS TRACION Contrato Número POSDE

5/20/2020 ahout-blank

rbr Data Report rage 29 01 04

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

Is there an enrollee

Copayment?

: Medicare-covered Glaucoma Screening

Select which Services have a Copayment

: Medicare-covered Diabetes Self-Management Training

(Select all that apply):

: Medicare-covered Digital Rectal Exams

Indicate Minimum

Copayment amount for Medicare-covered

Glaucoma Screening:

Indicate Maximum Copayment amount for

Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-

Management Training:

Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-

Management Training:

Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:

Copayment amount for Medicare-covered

Indicate Minimum Copayment amount for Medicare-covered

Digital Rectal Exams:

Copayment amount for Medicare-covered Digital Rectal Exams:

Indicate Minimum Copayment amount for following Welcome

Visit:

Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome

Visit:

Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services:

Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services:

Is authorization required for Medicare-covered Glaucoma Screening?

: Medicare-covered Barium Enemas

: Medicare-covered EKG following Welcome Visit

: Other Medicare-covered Preventive Services

**\$**0

\$0

\$0

\$0

\$0

Yes

\$0

\$0

Indicate Maximum

Barium Enemas:

\$0

Indicate Maximum \$0

Medicare-covered EKG

\$0

\$0

No





5/28/2020 ahout-blank

гот рана кероп rage ou of 04

Is authorization required No

for Medicare-covered

Diabetes Self-

Management Training?

Is authorization required No for Medicare-covered

Barium Enemas?

Is authorization required No for Medicare-covered

Digital Rectal Exams?

Is authorization required No for Medicare-covered

EKG following Welcome Visit?

Is authorization required No

for Other Medicarecovered Preventive

Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4 Is a referral required for

any Services?

Is there a Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee No

Coinsurance?

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

Yes

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

Is there an enrollee

Copayment?

Select which Medicare : Medicare Part B Chemotherapy/Radiation Drugs

: Other Medicare Part B Drugs

Part B Rx Drugs have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Maximum \$0.00

Copayment Amount for Medicare Part B

Chemotherapy/Radiation

Drugs:

\$0.00 Indicate Minimum

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum \$0.00

Copayment Amount for other Medicare Part B

Is there an enrollee No

Deductible?

Is Authorization Yes

Required? Does the plan offer step

therapy?

Yes

Does the benefit step

: Part B to Part B?

from (select all that apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide

ADMINISTRACION D Contrato Múrnero 1 - 00GUPOS DE



5/28/2020 ahout-blank

rage 51 01 04 гвг раца кероп

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

benefit?

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

Does the plan provide Preventive Dental Items as a supplemental benefit

under Part C?

Select enhanced benefits: : Oral Exams

: Prophylaxis (Cleaning)

: Dental X-Rays

Select type of benefit for

Oral Exams:

Mandatory

Is this benefit unlimited for Oral Exams?

Indicate number of visits

No, indicate number

for Oral Exams:

Select the Oral Exams

Other, Describe

periodicity:

Select type of benefit for

Mandatory

Prophylaxis (Cleaning):

Is this benefit unlimited

for Prophylaxis

No, indicate number

(Cleaning)?

Indicate number of visits

for Prophylaxis (Cleaning):

2

Select the Prophylaxis

Every year

(Cleaning) periodicity:

# 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:

Select the Dental X-Rays

Other, Describe

periodicity:

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Yes

Coinsurance?

Select which Preventive

: Oral Exams : Prophylaxis (Cleaning)

Dental Services have a Coinsurance (Select all

: Dental X-Rays

that apply):

Is there a combination of

services included in a single cost per Office

Visit?

Indicate Minimum 0%

Coinsurance percentage

for Oral Exams:

Indicate Maximum 0% Coinsurance percentage

No



Contrato Múnero POSDE



5/20/2020 about blank

гог раца кероп rage 32 of 04

for Oral Exams:

Indicate Minimum 0%

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Maximum 0%

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Minimum 0%

Coinsurance percentage for Dental X-Rays:

Indicate Maximum 0%

Coinsurance percentage for Dental X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5 No

Is authorization

required?

Is a referral required for

Preventive Dental

No

Services?

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

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

years.

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

Does the plan provide

Comprehensive Dental Items as a supplemental benefit under Part C?

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

No, indicate number

for Restorative Services? Indicate number of visits

for Restorative Services:

Select the Restorative

Other, Describe

Services periodicity:

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:

Select the Periodontics

Every year

periodicity:

Select type of benefit for Mandatory

Extractions:





5/20/2020 ahout-blank

rage 33 01 04 гог рана кероп

Is this benefit unlimited

for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited

No, indicate number

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services? Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the

Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Maximum Plan Benefit Coverage amount?

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

Every year

periodicity:

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

No

Is there an enrollee Yes

Coinsurance?

Select which : Restorative Services

Comprehensive Dental : Endodontics Services have a : Periodontics Coinsurance (Select all : Extractions

that apply): : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Minimum 0%

Coinsurance percentage for Restorative Services:

Indicate Maximum 50%

Coinsurance percentage for Restorative Services:

0% Indicate Minimum

Coinsurance percentage

for Endodontics:

Indicate Maximum 0%

Coinsurance percentage for Endodontics:

Indicate Minimum

50%

Coinsurance percentage for Periodontics:

Indicate Maximum

50%

Coinsurance percentage for Periodontics:

Indicate Minimum Coinsurance percentage

0%





5/28/2020 about blook

rage 34 01 04 гог раш кероп

for Extractions:

Indicate Maximum 0%

Coinsurance percentage

for Extractions:

50% Indicate Minimum

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

Indicate Maximum 50%

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

Is there an enrollee No

Deductible?

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

Is there an enrollee

Yes

Copayment?

Select which : Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

No

Is authorization Yes

required?

Is a referral required for

Comprehensive Dental

Services?

Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to Notes:

> 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

Every year

No

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited No, indicate number

for Routine Eye Exams?

Indicate number of

exams for Routine Eye Exams:

Select the Routine Eye

Exams periodicity:

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

No







5/28/2020 abouteblank

гыг цана кероп rage 33 01 04

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Yes

Copayment?

Select which Eye Exams : Medicare-covered Benefits

have a Copayment

: Routine Eye Exams

(Select all that apply):

Indicate Minimum

\$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

No

No

No

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

Is authorization required?

Is a referral required for

Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Eyewear as a supplemental benefit under Part C?

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:

Select Contact lenses periodicity:

Select type of benefit for

Every year Mandatory

Eyeglasses (lenses and

frames):

No, indicate number

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Indicate quantity for Eyeglasses (lenses and

frames):

Select Eyeglasses (lenses Every year

and frames) periodicity:

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

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

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period



5/29/2020 ahoutchlank

PBF Data Report rage 30 01 04

type:

Do you offer a Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 400.00

Maximum Plan Benefit Coverage amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

Select which Eyewear : Medicare-covered Benefits

Benefits have a : Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for

Contact lenses:

Indicate Maximum \$0.00

Copayment amount for

Contact lenses:

Indicate Minimum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

No

Is a referral required for

No

Eyewear?

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

Does the plan provide Yes

Hearing Exams as a supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams

Mandatory

: Fitting/Evaluation for Hearing Aid

Select type of benefit for

Routine Hearing Exams:



ahout-blank 5/28/2020

rage 57 01 04 гог раца кероп

Is this benefit unlimited

for Routine Hearing

Exams?

Indicate number for

Routine Hearing Exams:

Select Routine Hearing

Exams periodicity:

Every year

No, indicate number

No, indicate number

Select type of benefit for

Fitting/Evaluation for

Hearing Aid:

Mandatory

Is this benefit unlimited

for Fitting/Evaluation for

Hearing Aid?

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation

for Hearing Aid periodicity:

Every year

1

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

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

Is there an enrollee No

Deductible?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Yes

\$0.00

Is there an enrollee

Copayment?

: Medicare-covered Benefits : Routine Hearing Exams

Exam Benefits have a Copayment (Select all

Select which Hearing

that apply):

: Fitting/Evaluation for Hearing Aid

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Minimum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid: Is authorization No

required?

Is a referral required for No

Hearing Exams?







5/20/2020 ahaut hlank

rage 38 01 04 гвт раца кероп

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide

Hearing Aids as a supplemental benefit

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited for Hearing Aids (all

types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all

types) periodicity:

Every year

Mandatory

No, indicate number

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Both ears combined

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

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage type:

Indicate Maximum Plan

Benefit Coverage

amount:

Indicate Maximum Plan

Benefit Coverage periodicity:

Every year

75.00

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per Hearing Aid (all types):

Indicate Maximum \$0.00

Copayment amount per Hearing Aid (all types):

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization No

required?

Is a referral required for No

Hearing Aids?

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

Does your plan include

MA Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special

Supplemental Benefits

Yes







5/28/2020 about-blank

гог рана кероп rage 39 01 04

for the Chronically III?

Select what type of : Reduced Cost Sharing benefit your SSBCI : Additional Benefits

includes:

Are you offering a VBID

Hospice Benefit?

No

Yes

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)

In addition to wellness : Value-Based Design Flexibilities by Condition or Socioeconomic Status

and health care planning, what other interventions have you been approved by CMMI to offer?

Value-Based Insurance

: I attest that

Design Attestation

### SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type

: Other Program

(choose one or more): Specify Other Program:

Advance Care Planning

WHP Mode of : Telephonic : In-Person Engagement (choose one or more): : Web-Based

Does your organization

offer Part C Rewards or

Incentives for

beneficiaries for the offer of WHP Services?

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP

No

No

activities?

Program Connectedness: : Electronic Health Records/Electronic Medical Records

: Provider/Patient portals Please check the way : Health Information Exchanges that advance care plans

and/or advance : Data Warehouses : Other

directives are connected

from your program to access points of care.

Expected Number of

4572

Beneficiaries to be

Engaged Annually:

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI Does your VBID/MA Yes

Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?

How many packages does your 19a Reduction

in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)



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

Is this package SSBCI

applicable to VBID, MA Uniformity Flexibility or SSBCI?

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

5/28/2020 ahout-blank

гыг раца кероп rage 40 of 64

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

Which prerequisites are required for this

Yes

: Participation in a Care Management Program

package? Select the benefits that apply to reduced cost

sharing:

: Medicare-covered benefits : Non-Medicare-covered benefits

Select the Medicarecovered benefits that will : 3-1: Cardiac Rehabilitation Services : 3-2: Intensive Cardiac Rehabilitation Services : 3-3: Pulmonary Rehabilitation Services

receive reduced cost sharing:

: 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

All specialists

Does your VBID/MA

Uniformity

Flexibility/SSBCI cost reduction cover all or some Specialists under 7d: Physician Specialist Services?

Select the Non-: 18b1: Hearing Aids (all types)

Medicare-covered benefits that will receive reduced cost sharing:



WINISTRACION O

Contrato Número



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

Are any benefits exempt No from the plan-level

#1 Do you offer reduced

Coinsurance?

deductible?

No

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

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

5/28/2020 aboutchlask

rbr Data Keport rage 41 01 04

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 Medicarecovered benefits that will : 3-1: Cardiac Rehabilitation Services

receive reduced Copayment: : 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

: 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

: 18b1: Hearing Aids (all types)

: 17a: Eye Exams : 17b: Eyewear : 18a: Hearing Exams

Select all the Non-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

\$0.00

Copayment for Intensive Cardiac Rehabilitation Services

Indicate Maximum
Copayment for Intensive
Cardiac Rehabilitation

\$0.00

Services

Indicate Minimum \$0.00

Copayment for





about-blank 5/28/2020

rar Data Report rage 42 of 04

Pulmonary Rehabilitation Services	
Indicate Maximum Copayment for Pulmonary	\$0.00
Rehabilitation Services Indicate Minimum	\$0.00
Copayment for SET for PAD Services	<b>9</b> 0.00
Indicate Maximum Copayment for SET for PAD Services	\$0.00
Indicate Minimum Copayment for Urgently	\$0.00
Needed Services	
Indicate Maximum Copayment for Urgently Needed Services	\$0.00
Indicate Minimum Copayment for Chiropractic Services	\$0.00
Indicate Maximum Copayment for	\$0.00
Chiropractic Services Indicate Minimum Copayment for	\$0.00
Occupational Therapy Services	
Indicate Maximum Copayment for Occupational Therapy	\$0.00
Services	
Indicate Minimum Copayment for Physician Specialist Services	\$0.00
Indicate Maximum Copayment for Physician	\$0.00
Specialist Services Indicate Minimum	\$0.00
Copayment for Individual Sessions for Mental Health Specialty	<b>V</b> 0100
Services Indicate Maximum	\$0.00
Copayment for Individual Sessions for	
Mental Health Specialty Services	
Indicate Minimum Copayment for Group	\$0.00
Sessions for Mental Health Specialty Services	
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







shout-blank 5/28/2020

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







shout-blank 5/28/2020

rbr Data Kepoti rage 44 01 04

\$0.00 Indicate Minimum Copayment for Outpatient X-Ray Services Indicate Maximum \$0.00 Copayment for Outpatient X-Ray Services SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 12 (REDUCED COPAYMENT): PACKAGE #1 Indicate Minimum Copayment for Outpatient Hospital Services Indicate Maximum \$0.00 Copayment for Outpatient Hospital Services Indicate Minimum \$0.00 Copayment for Ambulatory Surgical Center (ASC) Services Indicate Maximum \$0.00 Copayment for Ambulatory Surgical Center (ASC) Services Indicate Minimum \$0.00 Copayment for Individual Sessions for Outpatient Substance Abuse Indicate Maximum \$0.00 Copayment for Individual Sessions for Outpatient Substance Abuse Indicate Minimum \$0.00 Copayment for Group Sessions for Outpatient Substance Abuse \$0.00 Indicate Maximum Copayment for Group Sessions for Outpatient Substance Abuse Indicate Minimum \$0.00 Copayment for Durable Medical Equipment (DME) Indicate Maximum \$0.00 Copayment for Durable Medical Equipment (DME) Indicate Minimum \$0.00 Copayment for Prosthetic Devices Indicate Maximum \$0.00

Copayment for Prosthetic Devices

Supplies

Supplies

Indicate Minimum

Indicate Maximum

Indicate Minimum

Copayment for Medical

Copayment for Medical

\$0.00

\$0.00

\$0.00







about-blank 5/28/2020

rbr Data Report rage 40 01 04

Copayment for Diabetic Supplies	
Indicate Maximum	\$0.00
Copayment for Diabetic Supplies	φοισο
Indicate Minimum	\$0.00
Copayment for Diabetic Therapeutic	\$0.00
Shoes/Inserts	***
Indicate Maximum Copayment for Diabetic Therapeutic Shoes/Inserts	\$0.00
Indicate Minimum	\$0.00
Copayment for Dialysis Services	<b>\$</b> 0.00
Indicate Maximum	\$0.00
Copayment for Dialysis Services	***
Indicate Minimum	\$0.00
Copayment for Medicare	
Part B	
Chemotherapy/Radiation	
Drugs	
Indicate Maximum	\$0.00
Copayment for Medicare	
Part B	
Chemotherapy/Radiation	
Drugs	
Indicate Minimum	\$0.00
Copayment for Other	
Medicare Part B Drugs	<b>#</b> 0.00
Indicate Maximum	\$0.00
Copayment for Other	
Medicare Part B Drugs	<b>#</b> 0.00
Indicate Minimum	\$0.00
Copayment for Comprehensive Dental	
•	<b>ተ</b> ለ ለለ
Indicate Maximum Copayment for	\$0.00
Comprehensive Dental	
Indicate Minimum	\$0.00
Copayment for Eye	\$0.00
Exams	
Indicate Maximum	\$0.00
Copayment for Eye	\$0.00
Exams	
Indicate Minimum	\$0.00
Copayment for Eyewear	ψο.σσ
Indicate Maximum	\$0.00
Copayment for Eyewear	Φ0.00
Indicate Minimum	\$0.00
Copayment for Hearing	Ψ0.00
Exams	
Indicate Maximum	\$0.00
Copayment for Hearing	20.00
Exams	



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

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

Exams

\$0.00

Indicate Maximum \$0.00 Copayment for Hearing

about blank 5/29/2020

rdr Data Report rage 40 01 04

Aids (all types)

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

Are you offering

No

retroactive reimbursement?

Is there a maximum Yes

aggregate amount of reduced cost sharing?

Specify the maximum 500.00

aggregate amount of reduced cost sharing:

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 Yes

Uniformity

Flexibility/SSBCI benefit offer additional Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

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

Is this package VBID

applicable to VBID or MA Uniformity Flexibility or SSBCI?

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

Targeting Methodology -

Please choose one or

both:

odology - : Socioeconomic Status

2

Select LIS reduction : LIS Level 1 level: : LIS Level 2

: LIS Level 3 : LIS Level 4

Expected Number of 4572

Enrollees to be Targeted:

Expected Number of 3200

Enrollees to be engaged and receive Model

benefits:

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

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-: 13d: Other 1

Medicare-covered additional benefits offered in this package:

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

PACKAGE #1

Are any benefits exempt No

from the plan-level

deductible?

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

PACKAGE #1

Are you offering No

about-blank 5/29/2020

Contrato Número
ACE TO TOS DE SEV

retroactive reimbursement?

Is there a maximum

Yes

benefit amount?

Specify the maximum

25.00

benefit amount:

### 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

Healthy Foods Card

(Optional):

Select type of benefit for

Mandatory

Other 1:

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

25.00

Benefit Coverage

amount:

Select Maximum Plan

Other, Describe

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

No

Copayment?

Is authorization

No

No

required?

Is a referral required for

Other Services?

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

\$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

SSBCI

applicable to VBID or MA Uniformity Flexibility or 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-: 10b: Transportation Services : 13b: Over-the-Counter (OTC) Items Medicare-covered

additional benefits : 13c: Meal Benefit

offered in this package: : 13i: Non-Primarily Health Related Benefits for the Chronically III

: 14c: Other Defined Supplemental Benefits

: 16a: Preventive Dental : 16b: Comprehensive Dental

: 17a: Eye Exams : 17b: Eyewear

Contrato Número

POSDE

5/28/2020 ahout-blank

rage 48 01 04 гвт дана кероп

: 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

No from the plan-level

deductible?

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

Are you offering

No

retroactive reimbursement?

Is there a maximum No

benefit amount?

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 Yes Transportation Services as a supplemental benefit

under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for

Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited Yes

for number of trips for Plan Approved Healthrelated Location?

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Taxi

Transportation for Plan : Rideshare Services Approved Health-related : Bus/Subway

Location: : Van

: Medical Transport

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

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Select Maximum Plan Every year

Benefit Coverage periodicity:

No

Is there a service-specific Maximum Enrollee Out-

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

Is there an enrollee No

Deductible?

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

Is there an enrollee

Copayment?

No





5/20/2020 ahout-hlank

rage 49 01 04 гог рана керогі

Is authorization

Yes

Yes

required?

Is a referral required for Νo

Transportation Services?

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?

Select type of benefit for

Mandatory

OTC Items:

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage periodicity:

Every year

No

No

500.00

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Yes

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

Nicotine Replacement

Therapy (NRT) Attestation:

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

formulary drugs.

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

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Does this cover all of the Yes

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

Manual?

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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 Yes

limited duration Meal

Benefit as a

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

Select type of benefit for

Meals:

How many days does your Meal Benefit last? Mandatory

84







5/28/2020 ahout-blank

rage 30 01 04 гвг раца кероп

What is the maximum

168

number of meals the benefit provides?

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Copayment?

No

Is authorization

required?

Yes

Is a referral required for

No

the Meal Benefit?

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 : Food and Produce

benefit your Non-: Meals (beyond limited basis)

Primarily Health Related : Pest Control

Benefits for the : Transportation for Non-Medical Needs : Indoor Air Quality Equipment and Services Chronically Ill includes:

: 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 Yes

supplemental benefit under Part C?

Select type of benefit for Mandatory

Food and Produce:

Is there a service-specific

Maximum Plan Benefit

Yes

Coverage amount?

500.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

No

No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

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

Is there an enrollee

Is there an enrollee

Coinsurance?

No

Deductible?

Is there an enrollee No





5/20/2020 about blank

гот рана кероп rage 31 01 04

Copayment?

Is authorization Yes

No

Mandatory

150

Yes

500.00

Every year

required?

Is a referral required for

Food and Produce?

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?

Select type of benefit for

Meals (beyond limited

50 How many days do your

Meals (beyond limited

basis) last?

What is the maximum number of meals the

benefit provides?

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

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

periodicity. Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for

the Meals (beyond limited basis)?

No

No

No

Yes

Yes

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?

Select type of benefit for Mandatory

Pest Control:

Is there a service-specific Yes







5/28/2020 about-blank

rage 32 01 04 гог раца кероп

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

No

Copayment?

Is authorization

Yes

Yes

required?

Is a referral required for No

Pest Control?

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

Chronically ill members who participate with Humana's Care Management services can receive non-Notes:

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?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Mandatory

Plan-approved Location:

Is this benefit unlimited Yes for number of trips for Plan-approved Location?

Select Type of

One-way

Transportation for Non-Medical Needs for Planapproved Location:

Select Mode of : Taxi

Transportation for Non-: Rideshare Services : Bus/Subway Medical Need for Planapproved Location: : 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?

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

Every year

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?







5/28/2020 about blank

гвт раца кероп rage 33 01 04

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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 NonNo

Medical Needs?

Notes:

Chronically ill members who participate with Humana's Care Management services can receive nonprimarily 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?

Select type of benefit for

Mandatory

Indoor Air Quality

Equipment and Services:

Yes

Yes

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

500.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every year

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

No

Copayment?

Is authorization

Yes

required?

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 nonprimarily 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





5/28/2020 ahout blank

гог раца кероп rage 34 01 04

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan

500.00

Yes

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

No

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment? Is authorization

Yes

No

required?

Is a referral required for Social Needs Benefit?

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?

Mandatory

Yes

Complementary Therapies:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Select type of benefit for

500.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity: Is there a service-specific

No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes

required?

Is a referral required for No

Complementary

Therapies?





5/28/2020 ahout-blank

гог раца кероп rage 33 01 04

### 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 nonprimarily 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

Yes

Yes

500.00

No

No

No

Yes

No

Every year

Mandatory

Services Supporting Self-Direction as a supplemental benefit under Part C?

Select type of benefit for Services Supporting

Self-Direction: Is there a service-specific

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

periodicity:

Benefit Coverage

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for

Services Supporting Self-Direction?

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 nonprimarily 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 decisionmaking 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?

Select type of benefit for General Supports for

Living:

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

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific No

Yes

Mandatory

Yes 500.00 Every year

Contrate Núm

5/28/2020 obout blook

гог раца кероп rage 20 01 04

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

No

Coinsurance?

Is there an enrollee No

Deductible?

Nο

Is there an enrollee Copayment?

Is authorization

Yes

required?

Is a referral required for

General Supports for

Living?

Nο

## 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

Yes

Supplemental Benefits as

a benefit under Part C? Select enhanced benefit

: 14c8: Home and Bathroom Safety Devices and Modifications\*

(Select all that apply):

Select type of benefit for Mandatory

Home and Bathroom Safety Devices and Modifications:

### 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?

Select which Other : 14c8: Home and Bathroom Safety Devices and Modifications

Defined Supplemental Benefits have a Maximum Plan Benefit

Coverage amount (Select

all that apply):

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

Select Maximum Plan

Benefit Coverage

periodicity for Home and Bathroom Safety Devices and Modifications:

Every year

500.00



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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental Benefits?

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

Is there an enrollee No

5/28/2020 ahout hlank

гог рака кероп rage 37 01 04

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

No

Copayment?

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

Is authorization

Yes

required?

Is a referral required for Nο

Other Defined

Supplemental Benefits?

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 nonprimarily 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

ADMINISTRACIO

Contrate Nigmero

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?

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

Yes

(Cleaning)?

Select type of benefit for Mandatory

Fluoride Treatment:

Is this benefit unlimited

for Fluoride Treatment?

SECTION B: VBID/UF/SSBC1 19B #16A PREVENTIVE DENTAL - BASE 2: PACKAGE #2

Select type of benefit for

Dental X-Rays:

Mandatory Yes

Yes

Yes

Is this benefit unlimited

for Dental X-Rays?

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

Indicate Maximum Plan

Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage

500.00

Every year

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

periodicity:

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

Is there an enrollee

Deductible?

No



5/28/2020 ahoutehlank

0

гог рана кероп rage 28 01 04

Is there an enrollee

No

Copayment?

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

Is authorization

Yes

required?

Is a referral required for Preventive Dental

No

Yes

Services?

Chronically ill members who participate with Humana's Care Management services can receive additional Notes: 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?

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

Mandatory

Diagnostic Services:

Is this benefit unlimited Yes

for Diagnostic Services?

Select type of benefit for

Restorative Services:

Mandatory

Yes

Is this benefit unlimited

for Restorative Services?

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

Select type of benefit for

Endodontics:

Mandatory

Is this benefit unlimited

Yes

Select type of benefit for

for Endodontics?

Mandatory

Mandatory

Periodontics:

Is this benefit unlimited

for Periodontics?

Yes

Select type of benefit for

Extractions:

Is this benefit unlimited

Yes

for Extractions?

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services: Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?





ahout-blank 5/28/2020

(C)

тыт рана кероп rage 39 of 04

Select the Maximum

Plan Benefit Coverage

Plan-specified amount per period

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select the Maximum

Every year

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee

No

Yes

Copayment?

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

Is authorization

required?

Is a referral required for No

Comprehensive Dental

Services?

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

ADMINISTRACIO

Contrato Número

year and must be coordinated by Humana Care Manager based on Care Manager assessment and

authorization.

Yes

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?

: Routine Eye Exams

Select enhanced benefit: Select type of benefit for

Routine Eye Exams:

Mandatory

500.00

Every year

Is this benefit unlimited

Yes for Routine Eye Exams?

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select the Maximum

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

No

Deductible?

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

Is authorization

Yes



5/20/2020 ahout-blank

111

rbr Daia Report rage ou of 04

required?

Is a referral required for

Eye Exams?

No

Yes

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?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Yes

Yes

Is this benefit unlimited

for Contact lenses?

Mandatory

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited

for Eyeglasses (lenses

and frames)?

Select type of benefit for Mandatory

Eyeglass lenses:

Is this benefit unlimited Yes

for Eyeglass lenses?

Select type of benefit for Mandatory

Eyeglass frames:

Is this benefit unlimited Yes

for Eyeglass frames?

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

Plan-specified amount per period

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Do you offer a Yes

Combined Max Plan
Benefit Coverage
Amount for all Eyewear?

Indicate Combined 500.00

Maximum Plan Benefit Coverage amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

Contrato Número m 21 - 00 m contrato Número M

shout-blank 5/28/2020

rage of of 04 гог рана кероп

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

Is authorization

required?

Yes

Yes

Mandatory

Is a referral required for Eyewear?

Notes:

No

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?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited Yes

for Hearing Aids (all

types)?

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

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Both ears combined

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

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan 500.00

Benefit Coverage

amount:

Indicate Maximum Plan

Every year

Benefit Coverage periodicity:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Copayment?

No

No

Is there an enrollee

Deductible?

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?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network

Plan Deductible?





Contrato Múrnero

POSDE

20

5/28/2020 ahoutchlank

rbr Data Keport rage 02 01 04

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

Voluntary

Is there an In-Network

Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network

Maximum Enrollee Outof-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Indicate In-Network 3400.00

Maximum Enrollee Outof-Pocket Cost Amount:

Select the benefits that apply to the In-Network Maximum Enrollee Outof-Pocket cost: : In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

#### SECTION D: MAX PLAN BENEFIT COVERAGE

Yes

Is there a Maximum Plan N

Benefit Coverage

Amount?

#### SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Defined Standard

Do you offer Reductions No

in Cost Sharing?

### SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined No Supplemental Benefits with uniform cost

sharing?

## SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Yes

Medicare Prescription drug (Part D) benefit?

Select the type of drug

benefit:

Describe the components of your pharmacy : Standard Retail : Out-of-Network network (select all that apply): : 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 Yes

pricing?

Yes

No

Does plan utilize ceiling

pricing?

Are there quantity limits Yes

on certain prescription

drugs?

Is prior authorization Yes required for certain

prescription drugs?

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







shout-blank 5/28/2020

rbr Data Keport rage 05 01 04

indication-based formulary design)?

Do any drugs in your formulary require a step

Yes

No

therapy plan?

Do you pay for over-the-

counter medications (OTCs) under the utilization management program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

: Long-Term Care Pharmacy - 1-month supply

Cost sharing

Location/supply amount

(s) that apply:

Enter number of days for Standard Retail Cost Sharing 1-month supply:
Enter number of days for 90

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Select all Out-of- : Out-of-Network Pharmacy - one month supply

30

30

90

Network Pharmacy Location/supply amount

(s) that apply:

Enter number of days for

Out-of-Network Pharmacy 1-month

supply:

Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply

Location/supply amount

(s) that apply:

Enter number of days for Standard Mail-Order Cost Sharing 1-month

supply:

Enter number of days for Standard Mail-Order Cost Sharing 3-month

supply:

Select the Long-Term

Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for

Long-Term Care Pharmacy 1-month

supply:

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

supply?

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

31

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.

ROMINISTRACIO

Contrate Número

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

No

about-blank 5/29/2020

тыт папа кероп rage 04 01 04

programs through the model?



shout-blank 5/29/2020

гог раза кероп rage 1 of 41

### 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

05/28/2020 09:00:08 PM Eastern Daylight Time

Timestamp:

#### PLAN STATUS

Section A Status

Plan Ready for Upload

Section B1 Status Section B2 Status Completed Completed

Section B3 Status Section B4 Status Completed Completed

Section B5 Status Section B6 Status

Completed Completed

Section B7 Status Section B8 Status Completed

Section B9 Status

Completed Completed

Section B10 Status Section B11 Status Section B12 Status Completed Completed

Section B13 Status Section B14 Status

Completed Completed

Section B15 Status Section B16 Status Completed Completed Completed

Section B17 Status Section B18 Status Completed Completed

Section B19 Status Section C Status Section D Status

Completed Completed

Section Mrx Status

Completed Completed

#### SECTION A: SECTION A-1

Organization Legal

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization Marketing

Humana

Name:

Organization Web Site:

www.humana.com/medicare

Plan Name:

Humana Gold Plus SNP-DE H4007-022 (HMO D-SNP)

Organization Type: Plan Type:

Local CCP

**HMO** 

Enrollee Type: Service Area(s): Part A and Part B 40010 - Adjuntas, PR

Service Area(s): Service Area(s): Service Area(s): 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR

Service Area(s): Service Area(s): Service Area(s): Service Area(s): 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR

40090 - Barceloneta, PR Service Area(s): 40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR Service Area(s):

Service Area(s):

40120 - Cabo Rojo, PR



5/20/2020

ahoutchlank

rbr Data Keport rage 2 01 41

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):	V

Contrato Número

2 1 - 0 0 4

GRADESA

200

shout-blank 5/29/2020

rbr Data Keport rage 3 01 41

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

Yes

No

No

Dual-Eligible

Is this an Employer-Only No

plan?

#### **SECTION A: SECTION A-2**

Does this Plan have a No CMS-approved Continuation Area?

Do you intend to Yes

participate in the PLATINO program?

Is this a Special Needs

Plan?

Special Needs Plan

Type:

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-

SNP?

#### **SECTION A: SECTION A-3**

Participating Pharmacy Website Address:

https://www.humana.com/pharmacy/

Formulary Website

A JJ.....

http://www.humana.com/medicare/medicare\_prescription\_drugs/medicare\_drug\_tools/medicare\_drug\_list/

Address:

Physician Website

www.humana.com/members/tools

Address:

Customer Service (866)773-5959

Contact Phone Number for Current Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Medicare

Beneficiaries:

Customer Service (800)681-3625 Contact Local Phone





shout-blank 5/28/2020

rbr Data Keport rage 4 of 41

Number for Prospective Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part

D Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service (800)681-3625

Customer Service
Contact Local Phone
Number for Prospective
Part D Medicare
Beneficiaries:

Customer Service (711)-

Customer Service
Contact TTY/TDD for
Current Medicare

Beneficiaries:

(711)-

Customer Service Contact Local TTY/TDD for Current Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Part D Medicare

Beneficiaries:

Customer Service (711)-

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

Customer Service (711)-

Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

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

**SECTION A: SECTION A-5** 

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

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

**SECTION A: SECTION A-6** 

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







about-blank 5/28/2020

гог раца кероп rage 3 01 41

Do any of your

No outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

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

Does the plan provide

Inpatient Hospital-Acute

Services as a

supplemental benefit

under Part C?

Select enhanced benefits: : Additional Days Select type of benefit for Mandatory

Additional Days:

Is this benefit unlimited Yes

for Additional Days?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Does this plan's No

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

Is there an enrollee No

Coinsurance?

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

Does this plan's Additional Days cost

sharing vary by hospital (s) in which an enrollee

obtains care?

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

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

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

Medicare-covered stay:

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

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

Medicare-covered Lifetime Reserve Days:

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

Indicate the number of

day intervals for Additional Days: Zero (No Copayment per Day)





5/28/2020 ahout-blank

rage o of 41 тыт папа кероп

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

Per Admission or Per Stay

What is your Inpatient

Hospital-Acute benefit

period?

Do you charge cost

No

No

sharing on the day of

discharge?

Is authorization Yes

required?

Is a referral required for No Inpatient Hospital-Acute

Services?

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's No

Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment amount for the

\$0.00

No

Yes

Medicare-covered stay:

Indicate the number of

day intervals for the

Zero (No Copayment per Day)

Zero (No Copayment per Day)

Per Admission or Per Stay

Medicare-covered stay:

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

Indicate the number of day intervals for the Medicare-covered

Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required?

Yes

Is a referral required for No

Inpatient Psychiatric





5/28/2020 ahout-blank

rage / 01 41 гыг папа кероп

Hospital Services?

SECTION B: #2 SNF - BASE 1

No

Does the plan provide Skilled Nursing Facility

Services as a

supplemental benefit

under Part C?

Do you allow less than 3 Yes

day inpatient hospital stay prior to SNF admission?

Indicate the Number of Zero

Hospital Days Required Prior to SNF Admission

(0-2):

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's No

Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee No

Coinsurance?

SECTION B: #2 SNF - BASE 6

No

No

Is there an enrollee

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF Original Medicare

benefit period?

Is authorization Yes

required?

Is a referral required for

SNF Services?

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

: Medicare-covered Cardiac Rehabilitation Services

Pulmonary

: Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services have a Copayment

: Medicare-covered Pulmonary Rehabilitation Services

: Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services (Select all that apply):

Indicate Minimum \$0.00

Copayment amount per service for Medicare-



5/28/2020 ahoutchlank

rdr Data Keport rage 8 01 41

covered Cardiac Rehabilitation Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Minimum \$0.00

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

Indicate Maximum \$0.00

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

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

Is authorization Yes

required?

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

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Copayment?

Yes

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:



about-blank 5/29/2020

гог дана кероп rage 9 01 41

Indicate Maximum

\$0.00

Copayment amount for

Medicare-covered

Benefits:

Is the Copayment for Yes

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for

waiver:

Enter number of Days or 24

Hours:

Does the No

Emergency/Post-Stabilization Services cost sharing count towards any plan-level

deductible?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No Coinsurance?

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

Yes

\$0.00

No

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Does the Urgently

Needed Services cost sharing count towards any plan-level

deductible?

Is the Copayment for No

Medicare-covered Benefits waived if admitted to hospital?

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

Does the plan provide

Worldwide

Emergency/Urgent Coverage as a

supplemental benefit

under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

Yes

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for

Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Mandatory

Coverage:

Select type of benefit for

Worldwide Emergency

Mandatory





5/20/2020 ahout-blank

rage 10 01 41 гъг папа кероп

Transportation:

Is there a Maximum Plan No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee

Yes

Copayment?

Select which Worldwide : Worldwide Emergency Coverage Services have a : Worldwide Urgent Coverage Copayment (Select all : Worldwide Emergency Transportation

that apply):

\$0.00

Indicate Minimum Copayment amount for

Worldwide Emergency

Coverage:

\$0.00 Indicate Maximum

Copayment amount for Worldwide Emergency

Coverage:

Is this Copayment Yes

waived for Worldwide Emergency Coverage if admitted to hospital?

Indicate Minimum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

Is this Copayment Yes

waived for Worldwide Urgent Coverage if admitted to hospital?

Indicate Minimum \$0.00

Copayment amount for Worldwide Emergency

Transportation:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency

Transportation:

Is this Copayment Yes

waived for Worldwide

Emergency Transportation if admitted to hospital?

Is there an enrollee No

Deductible?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

DMINISTRACION DE Contrato Número POSDE

5/28/2020 ahout-hlank

гог рата кероп rage II of 41

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2 Yes

Is there an enrollee

Copayment?

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Benefits per day:

Is authorization Yes

required?

Is a referral required for No

Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2 No

Yes

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Is a referral required for No

Home Health Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-

covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

No





about-blank 5/28/2020

rage 12 01 41 гът папа кероп

a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2 No

Is there an enrollee

Coinsurance?

Yes

Is there an enrollee

Copayment? Select which

: Medicare-covered Chiropractic Services

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

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Benefits:

Is there an enrollee

No

Deductible?

Is authorization No

required?

Is a referral required for Yes

Chiropractic Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization Yes

required?

Yes

Is a referral required for

Occupational Therapy

Services?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

Yes

No

Is there an enrollee

Copayment?

OMINISTRACION POR Contrato Número POSDE



5/28/2020 ahout-blank

rbr Data Keport rage 15 01 41

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization No

required?

Is a referral required for Yes

Physician Specialist

Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

n enrollee No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Mental : Medicare-covered Individual Sessions Health Specialty : Medicare-covered Group Sessions

Services have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions

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

Is authorization Yes

required?

Is a referral required for Yes

Mental Health Specialty

Services - Non-

Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide No

Podiatry Services as a supplemental benefit under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

**SECTION B: #7F PODIATRY SERVICES - BASE 2** 

Is there an enrollee No





about-blank 5/28/2020

гог раца кероп rage 14 01 41

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Yes

No

Select which Podiatry

Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

**SECTION B: #7F PODIATRY SERVICES - BASE 3** 

Is authorization

required?

No No

Is a referral required for Podiatrist Services?

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

: Medicare-covered Podiatry Services

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

No

No

Is a referral required for

Other Health Care Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

**SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2** No

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment? Select which Psychiatric

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

Services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Contrato Número POSDE

5/28/2020 about-blank

rbr Data Report rage 13 01 41

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

### SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization

Yes

required?

Is a referral required for No

Psychiatric Services?

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

Is there a service-specific Maximum Enrollee Out-

1 11

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization

required?

Yes No

Is a referral required for Physical Therapy and Speech-Language

Pathology Services?

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

Do you offer an Yes

Additional Telehealth benefit for Part B

services?

Select the Medicarecovered benefits that : 7a: Primary Care Physician Services may have Additional : 7d: Physician Specialist Services

No

Telehealth Benefits : 7e1: Individual Sessions for Mental Health Specialty Services available: : 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 Outof-Pocket Cost for Additional Telehealth? Services vices use



shout-blank 5/28/2020

rage 10 01 41 гог рана кероп

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization required

for Additional Telehealth

Services?

Is a referral required for No

Additional Telehealth

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization

required?

No No

Is a referral required for Opioid Treatment

Program Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee No

Coinsurance?

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



5/28/2020 ahout-blank

rage 17 01 41 гвт раца кероп

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Lab

Services:

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

same day, does only the maximum copay apply?

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

Yes

No

Is authorization

required?

Is a referral required for Yes

Outpatient Diagnostic Procedures/Test/Lab

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Select which Outpatient : Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services Diag/Therapeutic Rad Services have a : Medicare-covered X-Ray Services

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum \$0.00

Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological

Services:







5/20/2020 about blank

гыг папа кероп rage 18 01 41

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

If a member receives Yes multiple services at the

same location on the same day, does only the maximum copay apply?

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

Is authorization Yes

required?

Is a referral required for No

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment? Select which Services

: Medicare-covered Outpatient Hospital Services

have a Copayment : Medicare-covered Observation Services

(Select all that apply):

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

Is authorization required for Medicare-covered Outpatient Hospital

Services?







5/28/2020 ahout-blank

rage 19 01 41 гыг рана кероп

Is authorization required Yes for Medicare-covered

Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient Hospital

Services?

Is a referral required for Yes

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

Νo

Is there an enrollee

Yes

\$0.00

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per visit for Medicarecovered Benefits:

Is authorization Yes

required?

Is a referral required for No

Ambulatory Surgical Center Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Outpatient : Medicare-covered Individual Sessions Substance Abuse : Medicare-covered Group Sessions

services have a Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00 Copayment amount for

Medicare-covered Group Sessions:

Indicate Maximum \$0.00





5/20/2020 ahout-blank

rage 20 01 41 гвг рана кероп

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization

No

required?

Is a referral required for No

Outpatient Substance

Abuse?

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

Does the plan provide Outpatient Blood Services as a

supplemental benefit

under Part C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Mandatory

Yes

Select type of benefit for

Three (3) Pint Deductible Waived:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Νo

No

No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for No

Outpatient Blood

Services?

**SECTION B: #10A AMBULANCE SERVICES - BASE 1** 

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

\$0.00

\$0.00

Copayment?

Select which Services : Medicare-covered Ground Ambulance Services have a Copayment : Medicare-covered Air Ambulance Services

(Select all that apply):

Indicate the Minimum

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:







5/20/2020 about-blank

ror Data Report rage ZI OI 41

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment No

waived if admitted to

hospital?

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

Is authorization required

Yes

for non-emergency Medicare services?

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

Does the plan provide Yes Transportation Services as a supplemental benefit

under Part C?

Select enhanced benefit: Plan Approved Health-related Location Mandatory

12

Every year

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited No

for number of trips for Plan Approved Healthrelated Location?

Indicate number of trips

for Plan Approved Health-related Location:

Select Plan Approved

Health-related Location

Trips periodicity:

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Van

Transportation for Plan : Other, Describe

Approved Health-related

Location:

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

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

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

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per

trip:

Indicate Maximum \$0.00

Copayment amount per

Transportation Services?

trip:

Is authorization Yes

required?

Is a referral required for

No







5/28/2020 about-blank

rbr Data Keport rage 22 01 41

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-

e No

of-Pocket Cost?

Is there an enrollee

Yes

Coinsurance?

Indicate Minimum 10%

Coinsurance percentage for Medicare-covered

Benefits:

Indicate Maximum 10%

Coinsurance percentage for Medicare-covered

Benefits:

Is there an enrollee

No

No

Deductible?

Is there an enrollee No

Copayment?

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

Are there preferred vendors/manufacturers for Durable Medical

Equipment (DME)?

Is authorization Yes

required?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Yes

Coinsurance?

Select which : Medicare-covered Prosthetic Devices

Prosthetics/Medical Supplies have a Coinsurance (Select all

that apply):

Indicate Minimum 10%

Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Maximum 10%

Coinsurance percentage for Medicare-covered Prosthetic Devices:

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

Is there an enrollee

Deductible?

No

Is there an enrollee

is there all enfolice

Yes

Copayment?

Select which : Medicare-covered Medical Supplies

Prosthetics/Medical Supplies have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicare-covered Medical Supplies:

Indicate Maximum \$0.00

Copayment amount per







about-blank 5/28/2020

rBr Data Keport rage 25 01 41

item for Medicarecovered Medical Supplies:

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

Is authorization

Yes

required?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

Is there an enrollee

Yes

Copayment?

Select which Diabetic

: Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment

(Select all that apply):

Indicate Minimum

\$0.00

\$0.00

Copayment amount per item for Medicare-covered Diabetes

Supplies:

Indicate Maximum

Copayment amount per item for Medicare-covered Diabetes

Supplies:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Do you limit Diabetic Yes Supplies and Services to

those from specified manufacturers?

Is authorization No

required?

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

Is there a service-specific N Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No Coinsurance?

3.1

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount per session for Medicarecovered Benefits:







about-blank 5/29/2020

гыг раца кероп rage 24 01 41

Indicate Maximum

\$0.00

Copayment amount per session for Medicarecovered Benefits:

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

Is authorization

No

required?

Is a referral required for No

Dialysis Services?

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

Does the plan provide Acupuncture as a supplemental benefit

Yes

under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter

(OTC) Items as a supplemental benefit

under Part C?

Select type of benefit for

OTC Items:

Mandatory

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan Every three months

Benefit Coverage periodicity:

No

15.00

Does vour Maximum Plan Benefit Coverage amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Yes

No

Are you offering Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement

Therapy (NRT) Attestation:

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

OMINISTRACION

Contrato Número

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

No

Manual?

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

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

criteria.

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

5/28/2020 ahaut-hlank

ror Data Report rage 23 of 41

Does the plan provide a

limited duration Meal

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

Select type of benefit for

Mandatory

Yes

Meals:

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 No Maximum Plan Benefit

Coverage amount? Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

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.

Mandatory

### SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

COVID-19 Care Package

(Optional):

Select type of benefit for

Other 2:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

No

Copayment? Is authorization

Yes

required?

Is a referral required for No Contrato Número



5/28/2020 ahout-blank

гог рана кероп rage 20 01 41

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 la 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

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

services that are offered at zero dollar cost sharing.

Services Attestation Is authorization

No

required?

Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical

Exam;

Mandatory

Is there a service-specific No Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Nο

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for each Annual Physical

Exam:

\$0.00 Indicate Maximum

Copayment amount for each Annual Physical

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

Is authorization required?

No

Is a referral required for the Annual Physical

Nο

POSDE Exam? Notes:

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

DANINISTRACION

Contrato Número

2

prescription medication review. 4. Review of any recent hospitalization

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



гог рана кероп rage 2/ 01 41

Does the plan provide

Other Defined

Supplemental Benefits as a benefit under Part C?

Select enhanced benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling

Mandatory

Yes

(Select all that apply): : 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:

4

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for

Fitness Benefit:

Mandatory

Indicate type of Fitness

Benefit offered (Select

: Physical Fitness

all that apply):

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

Mandatory

Wigs for Hair Loss Related to Chemotherapy:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

: 14c15: Wigs for Hair Loss Related to Chemotherapy Select which Other

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select

all that apply):

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

Indicate Maximum Plan 500.00

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

Select Maximum Plan Every year

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

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental Benefits?

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

Is there an enrollee

Coinsurance?

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

Is there an enrollee No OMINISTRACION Contrato Número POSDE

5/20/2020 ahout-blank

rage Zo of 41 гыг раца кероп

Deductible?

Is there an enrollee

No

Yes

Copayment?

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

Is authorization

required?

Is a referral required for

Other Defined

No

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco

Cessation Counseling Notes:

Fitness Benefit Notes:\*

No authorization required for this service.

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

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

Safety Devices and Modifications Notes:\*

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

Wigs for Hair Loss

Authorization is required for this service.

Related to

Chemotherapy Notes:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization

No

required?

No

Is a referral required for Kidney Disease

**Education Services?** 

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Medicare-covered Preventive Services?

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

Is there an enrollee

Coinsurance?

No

Is there an enrollee No

Deductible?

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

OMINISTRACIO Contrato Número POSDE

rbr Data Keport rage 29 01 41

Is there an enrollee Yes Copayment? Select which Services : Medicare-covered Glaucoma Screening have a Copayment : Medicare-covered Diabetes Self-Management Training (Select all that apply): : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit : Other Medicare-covered Preventive Services Indicate Minimum \$0 Copayment amount for Medicare-covered Glaucoma Screening: \$0 Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: Indicate Minimum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Maximum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Minimum \$0 Copayment amount for Medicare-covered Barium Enemas: Indicate Maximum \$0 Copayment amount for Medicare-covered Barium Enemas: Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Minimum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Maximum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Minimum \$0 Copayment amount for Other Medicare-covered Preventive Services: COMMISTRACION PORTINION Indicate Maximum \$0 Copayment amount for Other Medicare-covered Preventive Services: Contrato Número Is authorization required No for Medicare-covered Glaucoma Screening? Is authorization required No GUROSDE

about-blank 5/29/2020

rage 50 01 41 rbr Data Keport

for Medicare-covered

Diabetes Self-

Management Training?

Is authorization required No

for Medicare-covered **Barium Enemas?** 

Is authorization required No

for Medicare-covered Digital Rectal Exams?

Is authorization required No

for Medicare-covered EKG following Welcome Visit?

Is authorization required No

for Other Medicarecovered Preventive

Services?

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

Is a referral required for

any Services?

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

No

Is there a Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

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

Copayment?

Select which Medicare : Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs

Part B Rx Drugs have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Maximum \$0.00

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Minimum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee

Deductible?

Is Authorization Required?

Does the plan offer step Yes

therapy?

Does the benefit step : Part B to Part B?

from (select all that

apply):

**SECTION B: #15 HOME INFUSION BUNDLED SERVICES** 

Does the plan provide

Part D home infusion

Νo

No

Yes



5/28/2020 ahaut-hlank

гог раза кероп rage 31 0141

drugs as part of a bundled service as a mandatory supplemental

benefit?

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

Does the plan provide Preventive Dental Items as a supplemental benefit

under Part C?

Select enhanced 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:

Select the Oral Exams

periodicity:

Other, Describe

Select type of benefit for

Prophylaxis (Cleaning):

Mandatory

Is this benefit unlimited

No, indicate number

for Prophylaxis (Cleaning)?

Indicate number of visits

for Prophylaxis (Cleaning):

2

Select the Prophylaxis

Every year

(Cleaning) periodicity:

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:

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?

Is there an enrollee

Yes

Coinsurance?

Select which Preventive : Oral Exams

Dental Services have a

: Prophylaxis (Cleaning) : Dental X-Rays

Coinsurance (Select all

that apply):

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

Visit?

Indicate Minimum

0%

Coinsurance percentage for Oral Exams:

Indicate Maximum 0%

Coinsurance percentage for Oral Exams:



SMINISTRACION SMINISTRACION Contrato Número

rbr Data Keport rage 32 of 41

Indicate Minimum 0%

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Maximum 0%

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Minimum 0%

Coinsurance percentage for Dental X-Rays:

0% Indicate Maximum

Coinsurance percentage for Dental X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 4 No

Is there an enrollee

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5 No

Is authorization

required?

Is a referral required for No

Preventive Dental

Services? Notes:

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

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

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

Does the plan provide

Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Endodontics : Periodontics : Extractions

Mandatory

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for

Restorative Services:

Is this benefit unlimited No, indicate number

for Restorative Services?

Indicate number of visits 2

for Restorative Services:

Select the Restorative

Other, Describe

Services periodicity:

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

Mandatory

Periodontics:

Is this benefit unlimited

for Periodontics?

Indicate number of visits

for Periodontics:

Select the Periodontics

periodicity:

Every year

Select type of benefit for

Mandatory

Extractions:

Is this benefit unlimited Yes





5/20/2020 ahaut-hlank

гыг рана кероп rage 33 01 41

for Extractions?

Select type of benefit for

Prosthodontics, Other Oral/Maxillofacial

Mandatory

Surgery, Other Services: Is this benefit unlimited

No, indicate number

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services?

Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Other, Describe

Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

3

Is there a service-specific

Maximum Plan Benefit Coverage amount?

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

type:

Indicate Maximum Plan

500.00

Benefit Coverage

amount:

Select the Maximum Every year

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

: Restorative Services

Select which Comprehensive Dental : Endodontics Services have a : Periodontics Coinsurance (Select all : Extractions

that apply): : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Minimum 0%

Coinsurance percentage for Restorative Services:

Indicate Maximum 50%

Coinsurance percentage for Restorative Services:

0% Indicate Minimum

Coinsurance percentage

for Endodontics: 0%

Indicate Maximum Coinsurance percentage

for Endodontics:

50%

Indicate Minimum Coinsurance percentage

for Periodontics: Indicate Maximum 50%

Coinsurance percentage

for Periodontics:

Indicate Minimum Coinsurance percentage for Extractions:

0%







5/28/2020 ahout-blank

гыг раца кероп rage 34 01 41

Indicate Maximum 0%

Coinsurance percentage

for Extractions:

Indicate Minimum 50%

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

Indicate Maximum 50%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Is there an enrollee

No

Deductible?

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

Is there an enrollee

Copayment?

Yes

Select which

: Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

Is authorization

required?

Yes No

Is a referral required for

Comprehensive Dental

Services? 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 Yes

under Part C?

: Routine Eye Exams Select enhanced benefit:

Select type of benefit for

Routine Eye Exams:

Is this benefit unlimited for Routine Eye Exams? No, indicate number

Indicate number of

exams for Routine Eye

Exams:

Every year

Mandatory

Select the Routine Eye Exams periodicity:

No

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2





5/20/2020 ahout-blank

гог рана кероп rage 22 01 41

Is there an enrollee

No

Coinsurance?

Yes

Is there an enrollee Copayment?

: Medicare-covered Benefits

Select which Eye Exams have a Copayment

: Routine Eye Exams

(Select all that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered

Benefits:

Indicate Minimum

\$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum

\$0.00

Copayment amount for Routine Eye Exams:

Is there an enrollee No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization

required?

No

Is a referral required for

No

Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Yes

Eyewear as a supplemental benefit

under Part C?

: Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for

Select enhanced benefits:

Contact lenses:

Mandatory

Is this benefit unlimited

for Contact lenses?

No, indicate number

Indicate quantity (number of pairs) for

Contact lenses:

Select Contact lenses

Every year

periodicity:

Select type of benefit for

Eyeglasses (lenses and

frames):

Mandatory

Is this benefit unlimited

for Eyeglasses (lenses

and frames)?

No, indicate number

Indicate quantity for

Eyeglasses (lenses and

frames):

Select Eyeglasses (lenses

Every year

and frames) periodicity:

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

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount?

Plan-specified amount per period

Select the Maximum Plan Benefit Coverage

type:

DAINISTRACION PORTINISTRACION Contrato Número 21 - 004



5/20/2020 about-blank

rage 30 01 41 гог раца кероп

Do you offer a Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 100.00

Maximum Plan Benefit Coverage amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

Deductible?

No Yes

Is there an enrollee

Copayment?

Select which Eyewear : Medicare-covered Benefits

Benefits have a : Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for

Contact lenses:

Indicate Maximum \$0.00

Copayment amount for

Contact lenses:

Indicate Minimum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization No

required?

Is a referral required for No

Eyewear?

under Part C?

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit

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



ahaut-hlank 5/28/2020

rage 37 01 41 тът раца кероп

Exams?

Indicate number for Ī Routine Hearing Exams:

Select Routine Hearing

Every year

Exams periodicity:

Select type of benefit for

Mandatory

1

Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for No, indicate number

Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation Every year

for Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there an enrollee No

Deductible?

Is there a service-specific No

Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Copayment?

Yes

\$0.00

\$0.00

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

Copayment (Select all

that apply):

: Fitting/Evaluation for Hearing Aid

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

\$0.00 Indicate Minimum

Copayment amount for Routine Hearing Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Minimum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum \$0.00

Copayment amount for Fitting/Evaluation for Hearing Aid:

Is authorization required?

No

Is a referral required for No

Hearing Exams?

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







rbr Data Keport rage 38 01 41

Does the plan provide

Yes

Mandatory

No, indicate number

Hearing Aids as a supplemental benefit

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited

for Hearing Aids (all

types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all Every year

types) periodicity:

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

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan Both ears combined

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

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

type:

Indicate Maximum Plan

75.00

Benefit Coverage amount:

Indicate Maximum Plan

Every year

Benefit Coverage periodicity:

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

**SECTION B: #18B HEARING AIDS - BASE 4** 

Is there an enrollee

Yes

Copayment?

\$0.00 Indicate Minimum

Copayment amount per Hearing Aid (all types):

Indicate Maximum \$0.00

Copayment amount per Hearing Aid (all types): Is there an enrollee

No

No

Deductible?

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

Is authorization No

required?

Is a referral required for No

Hearing Aids?

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

Does your plan include

MA Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special No Supplemental Benefits

for the Chronically Ill?







rbr Data Keport rage 39 01 41

SECTION C: V/T - GENERAL - US

Do you offer a US No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network N

Plan Deductible?

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

Is there an In-Network Ye

Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Voluntary

Maximum Enrollee Outof-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Indicate In-Network 3400.00

Maximum Enrollee Outof-Pocket Cost Amount:

Select the benefits that apply to the In-Network

: In-Network Medicare-covered benefits

Maximum Enrollee Outof-Pocket cost:

Does the In-Network

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan

services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Yes

Is there a Maximum Plan No

Benefit Coverage

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions No

in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost

sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Yes Medicare Prescription

drug (Part D) benefit?

Select the type of drug Defined Standard

benefit:

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 Yes

pricing?

Does plan utilize ceiling Yes

pricing?

Are there quantity limits Yes

on certain prescription

drugs?

Is prior authorization Yes



shout-blank 5/29/2020

rage 40 of 41 гвг раца кероп

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)?

Yes

No

Do any drugs in your formulary require a step therapy plan?

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

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

Location/supply amount

(s) that apply:

Enter number of days for Standard Retail Cost Sharing 1-month supply:

30

90

Enter number of days for

Standard Retail Cost Sharing 3-month supply:

: Out-of-Network Pharmacy - one month supply

: Standard Mail-Order - 1-month supply

: Standard Mail-Order - 3-month supply

Select all Out-of-Network Pharmacy Location/supply amount

(s) that apply:

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: Enter number of days for Standard Mail-Order Cost Sharing 1-month

30

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:

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

Are any of the drugs available at an extended day supply limited to a 1-month supply for the

No

31

No





rage 41 01 41

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.







about blank 5/28/2020

гог раза кероп rage I OI 40

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

DATA REPORT FOR Contract H4007, PLAN 023, SEGMENT 0

Module: PBP h6j9 Requested By: PLAN SYSTEM INFORMATION Last entry Date: 05/28/2020 PBP Software Version: 2021.01

Plan Ready for Upload

05/28/2020 09:00:47 PM Eastern Daylight Time

Timestamp:

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Completed Section B5 Status 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 Completed Section B13 Status Section B14 Status Completed Section B15 Status Completed Completed Section B16 Status Section B17 Status Completed Section B18 Status Completed Completed Section B19 Status Section C Status Completed Section D Status Completed Section Mrx Status Completed

**SECTION A: SECTION A-1** 

Organization Legal HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization Marketing

Service Area(s):

Name:

Humana

Organization Web Site: www.humana.com/medicare

Humana Gold Plus SNP-DE H4007-023 (HMO D-SNP) Plan Name:

40120 - Cabo Rojo, PR

Organization Type: Local CCP Plan Type: **HMO** 

Part A and Part B Enrollee Type: 40010 - Adjuntas, PR Service Area(s): Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR Service Area(s): 40050 - Aibonito, PR Service Area(s): Service Area(s): 40060 - Anasco, PR Service Area(s): 40070 - Arecibo, PR 40080 - Arroyo, PR Service Area(s): 40090 - Barceloneta, PR Service Area(s): Service Area(s): 40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR

PONINISTRACION Contrato Número 0.0 POSDE

about blank 5/20/2020 rbr Data Kepon rage 2 01 40

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):	l l



about-blank 5/29/2020

rbr Data Keport rage 5 01 40

40670 - Santa Isabel, PR

40680 - Toa Alta, PR Service Area(s): Service Area(s): 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR Service Area(s): 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 No

plan?

## **SECTION A: SECTION A-2**

Does this Plan have a No CMS-approved

Continuation Area?

Do you intend to Yes

participate in the PLATINO program?

Is this a Special Needs Yes

Plan?

Special Needs Plan Dual-Eligible

Type:

Is this D-SNP plan a No

Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-

SNP?

## **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 (866)773-5959

Contact Phone Number for Current Medicare

Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Medicare

Beneficiaries:

Customer Service Contact Local Phone (000)001-3023

(800)681-3625





rage 4 01 40 гыг пана кероп

Number for Prospective Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service (866)773-5959

Contact Local Phone Number for Current Part D Medicare

Beneficiaries:

Customer Service (800)681-3625

Contact Phone Number for Prospective Part D Medicare Beneficiaries:

**SECTION A: SECTION A-4** 

Customer Service (800)681-3625

Contact Local Phone Number for Prospective Part D Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Current Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Prospective Medicare Beneficiaries:

Customer Service (711)-

Contact Local TTY/TDD for Prospective Medicare

Beneficiaries:

Customer Service (711)-

Contact TTY/TDD for Current Part D Medicare

Beneficiaries:

(711)-Customer Service

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

Customer Service (711)-

Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:

Customer Service (711)-

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

**SECTION A: SECTION A-5** 

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

Is your organization No

filing a standard bid for Section C of the PBP?

**SECTION A: SECTION A-6** 

Is your organization filing a standard bid for Section D of the PBP?







rbr Data Report rage 3 of 40

Do any of your

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

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

No

Does the plan provide Yes

Inpatient Hospital-Acute

Services as a

supplemental benefit

under Part C?

Select enhanced benefits: : Additional Days

Select type of benefit for

r Mandatory

Yes

Additional Days:

Is this benefit unlimited

for Additional Days?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Does this plan's No

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

Is there an enrollee

No

Coinsurance?

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

Does this plan's No

Additional Days cost sharing vary by hospital (s) in which an enrollee

obtains care?

SECTION B: #IA INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee

Deductible?

No

Is there an enrollee

e Yes

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

Indicate the number of Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

SECTION B: #IA 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)



KM

about-blank 5/28/2020

гог рана кероп rage o oi 40

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

What is your Inpatient

Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost

sharing on the day of

No

discharge?

Is authorization Yes

required?

Is a referral required for No Inpatient Hospital-Acute

Services?

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's No

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

Is there an enrollee Nο

Coinsurance?

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

No

Yes

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Do you charge the No

Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient

facility.)

Indicate Copayment \$0.00

amount for the

Medicare-covered stay:

Indicate the number of Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

SECTION B: #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 Per Admission or Per Stay

No

What is your Inpatient Hospital Psychiatric

benefit period? No

Do you charge cost sharing on the day of

discharge?

Is authorization Yes required?

Is a referral required for Inpatient Psychiatric







5/28/2020 ahoutchlank

rbr Data Kepon rage / 01 40

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide No

Skilled Nursing Facility

Services as a

supplemental benefit

under Part C?

Do you allow less than 3 Yes

day inpatient hospital stay prior to SNF admission?

Indicate the Number of Zero

Hospital Days Required Prior to SNF Admission

(0-2):

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's No

Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF Original Medicare

benefit period?

Is authorization Yes

required?

Is a referral required for No

SNF Services?

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

Does the plan provide
Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific No.

of-Pocket Cost?

T is

Is there an enrollee N

Coinsurance?

No

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

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

Select which Cardiac and : Medicare-covered Cardiac Rehabilitation Services

Pulmonary : Medicare-covered Intensive Cardiac Rehabilitation Services

Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services

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

(Select all that apply): (PAD) Services

Indicate Minimum \$0.00

Copayment amount per service for Medicare-

Contrato Número

21 - 0 0 4

Aw)

rbr Data Report rage o of 40

Covered Cardiac

Rehabilitation Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Minimum \$0.00 Copayment amount per service for Medicarecovered Intensive

Cardiac Rehabilitation Services:

Indicate Maximum \$0.00 Copayment amount per service for Medicarecovered Intensive

Services:

Indicate Minimum \$0.00 Copayment amount per service for Medicarecovered Pulmonary

Rehabilitation Services:

Cardiac Rehabilitation

Indicate Maximum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Minimum \$0.00

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

Peripheral Artery Disease (PAD) Services:

Indicate Maximum \$0.00

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

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

Is authorization Yes

required?

Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

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

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:





about-blank 5/28/2020

rage 9 of 40 rbr Data Keport

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Is the Copayment for Yes

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for

waiver:

Enter number of Days or 24

Hours:

Does the No

Emergency/Post-Stabilization Services cost sharing count towards any plan-level

deductible?

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

\$0.00

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

deductible?

Is the Copayment for No Medicare-covered

Benefits waived if admitted to hospital?

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

Does the plan provide

Worldwide

Emergency/Urgent Coverage as a

supplemental benefit

under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

Yes

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for

Worldwide Emergency

Coverage:

Select type of benefit for

Worldwide Urgent

Coverage:

Select type of benefit for

Worldwide Emergency

Mandatory







5/28/2020 ahaut-hlank

гог раца кероп rage to of 40

Transportation:

Is there a Maximum Plan No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee Yes

Copayment?

Select which Worldwide : Worldwide Emergency Coverage : Worldwide Urgent Coverage Services have a : Worldwide Emergency Transportation

Yes

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Worldwide Emergency

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency

Coverage:

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

Indicate Minimum \$0.00

Copayment amount for Worldwide Urgent

Coverage:

\$0.00 Indicate Maximum

Copayment amount for Worldwide Urgent

Coverage:

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

Indicate Minimum

Copayment amount for Worldwide Emergency

Transportation:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency Transportation:

Is this Copayment

waived for Worldwide

Emergency Transportation if admitted to hospital?

Is there an enrollee No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Yes

\$0.00

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?





about-blank 5/28/2020

rage 11 01 40 гог раза кероп

Is there an enrollee

Deductible?

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

Is there an enrollee

Yes

No

Copayment?

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Benefits per day:

Indicate Maximum

\$0.00

Yes

Copayment amount for Medicare-covered Benefits per day:

Is authorization

required?

Is a referral required for No Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Yes

Is a referral required for

No

Home Health Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance? Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as No

OMINISTRACION D Contrato Número

гвг раца кероп rage 12 01 40

a supplemental benefit

under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Yes

Copayment?

Select which : Medicare-covered Chiropractic Services

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

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is there an enrollee

Deductible?

No

No

Is authorization No

required?

Is a referral required for Yes

Chiropractic Services?

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance? Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

Yes Yes

Is a referral required for

Occupational Therapy

Services?

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

Yes

Copayment?

OMINISTRACION Contrato Número



5/29/2020 ahaut-hlank

rdr Data Report I age 13 OI 70

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

No

required?

Is a referral required for Yes

Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

: Medicare-covered Individual Sessions Select which Mental Health Specialty : Medicare-covered Group Sessions

Services have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization Yes required?

Is a referral required for

Yes

Mental Health Specialty

Services - Non-Physician?

**SECTION B: #7F PODIATRY SERVICES - BASE 1** 

Does the plan provide No

Podiatry Services as a supplemental benefit under Part C?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

**SECTION B: #7F PODIATRY SERVICES - BASE 2** 

Is there an enrollee





гог раца кероп rage 14 01 40

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

: Medicare-covered Podiatry Services

Copayment?

Select which Podiatry

Services have a

Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

No

Is authorization

required?

Is a referral required for No

Podiatrist Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No No

\$0.00

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization

required?

No

Is a referral required for No

Other Health Care Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 No

No

Is there an enrollee

Is there an enrollee

Deductible?

Coinsurance?

Is there an enrollee

Copayment?

Yes

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

Copayment (Select all

that apply):

\$0.00 Indicate Minimum



rdr Data Keport rage 13 of 40

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

#### SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization Yes

required?

Is a referral required for No

Psychiatric Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

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

Is authorization

required?

Yes

Is a referral required for No

Physical Therapy and Speech-Language Pathology Services?

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

Do you offer an Yes

Additional Telehealth benefit for Part B

services?

available:

Select the Medicarecovered benefits that : 4b: Urgently Needed Services
: 7a: Primary Care Physician Services
: 7d: Physician Specialist Services

may have Additional : 7d: Primary Care Physician Services
Telehealth Benefits : 7d: Physician Specialist Services
: 7el: 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 Outof-Pocket Cost for Additional Telehealth?





rage 10 01 40 rbr Data Keport

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Yes

Deductible?

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization required Nο for Additional Telehealth

Services?

Is a referral required for

Additional Telehealth

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

\$0.00

Copayment?

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

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

Is authorization

required?

No

Is a referral required for No

Opioid Treatment Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

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

: Medicare-covered Diagnostic Procedures/Tests

Diag Procs/Tests/Lab Services have a

Copayment (Select all

: Medicare-covered Lab Services

FOSDE

5/28/2020 about-blank

Contrato Número 63

гог рака кероп rage 1/ 0140

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Diagnostic

Procedures/Tests:

Procedures/Tests:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Diagnostic

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Lab

Services:

If a member receives Yes multiple services at the same location on the same day, does only the maximum copay apply?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization Yes

required?

Is a referral required for Yes

Outpatient Diagnostic Procedures/Test/Lab

Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

: Medicare-covered X-Ray Services

: Medicare-covered Diagnostic Radiological Services

: Medicare-covered Therapeutic Radiological Services

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):

\$0.00

Indicate Minimum Copayment amount for other Medicare-covered

Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum \$0.00

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:





about-blonk 5/28/2020 rdr Data Report rags to Ot 40

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

If a member receives Yes multiple services at the same location on the same day, does only the maximum copay apply?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization

required?

Yes

No

Is a referral required for

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Yes

Select which Services : Medicare-covered Outpatient Hospital Services have a Copayment : Medicare-covered Observation Services

(Select all that apply):

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount per visit for Medicare-covered Observation

Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Observation

Services:

Is authorization required for Medicare-covered

Outpatient Hospital

Services?







about:blank 5/28/2020

гог раза кероп Fage 17 UI 40

Is authorization required

for Medicare-covered Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient Hospital

Services?

Is a referral required for Yes

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Yes

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicarecovered Benefits:

Is authorization Yes

required?

Is a referral required for No

Ambulatory Surgical Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

: Medicare-covered Individual Sessions Select which Outpatient Substance Abuse : Medicare-covered Group Sessions

services have a Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Individual Sessions:

\$0.00

Indicate Minimum Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00







Copayment amount for Medicare-covered Group

Sessions:

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization

No

required?

Is a referral required for

No

Outpatient Substance

Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide

Yes

Outpatient Blood Services as a

supplemental benefit

under Part C?

: Three (3) Pint Deductible Waived Select enhanced benefit:

Select type of benefit for

Mandatory

Three (3) Pint Deductible Waived:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization

No

required?

Is a referral required for

No

Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Services

: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services

have a Copayment

(Select all that apply):

\$0.00

Indicate the Minimum

Copayment amount for

Medicare-covered

Ground Ambulance

Services:

Indicate the Maximum

Copayment amount for Medicare-covered

Ground Ambulance Services:

Indicate Minimum

Copayment amount for Medicare-covered Air Ambulance Services:

\$0.00

\$0.00



SMINISTRACION Contrato Número \_ 0.0 CUROSDE



FDF Data Report Fage 41 Of 40

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment No

waived if admitted to

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required Yes

for non-emergency Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Yes
Transportation Services
as a supplemental benefit

under Part C?

Select enhanced benefit: Plan Approved Health-related Location

No

Select type of benefit for Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited for number of trips for Plan Approved Healthrelated Location?

Indicate number of trips 36

for Plan Approved Health-related Location:

Select Plan Approved Every year

Health-related Location Trips periodicity:

Select Type of One-way

Transportation for Plan Approved Health-related

Location:

Select Mode of : Van

Transportation for Plan : Other, Describe

Approved Health-related

Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific No Maximum Plan Benefit Coverage amount?

Is there a service-specific No Maximum Enrollee Outof-Pocket Cost?

T .1

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per

trip:

Indicate Maximum \$0.00

Copayment amount per

trip:

Is authorization Yes required?

Is a referral required for No Transportation Services?







about-blank 5/28/2020

the hara vehou I age 22 of to

Services arranged by the plan's transportation provider to approved locations by means of car, van, or Notes: wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

\$0.00

No

Copayment?

Indicate Minimum

Copayment amount per item for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Benefits:

**SECTION B: #11A DME - BASE 2** 

Are there preferred vendors/manufacturers for Durable Medical

Equipment (DME)? Is authorization Yes

required?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

: Medicare-covered Prosthetic Devices Select which Prosthetics/Medical : Medicare-covered Medical Supplies

Supplies have a Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum \$0.00

Copayment amount per item for Medicarecovered Medical Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Medical Supplies:







5/28/2020 ahout-blank

1 D1 Data Report 1 450 45 01 70

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization

Yes

required?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee

Copayment?

Yes

Select which Diabetic

: Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per item for Medicare-covered Diabetes

Supplies:

Indicate Maximum

\$0.00

Copayment amount per item for Medicare-covered Diabetes

Supplies:

Indicate Minimum

\$0.00

\$0.00

Copayment amount per item for Medicarecovered Diabetic Therapeutic Shoes or

Inserts:

Indicate Maximum

Copayment amount per item for Medicare-covered Diabetic
Therapeutic Shoes or

Inserts:

Do you limit Diabetic Supplies and Services to those from specified manufacturers?

Yes

Is authorization

No

required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per session for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per session for Medicare-







гог раца кероп rage 24 01 40

covered Benefits:

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

required?

Is a referral required for No

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

No

Acupuncture as a supplemental benefit

under Part C?

**SECTION B: #13B OTC ITEMS - BASE 1** 

Does the plan provide Over-The-Counter (OTC) Items as a

Yes

supplemental benefit under Part C?

Select type of benefit for

Mandatory

OTC Items:

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Yes

Indicate Maximum Plan

45.00

Benefit Coverage

amount:

Select Maximum Plan

Benefit Coverage

Every three months

periodicity:

Does your Maximum No Plan Benefit Coverage amount carry forward to the next period if it is

unused?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Are you offering

Nicotine Replacement Therapy (NRT) as a Part

C OTC benefit?

Nicotine Replacement

Therapy (NRT)

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or

formulary drugs.

Attestation:

**SECTION B: #13B OTC ITEMS - BASE 2** 

Is there an enrollee

Coinsurance?

No

Yes

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

No

Does this cover all of the OTC list which may be

found in Chapter 4 of the Medicare Managed Care

Manual?

**SECTION B: #13B OTC ITEMS - BASE 3** 

Notes: The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical

criteria.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal

Yes

Benefit as a

Contrato Número 0 0

TOT Data INTPORT 1 agc 22 01 TO

supplemental benefit under Part C? Note: Only primarily healthrelated meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for

Meals:

Mandatory

How many days does your Meal Benefit last?

28 What is the maximum

56

number of meals the benefit provides?

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

**SECTION B: #13C MEAL BENEFIT - BASE 2** 

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount:

\$0.00 Indicate Maximum

Copayment amount:

Is authorization Yes

required?

Is a referral required for

the Meal Benefit?

# **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.

No

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 No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes required?

Is a referral required for No

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





LDI Data Vehori 1 age 20 01 TO

> 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

No

required?

No

Is a referral required?

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide Yes the Annual Physical Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical

Mandatory

Exam:

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-

of-Pocket Cost?

### SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Yes

Is there an enrollee Copayment?

\$0.00

Indicate Minimum Copayment amount for each Annual Physical

Exam:

Indicate Maximum Copayment amount for

each Annual Physical

\$0.00

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization

No

required?

Is a referral required for the Annual Physical

No

Exam?

Notes:

An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the 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





ONINISTRACION

Contrato Número

POSDE

ahout-hlank 5/28/2020 гог рага мероп 1 agc 2/ 01 70

a benefit under Part C?

Select enhanced benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling

(Select all that apply): : 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:

Select type of benefit for

Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness

all that apply):

Select type of benefit for

Mandatory

Home and Bathroom Safety Devices and Modifications:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Mandatory

Wigs for Hair Loss Related to

Chemotherapy: SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific

Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other : 14c15: Wigs for Hair Loss Related to Chemotherapy

Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select

all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Indicate Maximum Plan 500.00

Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:

Select Maximum Plan Every year

Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

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 No

Copayment?





ahout-blank 5/20/2020 I DI Data Keputi 1 age 20 01 TO

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization

required?

Yes

Is a referral required for

Other Defined

Nο

Supplemental Benefits?

Additional Sessions of

Smoking and Tobacco Cessation Counseling

Notes:

Fitness Benefit Notes:\*

No authorization required for this service.

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

The plan will provide 1 bath chair every 5 years. Authorization is required for this service.

Safety Devices and Modifications Notes:\*

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Wigs for Hair Loss

Related to

Authorization is required for this service.

Chemotherapy Notes:

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee

Deductible?

Is there an enrollee

Yes

\$0.00

\$0.00

No

Copayment?

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for

Medicare-covered

Benefits:

Is authorization

No

required?

Is a referral required for

No

Kidney Disease **Education Services?** 

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE/I

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Medicare-covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee

Coinsurance?

No

Yes

Is there an enrollee

Deductible?

No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee

Copayment?

Select which Services

: Medicare-covered Glaucoma Screening

DANNISTRACION

POSDE

Contrato Número

5/20/2020

about-blank

TOT Data Report

have a Copayment : Medicare-covered Diabetes Self-Management Training (Select all that apply): : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit : Other Medicare-covered Preventive Services Indicate Minimum \$0 Copayment amount for Medicare-covered Glaucoma Screening: \$0 Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: Indicate Minimum \$0 Copayment amount for Medicare-covered Diabetes Self-Management Training: \$0 Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: Indicate Minimum \$0 Copayment amount for Medicare-covered Barium Enemas: \$0 Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Minimum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: Indicate Maximum \$0 Copayment amount for Medicare-covered EKG following Welcome Visit: \$0 Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: Indicate Maximum \$0 Copayment amount for Other Medicare-covered Preventive Services: Is authorization required No for Medicare-covered Glaucoma Screening? Is authorization required No for Medicare-covered Diabetes Self-

Management Training?





5/20/2020 ahaut-hlank

TOT Data Mehort I ago JU UI TU

Is authorization required

for Medicare-covered Barium Enemas?

Is authorization required No for Medicare-covered

Digital Rectal Exams?

Is authorization required No

for Medicare-covered EKG following Welcome Visit?

Is authorization required No

for Other Medicarecovered Preventive

Services?

# SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

: Medicare Part B Chemotherapy/Radiation Drugs

Is a referral required for

any Services?

#### SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

No

No

No

Is there a Maximum

Enrollee Out-of-Pocket

Cost?

Is there an enrollee

Coinsurance?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee

Copayment?

Yes

Select which Medicare

: Other Medicare Part B Drugs Part B Rx Drugs have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Maximum \$0.00

Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Minimum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum \$0.00

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee

Deductible?

No

Is Authorization

Yes

Required?

Yes

Does the plan offer step therapy?

Does the benefit step

: Part B to Part B?

from (select all that

apply):

#### **SECTION B: #15 HOME INFUSION BUNDLED SERVICES**

Does the plan provide Part D home infusion drugs as part of a

bundled service as a mandatory supplemental







ahoutchlank 5/28/2020 LDL Data Keport I ago DI OI TO

#### benefit?

### SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Yes Preventive Dental Items as a supplemental benefit

under Part C?

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:

Select the Oral Exams

periodicity:

Select type of benefit for

Other, Describe

Mandatory

Prophylaxis (Cleaning):

Is this benefit unlimited

No, indicate number

for Prophylaxis (Cleaning)?

Indicate number of visits

for Prophylaxis

(Cleaning): Select the Prophylaxis

Every year

(Cleaning) periodicity:

# SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for

Dental X-Rays:

Mandatory

Is this benefit unlimited

No, indicate number

for Dental X-Rays?

Indicate number of visits 8

for Dental X-Rays:

Other, Describe

Select the Dental X-Rays periodicity:

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

# SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Yes

Coinsurance?

Select which Preventive Dental Services have a

: Prophylaxis (Cleaning)

Coinsurance (Select all

: Dental X-Rays

: Oral Exams

that apply):

Is there a combination of services included in a

single cost per Office

Visit?

Indicate Minimum Coinsurance percentage

for Oral Exams: Indicate Maximum

Coinsurance percentage for Oral Exams: Indicate Minimum

Coinsurance percentage for Prophylaxis

0%

No



OMINISTRACION PORTINISTRACION Contrato Número 21 - 00POSDE

5/20/2020 ahoutehlank

LDL Data Keport 1 age 22 of to

(Cleaning):

Indicate Maximum 0% Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Minimum 0%

Coinsurance percentage for Dental X-Rays:

Indicate Maximum 0%

Coinsurance percentage for Dental X-Rays:

**SECTION B: #16A PREVENTIVE DENTAL - BASE 4** No

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

**SECTION B: #16A PREVENTIVE DENTAL - BASE 5** No

No

Is authorization

required?

Is a referral required for

Preventive Dental

Services?

Notes:

Dental X-Rays include bitewing x-rays up to 1 set(s) every 2 years, panoramic film up to 1 every 3 years.

Oral exams include periodic oral exam up to 2 per year and comprehensive oral evaluation up to 1 every 3

years.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Yes Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits:

: Restorative Services : Endodontics : Periodontics : Extractions

Mandatory

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for

Restorative Services:

Is this benefit unlimited

No, indicate number

for Restorative Services?

Indicate number of visits

for Restorative Services:

Select the Restorative

Other, Describe

Services periodicity:

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

Mandatory

No, indicate number

Periodontics:

Is this benefit unlimited for Periodontics?

Indicate number of visits

for Periodontics:

Select the Periodontics

Every year

periodicity:

Mandatory

Select type of benefit for

Extractions:

Is this benefit unlimited

for Extractions?

Yes

Select type of benefit for

Mandatory

Prosthodontics, Other

OMMISTRACION P Contrato Número



5/28/2020 ahautchlank

i Di Daia Kepuii Tage 22 OF TO

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited

No, indicate number

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services? Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Select the Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

3

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Indicate Maximum Plan

2000.00

Benefit Coverage

amount:

Select the Maximum

Every year

Plan Benefit Coverage

periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

Coinsurance?

Yes

Select which : Restorative Services

: Endodontics Comprehensive Dental Services have a : Periodontics Coinsurance (Select all : Extractions

that apply): : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Minimum

Coinsurance percentage for Restorative Services:

Indicate Maximum 0%

Coinsurance percentage for Restorative Services:

0%

Indicate Minimum Coinsurance percentage

for Endodontics: Indicate Maximum

0%

Coinsurance percentage for Endodontics:

Indicate Minimum Coinsurance percentage 0%

for Periodontics:

Indicate Maximum

0%

Coinsurance percentage for Periodontics:

Indicate Minimum Coinsurance percentage 0%

for Extractions:

Indicate Maximum

Coinsurance percentage for Extractions:

0%





TDI Data Kepuli I ago ot ot to

Indicate Minimum 0%

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum 0% Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services: Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Select which : Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

No

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Yes

\$0.00

\$0.00

Is authorization Yes

required?

Is a referral required for

Comprehensive Dental

Services?

Notes: Endodontics includes root canal up to unlimited per year. Periodontics includes scaling and root planing

(deep cleaning) per quadrant up to 1 per year. Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year. Partial dentures and complete dentures up to 1 set(s) every 5 years. Restorative services include 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?

: Routine Eye Exams Select enhanced benefit:

Yes

Select type of benefit for

Routine Eye Exams:

Mandatory

Is this benefit unlimited

No, indicate number

for Routine Eye Exams?

Indicate number of

exams for Routine Eye

Exams:

Select the Routine Eye

Every year

Exams periodicity:

Is there a service-specific

Maximum Plan Benefit

No

1

Coverage amount? Is there a service-specific

No

Maximum Enrollee Outof-Pocket Cost?

**SECTION B: #17A EYE EXAMS - BASE 2** 

Is there an enrollee Coinsurance?

No





LDL Data Vehout I age JJ OL TO

Is there an enrollee

Yes

\$0.00

Copayment?

Select which Eye Exams : Medicare-covered Benefits have a Copayment

: Routine Eye Exams

(Select all that apply):

Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Eye Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

No

# SECTION B: #17A EYE EXAMS - BASE 3

Is authorization

No

No

Yes

required?

Is a referral required for

Eye Exams?

#### SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Eyewear as a

supplemental benefit

under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

No, indicate number

Select type of benefit for

Contact lenses:

Mandatory

Is this benefit unlimited

for Contact lenses?

Indicate quantity

(number of pairs) for Contact lenses:

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

frames):

1 Eyeglasses (lenses and

Select Eyeglasses (lenses

Every year

Plan-specified amount per period

and frames) periodicity:

#### **SECTION B: #17B EYEWEAR - BASE 3**

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Yes

POMINISTRACION Contrato Número
2 I - 0 0



5/28/2020 about blank

гот рака кероп I ago oo oi to

Benefit Coverage

Amount for all Eyewear?

Indicate Combined

500.00

Maximum Plan Benefit Coverage amount:

Select the Combined

Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

**SECTION B: #17B EYEWEAR - BASE 5** 

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Eyewear : Medicare-covered Benefits

Benefits have a

: Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for

Contact lenses:

Indicate Maximum \$0.00

Copayment amount for

Contact lenses:

Indicate Minimum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

Indicate Maximum \$0.00

Copayment amount for Eyeglasses (lenses and

frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization No

required?

Is a referral required for No

Eyewear?

SECTION B: #18A HEARING EXAMS - BASE 1

Yes

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Select type of benefit for

Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

Exams?

Mandatory

No, indicate number





5/28/2020 about blank

DE Data Export I age 27 OL TO

Indicate number for

Routine Hearing Exams:

Select Routine Hearing Every year Exams periodicity:

Select type of benefit for

Mandatory

1

Fitting/Evaluation for Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for No, indicate number

Hearing Aid?

Indicate number for

Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation Every year

for Hearing Aid periodicity:

**SECTION B: #18A HEARING EXAMS - BASE 2** 

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there an enrollee No Deductible?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Yes

Select which Hearing : Medicare-covered Benefits Exam Benefits have a : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

Copayment (Select all that apply):

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Hearing Exams:

Indicate Minimum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum \$0.00

Copayment amount for Fitting/Evaluation for

Hearing Aid:

Is authorization No required?

Is a referral required for No

Hearing Exams?

**SECTION B: #18B HEARING AIDS - BASE 1** 

Does the plan provide Hearing Aids as a

Yes







5/28/2020 ahautihlank

I DI Data Neport נו מבל אם מד אם

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Mandatory

Hearing Aids (all types):

Is this benefit unlimited for Hearing Aids (all

No, indicate number

types)?

Indicate quantity for 2 Hearing Aids (all types):

Select Hearing Aids (all Every year

types) periodicity:

**SECTION B: #18B HEARING AIDS - BASE 2** 

Is there a service-specific Maximum Plan Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage

Both ears combined

Amount apply per ear or for both ears combined?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Indicate Maximum Plan

75.00

Yes

Benefit Coverage

amount:

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?

Is there an enrollee

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Yes

Is there an enrollee

Copayment?

Indicate Minimum \$0.00

Copayment amount per Hearing Aid (all types):

Indicate Maximum \$0.00

Copayment amount per Hearing Aid (all types):

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization No

required?

Is a referral required for

Hearing Aids?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include

MA Uniformity Flexibility with reductions in cost or additional benefits?

No

No

Do you offer Special Supplemental Benefits Yes

for the Chronically III? Select what type of

: Additional Benefits

benefit your SSBCI

Contrate Número

5/28/2020 ahout-blank

I DI Dala Nepoli I age uz ol to

: Value-Based Design Flexibilities by Condition or Socioeconomic Status

includes:

Are you offering a VBID No

Hospice Benefit?

Are you offering Part C Yes

benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)

In addition to wellness

and health care planning, what other interventions have you been approved by CMMI to offer?

Value-Based Insurance : I attest that

Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type : Other Program

(choose one or more):

Specify Other Program: Advance Care Planning

Nο

No

WHP Mode of : Telephonic
Engagement (choose one or more): : Web-Based

Does your organization

offer Part C Rewards or

Incentives for

beneficiaries for the offer

of WHP Services?

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP

activities?

Program Connectedness: : Electronic Health Records/Electronic Medical Records

Please check the way : Provider/Patient portals that advance care plans : Health Information Exchanges

: Other

and/or advance : Data Warehouses

directives are connected

from your program to access points of care.

Expected Number of 4572

Beneficiaries to be Engaged Annually:

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA No

Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Yes

Uniformity
Flexibility/SSBCI
benefit offer additional
Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package VBID applicable to VBID or

MA Uniformity
Flexibility or SSBCI?





ahout-blank 5/28/2020

LDL Data Report 1 450 TO 01 TO

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology -

Please choose one or

: Socioeconomic Status

hoth:

Select LIS reduction

level:

: LIS Level 1 : LIS Level 2

: LIS Level 3 : LIS Level 4

4572

3200

Expected Number of

Enrollees to be Targeted:

Expected Number of

Enrollees to be engaged and receive Model

benefits:

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?

Select all the Non-

: 13d: Other 1

Medicare-covered additional benefits offered in this package:

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?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT):

PACKAGE #1

Are you offering

No

No

retroactive reimbursement?

Is there a maximum

Yes

benefit amount?

Specify the maximum

25.00

benefit amount:

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

Healthy Foods Card

(Optional):

Select type of benefit for

Other 1:

Mandatory

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan

25.00

Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Nο Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No





TOT Data Nepuli I ago TI OI TO

Deductible?

Is there an enrollee

No

Copayment?

Is authorization

No

required?

Is a referral required for

No

Other Services?

#### SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

\$25.00 per month loaded to a card for members to purchase healthy food. Notes:

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package

**SSBCI** 

applicable to VBID or MA Uniformity Flexibility or 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?

Which prerequisites are

: Participation in a Care Management Program

required for this

package?

Select all the Non-

: 13c: Meal Benefit

Medicare-covered

: 13i: Non-Primarily Health Related Benefits for the Chronically III

additional benefits offered in this package:

### 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/SSBC1 - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering

No

retroactive reimbursement?

No

Is there a maximum benefit amount?

# 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 healthrelated meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for

Meals:

How many days does

your Meal Benefit last? What is the maximum

Mandatory

84

Yes

168

Contrato Numero POSDE

ahout-blank 5/28/2020 I DI Data Nepoli I age 72 of 70

number of meals the benefit provides?

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13C MEAL BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes

required?

Is a referral required for

the Meal Benefit?

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

- IIIE. I ACKAGE

Select what type of : Food and Produce

benefit your Non- : Transportation for Non-Medical Needs

Mandatory

Yes

No

No

Primarily Health Related : General Supports for Living

Benefits for the

Chronically III includes:

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?

Select type of benefit for

Food and Produce:

Is there a service-specific Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan 60.00

Benefit Coverage

amount:

Select Maximum Plan Other, Describe

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

No

Copayment?

Is authorization Yes

required?

Is a referral required for

Food and Produce?

B)

about-blank 5/28/2020

LDI Data Keport I ugo To OI TO

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Eligible members will receive a \$60 monthly debit card allowance for purchase of healthy food. Notes:

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?

Plan-approved Location

Select enhanced benefit: Select type of benefit for

Mandatory

Plan-approved Location:

Is this benefit unlimited for number of trips for Plan-approved Location? Indicate number of trips

24

No

for Plan-approved

Location:

Select Plan-approved

Location Trips periodicity:

Every year

One-way

Select Type of Transportation for Non-Medical Needs for Plan-

approved Location:

Select Mode of : Taxi Transportation for Non-Van

: Medical Transport Medical Need for Planapproved Location: : 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?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #2

Is there an enrollee

Copayment?

Is authorization Yes

required?

Is a referral required for No

Transportation for Non-

Medical Needs?

Eligible members may receive non-medical related transportation to locations such as the bank, Notes:

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?

Select type of benefit for General Supports for

Living:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

Benefit Coverage

Yes

Mandatory

60.00

No





5/20/2020 ahout-hlank

T DI Data Nepoti

amount:

Select Maximum Plan

Other, Describe

Benefit Coverage periodicity:

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization Yes

required?

Is a referral required for No

General Supports for

Living?

SECTION B: VBID/UF/SSBCI 19B #13I 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 No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network N

Plan Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Yes

Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Voluntary

Maximum Enrollee Outof-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Indicate In-Network 3400.00

Maximum Enrollee Outof-Pocket Cost Amount:

Select the benefits that : In-Network Medicare-covered benefits

apply to the In-Network Maximum Enrollee Out-

of Poolsot costs

of-Pocket cost:

Does the In-Network Yes

Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan

services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan No

Benefit Coverage

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions No

in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost

with uniform cost sharing?

Contrato Número

2 1 - 0

OFF

CUPOS DE SEV



ahout-blank 5/28/2020

тыг рака кереп i ago to oi to

#### SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

Yes

drug (Part D) benefit?

Select the type of drug

Defined Standard

benefit:

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

Yes

pricing?

Does plan utilize ceiling

Yes

pricing?

Are there quantity limits

Yes

on certain prescription drugs?

Is prior authorization

Yes

required for certain prescription drugs?

No

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your Yes

formulary require a step

No

therapy plan?

Do you pay for over-the-

counter medications (OTCs) under the utilization management

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail

Cost sharing

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

Location/supply amount

(s) that apply:

Enter number of days for Standard Retail Cost

30

Sharing 1-month supply:

90

Enter number of days for Standard Retail Cost Sharing 3-month supply:

Select all Out-of-Network Pharmacy

: Out-of-Network Pharmacy - one month supply

Location/supply amount

(s) that apply:

Enter number of days for 30

Out-of-Network Pharmacy 1-month

supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount

(s) that apply:

Enter number of days for 30

: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply

DMINISTRACION DM

Contrato Número

5/28/2020 ahout-blank

1 Di Data Nepoti 1 age 70 of 70

Standard Mail-Order Cost Sharing 1-month

supply:

Enter number of days for 90 Standard Mail-Order Cost Sharing 3-month

supply:

Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for 31

Long-Term Care Pharmacy 1-month supply:

Are all of the drugs on your formulary available with an extended day

supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the

first fill?

# **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.

: Long-Term Care Pharmacy - 1-month supply

# SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

No

No

No

Do you offer Part D Rewards and Incentives programs through the

model?





