MEDICARE PLATINO CONTRACT

APPENDIX C (1) (22)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)



HUMANA HEALTH PLAN OF PR, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4007-016





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 016, SEGMENT 0

Module: PBP
Requested By: r1ea
PLAN SYSTEM INFORMATION
Last entry Date: 06/02/2021

PBP Software Version: 2022.01

Plan Ready for Upload

06/02/2021 11:10:58 AM Eastern Daylight Time

Timestamp:

MA BPT Timestamp: 05/14/2021 01:25:59 PM Eastern Daylight Time PD BPT Timestamp: 05/10/2021 09:13:26 AM Eastern Daylight Time Last Upload File 05/24/2021 09:37:06 AM Eastern Daylight Time

Creation Timestamp:

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Completed Section B18 Status 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 H4007-016 (HMO D-SNP)

Organization Type: Local CCP
Plan Type: HMO

Enrollee Type: Part A and Part B Service Area(s): 40010 - Adjuntas, PR Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR Service Area(s): 40040 - Aguas Buenas, PR 40050 - Aibonito, PR Service Area(s): Service Area(s): 40060 - Anasco, PR Service Area(s): 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR



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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
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Service Area(s):

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40630 - San German, PR

40640 - San Juan, PR Service Area(s):

Service Area(s): 40650 - San Lorenzo, PR

Service Area(s): 40660 - San Sebastian, PR

Service Area(s): 40670 - Santa Isabel, PR

Service Area(s): 40680 - Toa Alta, PR

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

Service Area(s):

Service Area(s): 40710 - Utuado, PR

40720 - Vega Alta, PR Service Area(s): Service Area(s): 40730 - Vega Baja, PR

Service Area(s): 40740 - Viegues, PR

Service Area(s): 40750 - Villalba, PR

Service Area(s): 40760 - Yabucoa, PR

40770 - Yauco, PR Service Area(s):

Contract Number: H4007

016 Plan ID:

Segment ID: Contract Period: 2022

Plan Geographic Name: Puerto Rico Island Wide

Is this an Employer-Only

plan?

SECTION A: SECTION A-2

Does this Plan have a No

CMS-approved Continuation Area?

Yes

No

Do you intend to

participate in the

PLATINO program?

Is this a Special Needs Yes

Plan?

Special Needs Plan

Dual-Eligible

Type:

Is this D-SNP plan a

Medicare zero-dollar

cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has No

the state agreed to cover all Medicare premiums

and cost sharing for enrollees in your D-

SNP?

SECTION A: SECTION A-3

Participating Pharmacy

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

Website Address:

Formulary Website

http://www.humana.com/medicare/medicare prescription drugs/medicare drug tools/medicare drug list/

Address:

Physician Website

www.humana.com/members/tools

Address:

Customer Service

(866)773-5959

Contact Phone Number for Current Medicare

Beneficiaries:

Customer Service

(866)773-5959

Contact Local Phone Number for Current

Medicare Beneficiaries:

Customer Service

(800)681-3625



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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





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Section C of the PBP?

SECTION A: SECTION A-6

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

Do any of your No outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

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

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

Deductible?

No

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

Medicare-covered

Zero (No Copayment per Day)



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Lifetime Reserve Days:

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

Indicate the number of

Zero (No Copayment per Day)

day intervals for Additional Days:

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 No

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

Medicare-covered

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

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes 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

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered stay:

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

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost No



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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

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

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 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

Is there an enrollee

Yes

Copayment?

Select which Cardiac and : Medicare-covered Cardiac Rehabilitation Services

Pulmonary : Medicare-covered Intensive Cardiac Rehabilitation Services





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Rehabilitation Services : Medic

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment (Select all that apply):

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

(PAD) Services

Indicate Minimum

ım unt per \$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

Copayment amount per service for Medicarecovered Cardiac

Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicare-

covered Cardiac Rehabilitation Services:

Indicate Minimum Copayment amount per service for Medicarecovered Intensive

Cardiac Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicare-

service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Minimum
Copayment amount per

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

Disease (PAD) Services:

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

Peripheral Artery
Disease (PAD) Services:

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

Is authorization Yes

required?

Is a referral required 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





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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 the Copayment for

Yes

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours within which

Hours

admission must occur for

waiver:

Enter number of Days or

Hours:

24 No

Does the 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?

No

Is there an enrollee Coinsurance?

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

Is there an enrollee

Yes

Copayment?

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

\$0.00

\$0.00

Copayment amount for

Medicare-covered

Benefits:

Does the Urgently

Needed Services cost sharing count towards

any plan-level

deductible?

Is the Copayment for

No

No

Medicare-covered Benefits waived if

admitted to hospital?

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

Does the plan provide

Worldwide

Yes

Mandatory

Emergency/Urgent Coverage as a supplemental benefit

under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Emergency Transportation

Select type of benefit for

Worldwide Emergency

: Worldwide Urgent Coverage







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Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent

Coverage:

Select type of benefit for Mandatory

Worldwide Emergency

Transportation:

Is there a Maximum Plan

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee

Coinsurance?

No

No

No

Is there an enrollee

Yes

\$0.00

Yes

\$0.00

\$0.00

\$0.00

Copayment?

Select which Worldwide

Services have a

: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation

Copayment (Select all 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

Copayment amount for Worldwide Emergency

Transportation:

\$0.00 Indicate Maximum

Copayment amount for Worldwide Emergency Transportation:

Is this Copayment

waived for Worldwide

Emergency Transportation if admitted to hospital?

Is there an enrollee

Deductible?

No

Yes

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1





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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: #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

\$0.00

Copayment?

Indicate Minimum

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

Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-

covered Benefits: Indicate Maximum

Copayment amount per

\$0.00



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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 Out-

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee 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 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

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





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Coinsurance?

Is there an enrollee

Νø

Deductible?

Is there an enrollee

Yes

\$0.00

Copayment?

Indicate Minimum

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?

Is there an enrollee No

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?





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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

No

Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

\$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

Is there an enrollee

No

Deductible?

Copayment?

Yes



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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:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Group

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

No

Is authorization

required?

Is a referral required for

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

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

\$0.00

Indicate Minimum Copayment amount per visit for Medicarecovered Benefits:

\$0.00 Indicate Maximum

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

Additional Telehealth benefit for Part B

services?

Select the Medicare-: 4b: Urgently Needed Services covered benefits that : 7a: Primary Care Physician Services

Yes

may have Additional : 7d: Physician Specialist Services

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

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: 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

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

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 No

required?

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

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Yes

No





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Copayment?

Select which Outpatient

Diag Procs/Tests/Lab Services have a

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

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for

\$0.00

\$0.00

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

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

\$0.00

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 Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

: Medicare-covered X-Ray Services

: Medicare-covered Diagnostic Radiological Services

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

\$0.00

\$0.00

No

Select which Outpatient

Diag/Therapeutic Rad

Services have a

Copayment (Select all

that apply):

Indicate Minimum Copayment amount for

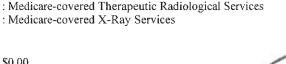
other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI,

etc):

Indicate Maximum

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

etc):







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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 No

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Yes

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

Is there an enrollee

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

No

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 Medicare-covered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Observation Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Observation Services:

Copayment is charged: Per stay





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Is authorization required

for Medicare-covered

Outpatient Hospital Services?

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 Outof-Pocket Cost?

Is there an enrollee

No

Yes

Yes

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

\$0.00

Indicate Minimum 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

\$0.00

\$0.00

Is there an enrollee

Yes

Copayment?

Select which Outpatient

Substance Abuse

services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum

: Medicare-covered Individual Sessions

: Medicare-covered Group Sessions





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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?

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 Outof-Pocket Cost?

Is there an enrollee

No

No

No

Coinsurance?

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

Is there an enrollee

Deductible?

ctible?

Copayment?

Is there an enrollee

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 No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

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 \$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:

Indicate the Maximum

\$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:





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\$0.00 Indicate Minimum

Copayment amount for Medicare-covered Air Ambulance Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Is this Copayment No waived if admitted to

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes

Is authorization required Yes

for non-emergency

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit

under Part C?

Medicare services?

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

Coinsurance?

No 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:

Yes Is authorization

required?

Is a referral required for No

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.



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SECTION B: #11A DME - BASE 1

Is there a service-specific N

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount per item for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per item for Medicare-covered Benefits:

SECTION B: #11A DME - BASE 2

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

Is authorization Yes

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?

No

Yes

Is there an enrollee

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):

Indicate Minimum \$0.00

Copayment amount per item for Medicare-covered Prosthetic

Devices:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum \$0.00

Copayment amount per item for Medicare-covered Medical Supplies:

Indicate Maximum \$0.00

Copayment amount per item for Medicarecovered Medical Supplies:

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

Is authorization Yes



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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

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

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?

Is there an enrollee

-

Deductible?

Yes

\$0.00

No

Is there an enrollee

ongyment?

Copayment?

Indicate Minimum

Copayment amount per session for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per session for Medicare-covered Benefits:

SECTION B: #12 DIALYSIS SERVICES - BASE 2



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Is authorization

No

required?

Is a referral required for

No

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a supplemental benefit

under Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Number of Treatments:

No

Is this benefit unlimited for Number of

Treatments?

Indicate limit for

20

Number of Treatments:

Indicate Number of

Every year

Mandatory

Treatments periodicity:

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: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

No

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

treatment:

Indicate Maximum

\$0.00

Copayment amount per

treatment:

Is authorization

Yes

No

Yes

required?

Is a referral required for

Acupuncture?

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

OTC Items:

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Yes

Indicate Maximum Plan

650.00

Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Every three months

periodicity:

Does your Maximum Plan Benefit Coverage No

amount carry forward to



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the next period if it is

unused?

Is there a service-specific

No Maximum Enrollee Outof-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.

No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Does this cover all of the No 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 I blood pressure monitoring unit every 5 years for members who meet the medical Notes:

criteria.

\$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and

wellness products through mail order.

Members who are home bound qualify for additional \$200 maximum benefit coverage amount per month

for adult diapers (briefs, pull-up), underpads,

disposable gloves, wipes, creams and lotions to prevent dry/cracked skin and decrease risk of ulcers,

nutritional drinks through contracted provider. Prior authorization is required.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a

limited duration Meal

Benefit as a

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

Select type of benefit for

Meals:

Mandatory

Select the type of

: Immediately following surgery or inpatient hospitilization

primarily health related meals benefit offered:

: For a medical condition or potential medical condition that requires the enrollee to remain at home for a

period of time 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: #13C MEAL BENEFIT - BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible? Is there an enrollee

Yes

No

Copayment?

Indicate Minimum \$0.00





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Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required for

Nο

the Meal Benefit?

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

Up to 28 meals over 14 days for members with a COVID-19 Diagnosis.

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

vear.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

COVID-19 Treatment

(Optional):

Select type of benefit for

Mandatory

Other 2:

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: #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

Other Services?

No

SECTION B: #13E OTHER 2 - BASE 3

Notes:

No cost share for 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

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

Does the plan provide

Yes

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

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

Select type of benefit for the Annual Physical

Mandatory

Is there a service-specific

No

Maximum Plan Benefit





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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?

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

\$0.00

Copayment amount for each Annual Physical

Indicate Minimum

Exam:

Indicate Maximum

\$0.00

Copayment amount for each Annual Physical

Exam:

SECTION B: #14B ANNUAL PHYSICAL EXAM BASE 3 No

Is authorization

required?

Is a referral required for

No

the Annual Physical

Exam?

Notes:

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

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

Yes

Supplemental Benefits as 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:

Indicate number of visits offered in addition to

Medicare:

4

Select type of benefit for

Mandatory

Mandatory

Fitness Benefit: Indicate type of Fitness

Benefit offered (Select

all that apply):

Modifications:

Mandatory

: Physical Fitness

Select type of benefit for Home and Bathroom

Safety Devices and

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 4

Is there a service-specific





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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 5

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 7

Is there a service-specific No Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

No No

Yes

No

No

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

Is authorization

required?

Is a referral required for

Other Defined

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 15

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 16

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





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Coinsurance?

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

Is there an enrollee

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:

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 N

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

Copayment?

Yes

\$0

\$0

\$0

Select which Services

: Medicare-covered Glaucoma Screening

have a Copayment

: Medicare-covered Diabetes Self-Management Training

(Select all that apply):

: Medicare-covered Barium Enemas

: Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit

Indicate Minimum

Copayment amount for Medicare-covered

Glaucoma Screening:

Giaucoma Screening:

Indicate Maximum
Copayment amount for

Medicare-covered

Glaucoma Screening:

Indicate Minimum \$0

Copayment amount for Medicare-covered Diabetes Self-

Management Training:

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





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Barium Enemas:

Indicate Minimum

\$0

Copayment amount for Medicare-covered

Digital Rectal Exams:

\$0

Indicate Maximum Copayment amount for

Medicare-covered

Digital Rectal Exams:

\$0

Indicate Minimum Copayment amount for Medicare-covered EKG

following Welcome

Visit:

Indicate Maximum

Copayment amount for Medicare-covered EKG following Welcome

Visit:

Is authorization required

for Medicare-covered Glaucoma Screening? No

\$0

Is authorization required

No

for Medicare-covered

Diabetes Self-

Management Training?

Is authorization required for Medicare-covered

No

Barium Enemas?

Is authorization required

No

for Medicare-covered Digital Rectal Exams?

No

Is authorization required for Medicare-covered

EKG following

Welcome Visit?

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

Is a referral required for

No

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

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

Is there an enrollee

Yes

Copayment?

Select which Medicare

: Medicare Part B Chemotherapy/Radiation Drugs

Part B Rx Drugs have a

Copayment (Select all

: Other Medicare Part B Drugs

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



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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?

No

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental

benefit?

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

Does the plan provide Preventive Dental Items as a supplemental benefit

under Part C?

Select enhanced 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

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 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

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 Maximum Plan Benefit

Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3



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Is there a service-specific

Maximum Enrollee Outof-Pocket Cost?

No

Is there an enrollee Coinsurance?

Yes

Select which Preventive

Dental Services have a

: Oral Exams

Coinsurance (Select all

: Prophylaxis (Cleaning) : Dental X-Rays

that apply):

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

No

Visit?

Indicate Minimum Coinsurance percentage

0%

for Oral Exams:

0%

Indicate Maximum Coinsurance percentage

for Oral Exams:

Indicate Minimum

0%

Coinsurance percentage for Prophylaxis

(Cleaning): Indicate Maximum

0%

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage 0%

for Dental X-Rays: Indicate Maximum

Coinsurance percentage for Dental X-Rays:

0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

No

Is there an enrollee

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, intraoral x-rays up to 6 per year,

panoramic film up to 1 every 3 years. Oral exams include comprehensive oral exam up to 1 every 3 years, periodic oral exam up to 2 per year.

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

: 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:



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Select the Restorative

Other, Describe

Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Mandatory

Endodontics:

Is this benefit unlimited

Yes

for Endodontics?

Select type of benefit for

Periodontics:

Mandatory

No, indicate number

Is this benefit unlimited

for Periodontics?

Indicate number of visits

for Periodontics:

Select the Periodontics periodicity:

Every year

Mandatory

No, indicate number

Select type of benefit for Mandatory

Extractions:

Is this benefit unlimited

for Extractions?

Yes

3

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited

for Prosthodontics, Other

Oral/Maxillofacial

Surgery, Other Services? Indicate number of visits

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

Select the

Other, Describe

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

Coinsurance?

Select which Comprehensive Dental Services have a

Coinsurance (Select all that apply):

: Extractions

Indicate Minimum 0%

Coinsurance percentage for Restorative Services:

0%

Indicate Maximum Coinsurance percentage

for Restorative Services: Indicate Minimum

0%

Coinsurance percentage for Endodontics:

Indicate Maximum

Coinsurance percentage

for Endodontics:

Yes

: Restorative Services

: Endodontics : Periodontics

: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services



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0%

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Indicate Minimum

0%

0%

Coinsurance percentage

for Periodontics:

Indicate Maximum

0% Coinsurance percentage

for Periodontics:

Indicate Minimum

Coinsurance percentage

for Extractions:

Indicate Maximum 0%

Coinsurance percentage

for Extractions:

Indicate Minimum 0% Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

0% Indicate Maximum Coinsurance percentage

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services: Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Select which : Medicare-covered Benefits

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

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 Yes

No

Is authorization

required?

Is a referral required for Comprehensive Dental

Services? Notes:

Periodontics include scaling and root planing (deep cleaning) up to 1 per quadrant per year.

Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year, bridges up to 1 every 5 years, complete dentures and partial dentures up to 1 every 5 years. Restorative services include fillings up to 1 per tooth every 3 years, crown up to 1 per tooth every 5

years.

Yes

SECTION B: #17A EYE EXAMS - BASE 1

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:

Mandatory

Is this benefit unlimited for Routine Eye Exams? No, indicate number

Indicate number of exams for Routine Eye



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Exams:

Select the Routine Eye

Every year

Exams periodicity:

Is there a service-specific Maximum Plan Benefit

Coverage amount? Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

No

No

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

Indicate Maximum

Benefits:

\$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

No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization

required?

No

Yes

Is a referral required for

No

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

Yes

for Contact lenses?

Select type of benefit for

Mandatory

Mandatory

Eyeglasses (lenses and

frames):

Is this benefit unlimited Yes

for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:







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Do you offer a Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 850.00

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

Deductible?

No

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):

\$0.00 Indicate Maximum

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

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

Select enhanced benefits:

Yes

: Fitting/Evaluation for Hearing Aid

Select type of benefit for

Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

: Routine Hearing Exams



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No, indicate number

Mandatory



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Exams?

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:

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

1

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

\$0.00

\$0.00

Select which Hearing Exam Benefits have a

: Medicare-covered Benefits : Routine Hearing Exams

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:

Indicate Minimum

\$0.00

Copayment amount for Routine Hearing Exams:

Indicate Maximum

\$0.00

Copayment amount for

Routine Hearing Exams:

Indicate Minimum Copayment amount for \$0.00

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





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Does the plan provide

Hearing Aids as a supplemental benefit

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Yes

No, indicate number

Plan-specified amount per period

Select type of benefit for Mandatory

Hearing Aids (all types):

Is this benefit unlimited

for Hearing Aids (all

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

type:

Indicate Maximum Plan

Benefit Coverage

amount:

Indicate Maximum Plan Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

1000.00

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

No

Yes

Is there an enrollee

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

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

No

Does your plan include

MA Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special No

Supplemental Benefits for the Chronically 111?







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Are you offering a VBID

Hospice Benefit?

No

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

: Cash or Monetary Rebates

Design Attestation

WHP Program Type

: Other Program

: I attest that

(choose one or more): Specify Other Program:

Advanced Care Planning

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Mode of : Telephonic Engagement (choose one or more):

: In-Person : Web-Based

Does your organization offer Part C Rewards or

No

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 : Data Warehouses

: Other

No

and/or advance directives are connected

from your program to access points of care.

Expected Number of 5540

Beneficiaries to be Engaged Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or : Debit Card/Check

Monetary Rebates:

Cash or Monetary 25.00

Rebates amount per

month:

Maximum Annual Cash 300.00

or Monetary Rebates

available:

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 No

Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?







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SECTION C: V/T - GENERAL - US

Do you offer a US No 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)

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

of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Yes

Do you offer Reductions

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?

Defined Standard Select the type of drug

benefit:

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

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?

program?

Do you pay for over-the-No

counter medications (OTCs) under the utilization management

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 Cost sharing





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Location/supply amount

(s) that apply:

Enter number of days for

Standard Retail Cost Sharing 1-month supply:

Enter number of days for

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:

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 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?

Notes:

90

30

30

90

30

: Standard Mail-Order - 1-month supply

: Out-of-Network Pharmacy - one month supply

: Standard Mail-Order - 3-month supply

: Long-Term Care Pharmacy - 1-month supply

No

31

No

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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 diagnosis for the full contract year.

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?



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HUMANA HEALTH PLAN OF PR, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4007-018



PDF Data Report Fage 1 01 45

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 018, SEGMENT 0

Module: PBP
Requested By: r1ea
PLAN SYSTEM INFORMATION
Last entry Date: 05/29/2021
PBP Software Version: 2022.01

Plan Ready for Upload

2022.01

Timestamp:

05/29/2021 11:51:03 AM Eastern Daylight Time

MA BPT Timestamp: 05/14/2021 01:28:25 PM Eastern Daylight Time PD BPT Timestamp: 05/10/2021 09:13:38 AM Eastern Daylight Time Last Upload File 05/24/2021 11:12:13 AM Eastern Daylight Time

Creation Timestamp:

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Completed Section B4 Status Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Completed Section B12 Status Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Completed Section B18 Status Section B19 Status Completed Section C Status Completed Section D Status Completed

SECTION A: SECTION A-1

Section Mrx Status

Organization Legal HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Completed

Name:

Organization Marketing Humana

Name:

Organization Web Site: www.humana.com/medicare

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

Organization Type: Local CCP
Plan Type: HMO

Part A and Part B Enrollee Type: Service Area(s): 40010 - Adjuntas, PR 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR Service Area(s): Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): 40050 - Aibonito, PR Service Area(s): 40060 - Anasco, PR 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR Service Area(s):



rbr 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
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Service Area(s):

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40630 - San German, PR

40640 - San Juan, PR Service Area(s):

40650 - San Lorenzo, PR Service Area(s):

40660 - San Sebastian, PR Service Area(s):

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):

Service Area(s): 40720 - Vega Alta, PR

Service Area(s): 40730 - Vega Baja, PR

Service Area(s): 40740 - Viegues, PR 40750 - Villalba, PR Service Area(s):

40760 - Yabucoa, PR Service Area(s):

40770 - Yauco, PR Service Area(s):

Contract Number: H4007 018 Plan ID:

Segment ID: 0

Contract Period: 2022

Puerto Rico Island Wide Plan Geographic Name:

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

Address:

Customer Service

Contact Phone Number

for Current Medicare Beneficiaries:

Customer Service

(866)773-5959

(866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service

(800)681-3625



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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







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Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for

Section D of the PBP?

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 for Additional Days?

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

Yes

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 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

Medicare-covered







Zero (No Copayment per Day)

Lifetime Reserve Days:

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

Indicate the number of day intervals for

Zero (No Copayment per Day)

Additional Days:

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

Hospital-Acute benefit

What is your Inpatient Per Admission or Per Stay

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

No

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

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

Is there an enrollee

No

No

No

No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

shares? (These are the total charges for all services provided to the

enrollee in the inpatient facility.)

Indicate Copayment

\$0.00

amount for the

Medicare-covered stay:

Indicate the number of

Zero (No Copayment per Day)

day intervals for the

Medicare-covered stay:

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

Indicate the number of

Zero (No Copayment per Day)

day intervals for the Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost

No







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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

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

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 Notice 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

Is there an enrollee

Yes

Copayment?

Select which Cardiac and : Medicare-covered Cardiac Rehabilitation Services

Pulmonary : Medicare-covered Intensive Cardiac Rehabilitation Services





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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

Indicate Minimum Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

\$0.00

Services: Indicate Maximum Copayment amount per service for Medicare-

\$0.00

covered Intensive Cardiac Rehabilitation

Services:

Indicate Minimum \$0.00

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services: \$0.00

Indicate Minimum Copayment amount per service for Medicarecovered Supervised

\$0.00

Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

\$0.00

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

Disease (PAD) Services:

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

required?

No

Is a referral required for 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







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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 the Copayment for

Yes

Medicare-covered Benefits waived if admitted to hospital?

Select either Days or Hours

Hours within which admission must occur for

24

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

Coinsurance?

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

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:

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

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





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Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent

Coverage:

Select type of benefit for

Worldwide Emergency

Transportation:

Mandatory

No

Is there a Maximum Plan

Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

Is there a service-specific 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

Copayment?

Yes

\$0.00

\$0.00

Yes

\$0.00

\$0.00

\$0.00

\$0.00

Yes

Select which Worldwide

Services have a

: Worldwide Emergency Coverage : Worldwide Urgent Coverage

Copayment (Select all

that apply):

: Worldwide Emergency Transportation

Indicate Minimum 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

Copayment amount for Worldwide Emergency

Transportation:

Indicate Maximum

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







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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

\$0.00

Is there an enrollee

Copayment?

Indicate Minimum

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

\$0.00

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?

Yes

Is there an enrollee

Copayment?

Indicate Minimum Copayment amount per

visit for Medicarecovered Benefits:

Indicate Maximum \$0.00

Copayment amount per







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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 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:

\$0.00 Indicate Maximum

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 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?

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







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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?

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?

under Part C?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide No Podiatry Services as a supplemental benefit







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Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Podiatry

Services have a

: Medicare-covered Podiatry Services

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

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

Yes

Coinsurance?

Is there an enrollee No

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: #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

No 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

Deductible?

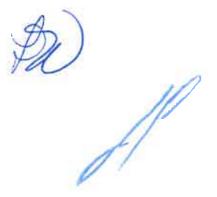
No

Is there an enrollee

Yes

Copayment?





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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:

\$0.00 Indicate Minimum

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?

Is a referral required for No

Psychiatric Services?

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

No

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee Yes

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: #71 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 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





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: 9c2: Group Sessions for Outpatient Substance Abuse

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

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

\$0.00

No

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

Copayment?

Yes

\$0.00

\$0.00

Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

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

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





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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):

\$0.00 Indicate Minimum

\$0.00

\$0.00

Yes

Yes

Copayment amount for

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum

Copayment amount for Medicare-covered

Diagnostic

Procedures/Tests:

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered Lab

Services:

Indicate Maximum

Copayment amount for Medicare-covered Lab

Services:

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

same day, does only the maximum copay apply?

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

Is authorization

required?

Is a referral required for 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?

No

Is there an enrollee

Copayment?

Yes

Select which Outpatient Diag/Therapeutic Rad

: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services ; Medicare-covered X-Ray Services

Services have a 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):





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Indicate Minimum \$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Therapeutic Radiological Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered X-Ray

Services:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered X-Ray

Services:

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

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

Is authorization Yes

required?

Is a referral required for

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

No

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

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

Is there an enrollee

Deductible?

No

Yes

No

Is there an enrollee

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 for Medicare-covered Observation Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Observation Services:

Copayment is charged: Per stay





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Is authorization required

Yes

for Medicare-covered Outpatient Hospital

Services?

Is authorization required

for Medicare-covered Observation Services?

Is a referral required for

Yes

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

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 : Medicare-covered Individual Sessions Substance Abuse : Medicare-covered Group Sessions

services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00

\$0.00

Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00





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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?

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?

No

Is there an enrollee

No

Copayment?

Is authorization

required? Is a referral required for No No

Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

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

\$0.00

Ground Ambulance Services:

Indicate the Maximum

\$0.00

Copayment amount for Medicare-covered Ground Ambulance

Services:





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Indicate Minimum \$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

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

Select type of benefit for Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited for number of trips for Plan Approved Health-related Location?

Indicate number of trips 48 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 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 Copayment?

Yes

Indicate Minimum \$0.00

Copayment amount per

trip:

Indicate Maximum \$0.00

Copayment amount per

trip:

Is authorization Yes





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required?

Is a referral required for Transportation Services?

No

Notes:

Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee Yes

Copayment?

\$0.00

Indicate Minimum 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 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

Coinsurance?

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

Is there an enrollee

Deductible?

No

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





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item for Medicarecovered Medical Supplies:

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

Is authorization

Yes

required?

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

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

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

\$0.00

Coinsurance?

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

Copayment?

Select which Diabetic : Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment

(Select all that apply):

Indicate Minimum

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 Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?

\$0.00 Indicate Minimum

Copayment amount per session for Medicarecovered Benefits:





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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

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited

No

for Number of

under Part C?

Treatments?

Indicate limit for

Number of Treatments:

20

No

Indicate Number of

Treatments periodicity:

Every year -

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE = BASE 2

Is there an enrollee

Coinsurance?

No

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes

Indicate Minimum

Copayment amount per

treatment:

Indicate Maximum

\$0.00

\$0.00

Copayment amount per

treatment:

Is authorization

Yes

Yes

required?

Is a referral required for

No

Acupuncture?

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

OTC Items:

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount? Indicate Maximum Plan

50.00

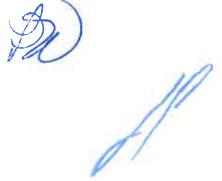
Benefit Coverage

amount:

Select Maximum Plan

Every three months





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Benefit Coverage periodicity:

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

No

unused?

Is there a service-specific Maximum Enrollee OutNo

of-Pocket Cost?

Are you offering Nicotine Replacement Therapy (NRT) as a Part Yes

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?

Νo

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 \$0 copayment for adult diapers box up to one (1) every month. Members who meet

medical criteria. Brand according to exclusive contracted DME provider.

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

criteria.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a 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

Mandatory

Meals:

Select the type of

primarily health related meals benefit offered:

: Immediately following surgery or inpatient hospitilization

: For a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time

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

No

Is there a service-specific Maximum Enrollee Out-

Νo

of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?



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Indicate Minimum

\$0.00

Copayment amount:

Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required for

No

the Meal Benefit?

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

Up to 28 meals over 14 days for members with a COVID-19 Diagnosis.

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 Treatment

(Optional):

Select type of benefit for

Mandatory

Other 2:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

No

Deductible?

No

Is there an enrollee Copayment?

Is authorization

Yes

required?

No

Is a referral required for Other Services?

SECTION B: #13E OTHER 2 - BASE 3

Notes:

No cost share for 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

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

Yes

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



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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

Indicate Minimum

\$0.00

Copayment amount for each Annual Physical

Exam:

Indicate Maximum

\$0.00

Copayment amount for each Annual Physical

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

Is authorization

No

required?

Is a referral required for

No

the Annual Physical

Exam? Notes:

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

different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the 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

Yes

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

Mandatory

Cessation Counseling:

Indicate number of visits

offered in addition to

Medicare:

Select type of benefit for

Fitness Benefit:

Mandatory

4

Indicate type of Fitness

: Physical Fitness

Benefit offered (Select

all that apply):

Modifications:

Mandatory

Select type of benefit for Home and Bathroom Safety Devices and

Select type of benefit for

Wigs for Hair Loss

Mandatory

Related to Chemotherapy:

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

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



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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 5

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 7

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

No

Yes

No

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization

required?

Is a referral required for

Other Defined

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco Cessation Counseling

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 15

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

Safety Devices and Modifications Notes:*

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Wigs for Hair Loss

Authorization is required for this service.

No authorization required for this service.

Related to

Chemotherapy Notes:

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

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





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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

No

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization No required?

Is a referral required for 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?

Is there an enrollee

No

Yes

\$0

No

Deductible?

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

Is there an enrollee

Copayment?

Select which Services : Medicare-covered Glaucoma Screening have a Copayment : Medicare-covered Diabetes Self-Management Training

: Medicare-covered Barium Enemas (Select all that apply):

: Medicare-covered Digital Rectal Exams

: Medicare-covered EKG following Welcome Visit

Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:

\$0 Indicate Maximum

Copayment amount for Medicare-covered Glaucoma Screening:

Indicate Minimum \$0 Copayment amount for Medicare-covered

Diabetes Self-

Management Training: \$0

Indicate Maximum Copayment amount for Medicare-covered

Diabetes Self-Management Training:

\$0 Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:

Indicate Maximum \$0 Copayment amount for





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Medicare-covered Barium Enemas:

Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams:

\$0

\$0

No

Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:

Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome

Visit:

\$0 Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:

Is authorization required for Medicare-covered Glaucoma Screening?

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?

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

Is a referral required for any Services?

No

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

No

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee Yes Copayment?

: Medicare Part B Chemotherapy/Radiation Drugs 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

Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:

\$0.00







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Indicate Minimum

\$0.00

\$0.00

Copayment Amount for other Medicare Part B

Drugs:

Indicate Maximum

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee

Deductible?

Is Authorization Required?

Yes Yes

No

Does the plan offer step

therapy?

Does the benefit step from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

No

: Part B to Part B?

Does the plan provide Part D home infusion

drugs as part of a bundled service as a mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

Preventive Dental Items as a supplemental benefit

under Part C?

Select enhanced 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

3

Indicate number of visits

for Oral Exams:

Select the Oral Exams

Other, Describe

periodicity: Select type of benefit for

Prophylaxis (Cleaning):

Mandatory

Is this benefit unlimited

for Prophylaxis

(Cleaning)?

No, indicate number

Indicate number of visits

for Prophylaxis

(Cleaning):

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 Maximum Plan Benefit Coverage amount?

No





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SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Yes

Select which Preventive

: Oral Exams

Dental Services have a

: Prophylaxis (Cleaning)

Coinsurance (Select all

: Dental X-Rays

that apply):

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

No

Visit?

Indicate Minimum 0% Coinsurance percentage

for Oral Exams:

0% Indicate Maximum

Coinsurance percentage

for Oral Exams:

Indicate Minimum

Coinsurance percentage for Prophylaxis

0%

0%

(Cleaning): Indicate Maximum

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

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, intraoral x-rays up to 6 per year,

panoramic film up to 1 every 3 years. Oral exams include comprehensive oral exam up to 1 every 3 years,

periodic oral exam up to 2 per year.

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

: 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





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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

periodicity:

Every year

Select type of benefit for

Extractions:

Mandatory

Is this benefit unlimited

for Extractions?

Yes

Select type of benefit for

Prosthodontics, Other Oral/Maxillofacial

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:

Select the

Other, Describe

Plan-specified amount per period

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

3000.00

Every year

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Indicate Maximum Plan

Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

No

Is there an enrollee

Coinsurance?

Yes

Select which

: Restorative Services : Endodontics

Comprehensive Dental Services have a

: Periodontics

Coinsurance (Select all that apply):

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

Indicate Minimum

0%







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Coinsurance percentage for Restorative Services:

0% Indicate Maximum Coinsurance percentage for Restorative Services:

Indicate Minimum 0% Coinsurance percentage

0%

0%

0%

for Endodontics:

Indicate Maximum Coinsurance percentage for Endodontics:

Indicate Minimum Coinsurance percentage for Periodontics:

Indicate Maximum 0% Coinsurance percentage

for Periodontics:

Indicate Minimum Coinsurance percentage for Extractions:

Indicate Maximum 0%

Coinsurance percentage for Extractions:

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 Yes

Copayment?

Select which : Medicare-covered Benefits

Comprehensive Dental Services have a Copayment (Select all that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization Yes

required?

Is a referral required for No

Comprehensive Dental Services?

Periodontics include scaling and root planing (deep cleaning) up to 1 per quadrant per year. Notes:

Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year, bridges up to 1 every 5 years, complete dentures and partial dentures up to 1 every 5 years. Restorative services include fillings up to 1 per tooth every 3 years, crown up to 1 per tooth every 5

years.

SECTION B: #17A EYE EXAMS - BASE I



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Does the plan provide

Yes

I

No

No

No

Yes

\$0.00

\$0.00

\$0.00

\$0.00

No

No

: Medicare-covered Benefits : Routine Eye Exams

: Routine Eye Exams

No, indicate number

Mandatory

Every year

Eye Exams as a supplemental benefit

under Part C?

Select enhanced benefit:

Select type of benefit for

Routine Eye Exams:

Is this benefit unlimited

for Routine Eye Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye

Exams periodicity: Is there a service-specific

Maximum Plan Benefit Coverage amount?

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

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

Copayment?

Select which Eye Exams

have a Copayment

(Select all that apply): Indicate Minimum

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

Indicate Minimum

Copayment amount for

Routine Eye Exams:

Indicate Maximum Copayment amount for Routine Eye Exams:

Is there an enrollee

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

No

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

Yes

: Eyeglasses (lenses and frames)

Select type of benefit for

Contact lenses:

Mandatory Yes

Is this benefit unlimited

for Contact lenses?

Select type of benefit for

Eyeglasses (lenses and

Mandatory





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frames):

Is this benefit unlimited Yes

for Eyeglasses (lenses

and frames)?

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 Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined 500.00

Maximum Plan Benefit Coverage amount:

Select the Combined

Every year

Plan-specified amount per period

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?

Is there an enrollee

Yes

No

Copayment?

: Medicare-covered Benefits Select which Eyewear

Benefits have a

Copayment (Select all

that apply):

\$0.00

: Contact lenses

: Eyeglasses (lenses and frames)

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

\$0.00 Indicate Minimum

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?







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SECTION B: #18A HEARING EXAMS - BASE 1

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:

Mandatory

Is this benefit unlimited for Routine Hearing

Exams?

No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

Every year

Select type of benefit for

Fitting/Evaluation for Hearing Aid:

Mandatory

Is this benefit unlimited

for Fitting/Evaluation for

No, indicate number

Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation

for Hearing Aid periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a 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

Yes

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Select which Hearing : Medicare-covered Benefits Exam Benefits have a : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

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:

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







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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 supplemental benefit

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Yes

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 2 Hearing Aids (all types):

Select Hearing Aids (all

types) periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific

Maximum Plan Benefit Coverage amount?

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

Benefit Coverage

amount:

Indicate Maximum Plan

Benefit Coverage

Every year

500.00

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific No 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







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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 Ill?

: Additional Benefits

Select what type of benefit your SSBCI

includes:

Are you offering a VBID

No

Yes

Hospice Benefit?

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 : Cash or Monetary Rebates

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: Advanced Care Planning

: Telephonic WHP Mode of 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

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 Beneficiaries to be

8567

Engaged Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or : Debit Card/Check

Monetary Rebates:

50.00

Cash or Monetary Rebates amount per

month:

Maximum Annual Cash

or Monetary Rebates

600.00







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available:

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 SSBCI

applicable to VBID or MA Uniformity Flexibility or SSBCI?

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

To which chronic : Other 1

condition does this benefit apply? (Select all

that apply):

Other 1 Description: CMS Defined Chronic Conditions

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-

n- : 13i: Non-Primarily Health Related Benefits for the Chronically III

: Participation in a Care Management Program

Medicare-covered additional benefits offered in this package:

additional benefits

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

retroactive reimbursement?

Is there a maximum No

benefit amount?

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

: Transportation for Non-Medical Needs

Notes: Eligible members may receive non-medical related transportation for locations such as the bank,

supermarket, church, or pharmacy, beach, post office, theaters, entertainment events (e.g. concerts, expos, community events), airport, local tourism sites, malls and any standalone stores (excluding liquor stores and gun shops), hotels, recreational and historical parks, sports facilities, family homes, restaurants, or any

utilities offices to pay a bill. Not limited to a same day appointment.

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

- TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the

Chronically III includes:

5/20/2021

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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

Yes

Plan-approved Location:

Is this benefit unlimited for number of trips for Plan-approved Location? Indicate number of trips

36

No

for Plan-approved

Location:

Select Plan-approved

Every year

Location Trips periodicity: Select Type of

One-way

Transportation for Non-Medical Needs for Planapproved Location:

Select Mode of : Taxi Transportation for Non- : Van

Medical Need for Plan- : Medical Transport

approved Location:

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

Is there a service-specific No Maximum Plan Benefit

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

No

Is there an enrollee

Deductible?

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

Is there an enrollee

Copayment?

Notes:

No

Is authorization required?

Yes

Is a referral required for

No

Transportation for Non-Medical Needs?

Eligible members may receive non-medical related transportation 36 one-way trips to longiful to the

include, but are not limited to, the bank, supermarket, church, pharmacy, beach, post office, or import. Not

limited to a same day appointment.

SECTION C: V/T - GENERAL - US

Do you offer a US No Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

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

Is there an In-Network No

Plan Deductible?

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





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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: 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

Yes

Does your plan offer a Medicare Prescription

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

Defined Standard

benefit:

apply):

Describe the components of your pharmacy network (select all that

: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care

Sponsor attests that it will comply with 42

CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor

pricing?

Yes

Does plan utilize ceiling

pricing?

Yes No

Do you pay for over-thecounter 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

Cost sharing Location/supply amount

(s) that apply:

Enter number of days for Standard Retail Cost

30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

90

Sharing 3-month supply:

Select all Out-of-Network Pharmacy Location/supply amount : Out-of-Network Pharmacy - one month supply

(s) that apply:

Enter number of days for

30

Out-of-Network Pharmacy 1-month





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supply:

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

90

31

No

No

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?

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.

: Standard Mail-Order - 1-month supply

: Standard Mail-Order - 3-month supply

: Long-Term Care Pharmacy - 1-month supply

SECTION RX: VBID - GENERAL

Are you offering Part D
Benefits and/or Part D
Rewards and Incentives
under the VBID Model?

\$

HUMANA HEALTH PLAN OF PR, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4007-019



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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 019, SEGMENT 0

Module: PBP Requested By: rlea PLAN SYSTEM INFORMATION Last entry Date: 05/29/2021 PBP Software Version: 2022.01

Plan Ready for Upload

05/29/2021 11:52:41 AM Eastern Daylight Time

05/14/2021 11:46:05 AM Eastern Daylight Time MA BPT Timestamp: PD BPT Timestamp: 05/10/2021 09:13:50 AM Eastern Daylight Time 05/24/2021 11:12:13 AM Eastern Daylight Time Last Upload File

Creation Timestamp:

PLAN STATUS

Timestamp:

Plan Ready for Upload Section A Status

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Completed Section B5 Status Completed Section B6 Status 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 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

Organization Legal HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization Marketing Humana

Name:

www.humana.com/medicare Organization Web Site:

Completed

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

Local CCP Organization Type: Plan Type: HMO

Enrollee Type: Part A and Part B Service Area(s): 40010 - Adjuntas, PR 40020 - Aguada, PR Service Area(s): 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): Service Area(s): 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR







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Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	





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40630 - San German, PR

40640 - San Juan, PR Service Area(s):

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):

Service Area(s): 40690 - Toa Baja, PR

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 - Viegues, PR Service Area(s):

40750 - Villalba, PR Service Area(s):

Service Area(s): 40760 - Yabucoa, PR Service Area(s): 40770 - Yauco, PR

Contract Number: H4007 019 Plan ID: 0 Segment ID:

Contract Period: 2022

Plan Geographic Name: Puerto Rico Island Wide

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/

http://www.humana.com/medicare/medicare prescription drugs/medicare drug tools/medicare_drug_list/

Formulary Website

Address:

Physician Website

www.humana.com/members/tools

Address:

(866)773-5959 Customer Service

Contact Phone Number for Current Medicare

Beneficiaries:

Customer Service

(866)773-5959

Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service

(800)681-3625



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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

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

Customer Service (711)-

(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







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Section C of the PBP?

SECTION A: SECTION A-6

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

Do any of your No outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

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

Deductible?

No

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:

Zero (No Copayment per Day)

Indicate the number of day intervals for the 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)





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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: #IA INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient

Hospital-Acute benefit

period?

No Do you charge cost

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 No 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

Coinsurance?

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

Is there an enrollee

Deductible?

No Yes

No

Is there an enrollee

Copayment?

Nο

\$0.00

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

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

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost No



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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

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

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 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

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?

Select which Cardiac and

: Medicare-covered Cardiac Rehabilitation Services

: Medicare-covered Intensive Cardiac Rehabilitation Services Pulmonary



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Rehabilitation Services

: Medicare-covered Pulmonary Rehabilitation Services

have a Copayment

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

(PAD) Services (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per service for Medicarecovered Cardiac

Rehabilitation Services: Indicate Maximum

\$0.00

Copayment amount per service for Medicarecovered Cardiac Rehabilitation Services:

Indicate Minimum Copayment amount per service for Medicare\$0.00

\$0.00

covered Intensive Cardiac Rehabilitation

Services:

Indicate Maximum

Copayment amount per service for Medicarecovered Intensive Cardiac Rehabilitation

Services:

\$0.00 Indicate Minimum

Copayment amount per service for Medicarecovered Pulmonary Rehabilitation Services:

\$0.00

Indicate Maximum 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 Out-

of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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



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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 the Copayment for Medicare-covered

Yes

Benefits waived if admitted to hospital?

Select either Days or

Hours

24

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 N

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

\$0.00

No

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

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



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Coverage:

Select type of benefit for

Worldwide Urgent

Coverage:

Select type of benefit for

Worldwide Emergency

Transportation:

Is there a Maximum Plan

Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Yes

Copayment?

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

Mandatory

Mandatory

No

No

No

Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment amount for Worldwide Emergency

Coverage:

Indicate Maximum \$0.00

Copayment amount for Worldwide Emergency

Coverage:

Is this Copayment Yes waived for Worldwide

Emergency Coverage if admitted to hospital?

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?

\$0.00 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



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Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2 Yes

\$0.00

Is there an enrollee

Copayment?

Indicate Minimum

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Copayment?

Yes \$0.00

Indicate Minimum

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 No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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







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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 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 No

Deductible?

No

Yes

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 Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Yes

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:

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

Is authorization

required?

for Yes

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 No





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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

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

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

Services have a Copayment (Select all

that apply):

Indicate Minimum \$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

No

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







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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

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 Coinsurance?

No

Is there an enrollee

Copayment?

Deductible?

No

Is there an enrollee

Yes \$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 No 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 Yes

Copayment?







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Select which Psychiatric

Services have a

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

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:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Group

Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization Yes

required?

Is a referral required for

No

Psychiatric Services?

SECTION B: #71 PT AND SP 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?

\$0.00

\$0.00

Indicate Minimum Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

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-

available:

: 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

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

: 9c1: Individual Sessions for Outpatient Substance Abuse







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: 9c2: Group Sessions for Outpatient Substance Abuse

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

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per visit for 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

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 Coinsurance?

No

Is there an enrollee

No

Is there an enrollee

Yes

Copayment?

Deductible?

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered

Benefits:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered

Benefits:

SECTION B: #7K OPIOID TREATMENT 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

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

Yes





Copayment?

Select which Outpatient

Diag Procs/Tests/Lab

Services have a

: Medicare-covered Lab Services

\$0.00

Yes

: Medicare-covered Diagnostic Procedures/Tests

Copayment (Select all

that apply):

Indicate Minimum

Copayment amount for Medicare-covered Diagnostic

Procedures/Tests: Indicate Maximum \$0.00

Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Lab

Services:

\$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?

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 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?

Yes

No

Copayment?

Is there an enrollee

Select which Outpatient Diag/Therapeutic Rad

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

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):

: Medicare-covered X-Ray Services

\$0.00

\$0.00







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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

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 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?

e No

Is there an enrollee

Copayment?

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 Medicare-covered Outpatient Hospital Services:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Observation Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Observation Services:

Copayment is charged: Per stay







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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 Yes

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Naximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

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 Medicare-covered Benefits:

Indicate Maximum

Copayment amount per visit for Medicare-covered Benefits:

Is authorization

Yes

\$0.00

required?

Is a referral required for

Ambulatory Surgical Center Services?

No

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

Is there a service-specific N 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?

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:

Indicate Minimum

\$0.00







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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 Outpatient Substance

No

Abuse?

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

Does the plan provide Outpatient Blood

Yes

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?

No

Is there an enrollee

No

Copayment? Is authorization

required?

Is a referral required for

No No

Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

No

Is there an enrollee

No

Deductible?

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:

\$0.00







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Indicate Minimum

\$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

Indicate Maximum

\$0.00

Copayment amount for Medicare-covered Air Ambulance Services:

No

Is this Copayment waived if admitted to

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required

Yes

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?

Plan Approved Health-related Location

Select enhanced benefit: Select type of benefit for

Mandatory

Plan Approved Healthrelated Location:

Is this benefit unlimited

No

for number of trips for Plan Approved Healthrelated Location?

24

Indicate number of trips for Plan Approved

Health-related Location: Select Plan Approved

Every year

Health-related Location

Trips periodicity:

One-way

Select Type of 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

No

Coinsurance?

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:

Is authorization

Yes





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required?

Is a referral required for Transportation Services?

No

Notes:

Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific

Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

Coinsurance?

Is there an enrollee

Deductible?

No Yes

Is there an enrollee

Copayment?

Indicate Minimum

Copayment amount per item for Medicare-

covered Benefits:

Indicate Maximum

\$0.00

\$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

No

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?

No

Is there an enrollee

Yes

\$0.00

\$0.00

Copayment? Select which

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

Supplies have a Copayment (Select all

that apply):

Indicate Minimum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Maximum

Copayment amount per item for Medicarecovered Prosthetic

Devices:

Indicate Minimum

Copayment amount per item for Medicarecovered Medical Supplies:

Indicate Maximum Copayment amount per

\$0.00







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item for Medicarecovered Medical Supplies:

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

Is authorization

Yes

No

required?

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

Is there a 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

Yes

Copayment?

Select which Diabetic

: Medicare-covered Diabetes Supplies

Supplies and Services

: Medicare-covered Diabetic Therapeutic Shoes or Inserts

have a Copayment (Select all that apply):

Indicate Minimum

\$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

Indicate Maximum

\$0.00

Copayment amount per item for Medicarecovered Diabetes

Supplies:

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 Supplies and Services to those from specified

Is authorization

Yes

manufacturers?

required?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

Copayment amount per session for Medicarecovered Benefits:

\$0.00







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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

Yes

supplemental benefit

under Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited

No

for Number of Treatments?

Indicate limit for

20

Number of Treatments:

Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

Coinsurance?

No

No

No

Is there an enrollee

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount per

treatment:

Indicate Maximum

\$0.00

Copayment amount per

treatment:

Is authorization

Yes

required?

Is a referral required for

No

Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

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

supplemental benefit

under Part C?

Yes

Select type of benefit for

Mandatory

OTC Items:

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

30.00

Benefit Coverage

amount:

Select Maximum Plan

Every three months







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Benefit Coverage periodicity:

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

No

unused?

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Are you offering Nicotine Replacement Yes

Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

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

formulary drugs.

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

No

Coinsurance?

No

Is there an enrollee Deductible?

Is there an enrollee

No

No

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

criteria.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a Yes

limited duration Meal

Benefit as a

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

Select type of benefit for

Meals:

Mandatory

Select the type of : Immediately following surgery or inpatient hospitilization

primarily health related meals benefit offered:

POSDE : For a medical condition or potential medical condition that requires the enrollee to remain at home for a

period of time

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 Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount:



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Indicate Maximum

\$0.00

Copayment amount: Is authorization

Yes

required?

Is a referral required for

No

the Meal Benefit?

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

Up to 28 meals over 14 days for members with a COVID-19 Diagnosis.

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

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

COVID-19 Treatment

(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 Out-

of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

No

Yes

No

Deductible?

Is there an enrollee No

Copayment?

Is authorization

required?

Is a referral required for No

Other Services?

SECTION B: #13E OTHER 2 - BASE 3

Notes:

No cost share for 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, 14b Prosthetics/Medical Supplies, 11c Diabetic Supplies and Services, 12 Dialysis Services, 13a Acupuncture, 15, Medicare Part B RX 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 Yes

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

No

Select type of benefit for

the Annual Physical

Mandatory

Exam:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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Is there a service-specific Maximum Enrollee Outof-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

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for each Annual Physical

Exam:

Indicate Maximum

\$0.00

Copayment amount for each Annual Physical

Exam:

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

Is authorization

No

required?

Is a referral required for

No

Yes

the Annual Physical

Exam?

Notes:

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

examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete

prescription medication review. 4. Review of any recent hospitalization

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

Does the plan provide

Other Defined

Supplemental Benefits as a benefit under Part C?

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

(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:

4

Select type of benefit for

Fitness Benefit:

Mandatory

Indicate type of Fitness

: Physical Fitness

Benefit offered (Select

all that apply):

Modifications:

Mandatory

Select type of benefit for Home and Bathroom Safety Devices and

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 4

Is there a service-specific

Maximum Plan Benefit





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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 5

Indicate Maximum Plan

500.00

Every year

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

Select Maximum Plan

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

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

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee

No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

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

Is authorization

required?

Yes

Is a referral required for

No

Other Defined Supplemental Benefits?

Additional Sessions of

Smoking and Tobacco

Cessation Counseling

Fitness Benefit Notes:*

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 15

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 16

Wigs for Hair Loss

Authorization is required for this service.

No authorization 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?



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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

Is authorization

No

No

required?

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

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

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

\$0

: Medicare-covered Digital Rectal Exams

: Medicare-covered EKG following Welcome Visit

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:





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Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum

\$0

Copayment amount for Medicare-covered Digital Rectal Exams:

\$0 Indicate Minimum Copayment amount for

Medicare-covered EKG following Welcome

Visit:

Indicate Maximum \$0 Copayment amount for Medicare-covered EKG following Welcome

Visit:

Is authorization required No for Medicare-covered Glaucoma Screening?

Is authorization required No for Medicare-covered

Diabetes Self-

Management Training?

Is authorization required No for Medicare-covered **Barium Enemas?**

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required No for Medicare-covered

EKG following 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

No

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee

No

No

Coinsurance?

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

Is there an enrollee

Copayment?

Select which Medicare Part B Rx Drugs have a : Medicare Part B Chemotherapy/Radiation Drugs : 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

Copayment Amount for other Medicare Part B

\$0.00







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Drugs:

Indicate Maximum

Copayment Amount for other Medicare Part B

Drugs:

Is there an enrollee

Deductible?

Is Authorization

Yes

No

\$0.00

Required?

Does the plan offer step Yes

therapy?

: Part B to Part B?

Does the benefit step from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide 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

Mandatory

Select type of benefit for

Prophylaxis (Cleaning):

Is this benefit unlimited

for Prophylaxis (Cleaning)?

No, indicate number

Indicate number of visits

for Prophylaxis (Cleaning):

2

Select the Prophylaxis (Cleaning) periodicity: Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

8

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits

No, indicate number

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-





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of-Pocket Cost?

Is there an enrollee

Yes

Coinsurance?

Select which Preventive

Dental Services have a

: Oral Exams : Prophylaxis (Cleaning)

Coinsurance (Select all

: Dental X-Rays

that apply):

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

No

Visit?

Indicate Minimum 0%

Coinsurance percentage

for Oral Exams:

0%

Indicate Maximum Coinsurance percentage

for Oral Exams:

Indicate Minimum Coinsurance percentage 0%

0%

for Prophylaxis

(Cleaning):

Indicate Maximum

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

Is authorization

required?

No

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, intraoral x-rays up to 6 per year, panoramic film up to 1 every 3 years. Oral exams include comprehensive oral exam up to 1 every 3 years,

periodic oral exam up to 2 per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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 2 for Restorative Services:

Select the Restorative

Other, Describe

Services periodicity:



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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?

No, indicate number

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

3

Select type of benefit for

Mandatory

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited

for Prosthodontics, Other

Oral/Maxillofacial

Surgery, Other Services? Indicate number of visits

for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services: Select the

Other, Describe

No, indicate number

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-specified amount per period

Plan Benefit Coverage

type:

Indicate Maximum Plan

Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

2000.00

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

Comprehensive Dental Services have a

: Endodontics : Periodontics

Coinsurance (Select all

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

that apply): Indicate Minimum

0%

Coinsurance percentage

for Restorative Services: Indicate Maximum

0%

Coinsurance percentage

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for Restorative Services:

0% Indicate Minimum Coinsurance percentage

for Endodontics:

Indicate Maximum 0% Coinsurance percentage

for Endodontics:

0% Indicate Minimum

Coinsurance percentage for Periodontics:

Indicate Maximum Coinsurance percentage

for Periodontics:

Indicate Minimum 0% Coinsurance percentage

for Extractions: Indicate Maximum

Coinsurance percentage for Extractions:

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

Indicate Maximum 0% Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: No

Is there an enrollee

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

0%

0%

0%

Is there an enrollee

Copayment?

Select which

: Medicare-covered Benefits

Yes

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 Yes required?

Is a referral required for No

Comprehensive Dental

Services?

Notes: Periodontics include scaling and root planing (deep cleaning) up to 1 per quadrant per year.

Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year, bridges up to 1 every 5 years, complete dentures and partial dentures up to 1 every 5 years. Restorative services include fillings up to 1 per tooth every 3 years, crown 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





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Select enhanced benefit: : Routine Eye Exams

Select type of benefit for Mandatory

Routine Eye Exams:

Is this benefit unlimited for Routine Eye Exams?

Indicate number of

Exams:

exams for Routine Eye

Select the Routine Eye Exams periodicity:

Every year

No

No, indicate number

: Routine Eye Exams

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

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

No

Coinsurance? Is there an enrollee

Yes

Copayment?

: Medicare-covered Benefits Select which Eye Exams

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:

\$0.00 Indicate Minimum

Copayment amount for Routine Eye Exams:

\$0.00 Indicate Maximum

Copayment amount for Routine Eye Exams:

Is there an enrollee No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization

No

required? 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?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for

Contact lenses:

Mandatory

Is this benefit unlimited

for Contact lenses?

Yes

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited

for Eyeglasses (lenses

and frames)?



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SECTION B: #17B EYEWEAR - BASE 3

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 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

Plan-specified amount per period

: Eyeglasses (lenses and frames)

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

Deductible?

Is there an enrollee Yes

Copayment?

Select which Eyewear : Medicare-covered Benefits

Benefits have a : Contact lenses

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

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







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under Part C?

: Routine Hearing Exams Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for

Routine Hearing Exams:

Mandatory

Is this benefit unlimited for Routine Hearing

Exams?

No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

Every year

Mandatory

Select type of benefit for

Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation

for Hearing Aid periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a 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

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

Copayment?

Yes

No

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

Copayment (Select all

: Fitting/Evaluation for Hearing Aid

that apply): Indicate Minimum

Copayment amount for

Medicare-covered

Benefits:

\$0.00

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 Copayment amount for Fitting/Evaluation for

Hearing Aid:

Indicate Maximum

Copayment amount for Fitting/Evaluation for



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\$0.00

\$0.00



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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

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Yes

Select type of benefit for

Hearing Aids (all types):

Is this benefit unlimited

No, indicate number

Mandatory

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

Benefit Coverage

amount:

Indicate Maximum Plan

Benefit Coverage

Every year

75.00

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

Copayment?

Yes

Indicate Minimum Copayment amount per \$0.00

Hearing Aid (all types):

\$0.00

Indicate Maximum Copayment amount per Hearing Aid (all types):

Is there an enrollee

Deductible?

No

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

No







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Flexibility with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the Chronically III?

No

Are you offering a VBID

No

Yes

Hospice Benefit?

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

: Cash or Monetary Rebates

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 (choose one or more): : Other Program

Specify Other Program: Advanced Care Planning

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

Does your organization offer Part C Rewards or

No

Incentives for

beneficiaries for the offer

of WHP Services?

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

No

activities? Program Connectedness:

: Electronic Health Records/Electronic Medical Records

: Provider/Patient portals Please check the way that advance care plans : Health Information Exchanges

and/or advance directives are connected

from your program to

: Data Warehouses

access points of care.

: Other

Expected Number of Beneficiaries to be

1693

Engaged Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or : Debit Card/Check

Monetary Rebates:

50.00 Cash or Monetary

Rebates amount per

month:

Maximum Annual Cash

600.00

or Monetary Rebates

available:

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

Does your VBID/MA No Uniformity Flexibility/SSBCI

benefit offer Part C reductions in cost?







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

Does your VBID/MA

Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?

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?

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

Is there an In-Network

Maximum Enrollee Out-

of-Pocket Cost?

Voluntary

Is your In-Network

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

Mandatory Level?

Indicate In-Network

3400.00

Maximum Enrollee Out-

of-Pocket Cost Amount: Select the benefits that

: In-Network Medicare-covered benefits

apply to the In-Network Maximum Enrollee Out-

of-Pocket cost:

Does the In-Network

Yes

Maximum Enrollee Outof-Pocket Cost apply to

all In-Network

Medicare-covered plan

services?

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?

Select the type of drug

benefit:

Defined Standard

Describe the components

: Standard Retail : Out-of-Network : Standard Mail-Order

of your pharmacy network (select all that

: Long-Term Care

apply): Sponsor attests that it

will comply with 42

CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor

pricing?

Yes

Does plan utilize ceiling

Yes

pricing?

Do you pay for over-the-

counter medications

No







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(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

Cost sharing 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-: Out-of-Network Pharmacy - one month supply Network Pharmacy

30

90

No.

No

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

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 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

\$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 - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

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

30

: Long-Term Care Pharmacy - 1-month supply







HUMANA HEALTH PLAN OF PR, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4007-022





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 022, SEGMENT 0

Module: PBP Requested By: rlea PLAN SYSTEM INFORMATION Last entry Date: 06/03/2021 2022.01 PBP Software Version:

Plan Ready for Upload 06/03/2021 12:12:36 PM Eastern Daylight Time

Timestamp:

PLAN STATUS

Section A Status Plan Ready for Upload

Completed Section B1 Status 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 Completed Section B13 Status Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Completed Section B17 Status Section B18 Status Completed Section B19 Status Completed Section C Status Completed Section D Status Completed

SECTION A: SECTION A-I

Section Mrx Status

Organization Legal HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Name:

Organization Marketing Humana

Organization Web Site:

Name:

Completed

www.humana.com/medicare Plan Name: Humana Gold Plus SNP-DE H4007-022 (HMO D-SNP)

Local CCP Organization Type: HMO Plan Type:

Enrollee Type: Part A and Part B Service Area(s): 40010 - Adjuntas, PR 40020 - Aguada, PR Service Area(s): 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 Service Area(s): 40090 - Barceloneta, PR 40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR Service Area(s): Service Area(s): 40120 - Cabo Rojo, PR



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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 40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s): Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	







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40670 - Santa Isabel, PR

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: 022
Segment ID: 0
Contract Period: 2022

Plan Geographic Name: Puerto Rico Island Wide

Yes

No

Is this an Employer-Only No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-approved

Continuation Area?

Do you intend to participate in the PLATINO program?

Is this a Special Needs Yes

Plan?

Special Needs Plan Dual-Eligible

Type:

Is this D-SNP plan a No

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

Services)?

Under this D-SNP, has 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

e (800)681**-**3625

Contact Local Phone



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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 Section C of the PBP?

SECTION A: SECTION A-6

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





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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

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 Zero (No Copayment per Day) day intervals for the Medicare-covered

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

Indicate the number of

Lifetime Reserve Days:

day intervals for Additional Days: Zero (No Copayment per Day)





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

Hospital-Acute benefit

What is your Inpatient Per Admission or Per Stay

period?

Do you charge cost

No

sharing on the day of

discharge?

Is authorization

Yes

No

required?

Is a referral required for

Inpatient Hospital-Acute

Services?

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

Does the plan provide

Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

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

Does this plan's

Medicare-covered benefit cost sharing vary by hospital(s) in which

an enrollee obtains care?

Is there an enrollee

No

No

Coinsurance?

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

Is there an enrollee

Deductible?

Is there an enrollee

Yes

No

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 Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost

sharing on the day of

No

discharge?

Is authorization

Yes

required?

Is a referral required for

Inpatient Psychiatric

No





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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 day inpatient hospital

stay prior to SNF admission?

Indicate the Number of Zero

Yes

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 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 Out-

of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

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

Is there an enrollee

Deductible?

No

Is there an enrollee

Yes

\$0.00

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

Copayment amount per service for Medicare-





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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 required?

Yes

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

Copayment?

Yes

Indicate Minimum

\$0.00

Copayment amount for

Medicare-covered

Benefits:







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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 Outof-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee Yes

Copayment?

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered

Benefits:

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

deductible?

Is the Copayment for No Medicare-covered

Benefits waived if admitted to hospital?

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

Does the plan provide Yes

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 Mandatory

Worldwide Urgent

Coverage:

Select type of benefit for

Worldwide Emergency

Mandatory

Mandatory







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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):

Indicate Minimum \$0.00

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? \$0.00 Indicate Minimum

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 Outof-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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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 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

No

No

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 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:

covered Benefits:

\$0.00 Indicate Maximum

Copayment amount per visit for Medicare-

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as





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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:

\$0.00 Indicate Maximum

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

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

required?

Is a referral required for

Yes

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

Coinsurance?

No

Is there an enrollee No

Deductible?

Is there an enrollee Yes

Copayment?







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\$0.00 Indicate Minimum

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

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 Outof-Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

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

Services have a Copayment (Select all

that apply):

\$0.00 Indicate Minimum

Copayment amount for Medicare-covered Individual Sessions:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Group

Sessions:

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

Is authorization required?

Is a referral required for Yes Mental Health Specialty

Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Yes

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







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Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Copayment?

Select which Podiatry

ich Podiatry

Services have a Copayment (Select all

that apply):

Indicate Minimum

\$0.00

Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum \$0.00

Copayment amount per visit for Medicare-covered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization

No

required?

Is a referral required for No

Podiatrist Services?

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

: Medicare-covered Podiatry Services

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: #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 No Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee

Yes

Copayment?

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

Select which Psychiatric Services have a

Copayment (Select all

that apply):

Indicate Minimum

\$0.00





Copayment amount for Medicare-covered Individual Sessions:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum

Copayment amount for Medicare-covered Group

Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

\$0.00

Is authorization

Yes

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

required?

Is a referral required for No

Psychiatric 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

\$0.00

Copayment amount per visit for Medicarecovered Benefits:

Indicate Maximum

Copayment amount per visit for Medicarecovered Benefits:

SECTION B: #71 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

No

Additional Telehealth benefit for Part B

services?

Select the Medicarecovered benefits that : 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services

may have Additional Telehealth Benefits available:

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

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

: 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse

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







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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?

\$0.00

Indicate Minimum

Copayment amount per visit for Medicare-

covered Benefits:

\$0.00

Indicate Maximum Copayment amount per visit for Medicarecovered Benefits:

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

Is authorization required for Additional Telehealth No

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

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

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

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

Select which Outpatient

Copayment?

Diag Procs/Tests/Lab

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

Services have a

Copayment (Select all







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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

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

Is there an enrollee

Deductible?

No Yes

Is there an enrollee

Copayment?

Select which Outpatient

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

Diag/Therapeutic Rad Services have a Copayment (Select all

that apply):

Indicate Minimum \$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

\$0.00

Copayment amount for Medicare-covered Therapeutic Radiological

Services:







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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

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 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?

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

Copayment amount per visit for Medicarecovered Outpatient

Hospital Services:

\$0.00

\$0.00

Indicate Maximum

Copayment amount per visit for Medicare-

covered Outpatient Hospital Services:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Observation Services:

Indicate Maximum \$0.00

Copayment amount for Medicare-covered Observation Services:

Copayment is charged: Per stay Is authorization required Yes

for Medicare-covered Outpatient Hospital

Services?

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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

Yes

Is there a service-specific No Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee No

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 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 Outof-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?

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:

Indicate Minimum \$0.00

Copayment amount for Medicare-covered Group

Sessions:

Indicate Maximum \$0.00







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Copayment amount for Medicare-covered Group

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?

Select enhanced benefit:

: Three (3) Pint Deductible Waived

Select type of benefit for

Mandatory

Three (3) Pint

Deductible Waived:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee

No

No

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

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

Coinsurance?

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

Is there an enrollee

No

\$0.00

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 \$0.00

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:





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\$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

Yes

24

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 No for number of trips for

Plan Approved Healthrelated Location?

Indicate number of trips

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 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

trip:

Is authorization Yes

required?

Is a referral required for No

Transportation Services?





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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?

Indicate Minimum 10%

No

Yes

10%

No

Coinsurance percentage for Medicare-covered

Benefits:

Indicate Maximum

Coinsurance percentage for Medicare-covered

Benefits:

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

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

Coinsurance?

: Medicare-covered Prosthetic Devices Select which

Yes

Prosthetics/Medical Supplies have a Coinsurance (Select all

that apply):

Indicate Minimum 10%

Coinsurance percentage for Medicare-covered Prosthetic Devices:

10% Indicate Maximum

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

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 Medicarecovered Medical Supplies:

Indicate Maximum \$0.00

Copayment amount per







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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

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 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 Medicarecovered Benefits:







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Indicate Maximum

\$0.00

Copayment amount per session for Medicarecovered Benefits:

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization

No

Yes

required?

Is a referral required for No

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit

under Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for Number of Treatments:

Mandatory

Is this benefit unlimited

No

for Number of Treatments?

Indicate limit for

20

Number of Treatments: Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - 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

treatment:

Indicate Maximum \$0.00

Copayment amount per

treatment:

Is authorization Yes

required?

Is a referral required for No

Acupuncture?

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?

15.00

Mandatory

Yes

Indicate Maximum Plan

Benefit Coverage

amount:

Select Maximum Plan

Every three months





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Benefit Coverage periodicity:

Does your Maximum No Plan Benefit Coverage amount carry forward to the next period if it is

unused?

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

No

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

No

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

Notes: 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

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

Meals:

: Immediately following surgery or inpatient hospitilization Select the type of

primarily health related : For a medical condition or potential medical condition that requires the enrollee to remain at home for a

meals benefit offered: period of time

Is there a service-specific 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 Coinsurance?

No

No

Is there an enrollee Deductible?

No

Is there an enrollee

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount:



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Indicate Maximum

\$0.00

Copayment amount:

Is authorization

Yes

required?

Is a referral required for

the Meal Benefit?

No

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

Up to 28 meals over 14 days for members with a COVID-19 Diagnosis.

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

year.

No

Nο

No

Yes

Nο

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

COVID-19 Treatment

(Optional):

Select type of benefit for

Other 2:

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?

Is there an enrollee

Deductible?

Is there an enrollee

Copayment?

Is authorization

required?

Is a referral required for

Other Services?

SECTION B: #13E OTHER 2 - BASE 3

Notes:

No cost share for 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

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

No

Is authorization required?

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?

Mandatory

Select type of benefit for the Annual Physical

Exam:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?



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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

Yes

Copayment?

Indicate Minimum

\$0.00

Copayment amount for each Annual Physical

Exam:

Indicate Maximum

\$0.00

Copayment amount for each Annual Physical

Exam:

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

Is authorization

No

No

required?

Is a referral required for

the Annual Physical

Exam?

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

different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the

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

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

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

: Physical Fitness

Mandatory

Mandatory

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

Select type of benefit for

Wigs for Hair Loss

Related to Chemotherapy: Mandatory

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

Is there a service-specific

Maximum Plan Benefit







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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 5

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 7

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee

Deductible?

No No

Yes

No

Is there an enrollee

Copayment?

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

No authorization required for this service.

Is authorization

required?

Is a referral required for

Other Defined

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco

Cessation Counseling

Notes:

Fitness benefit includes a health and wellness program which has the goal of helping older adults live Fitness Benefit Notes:*

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 15

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

Safety Devices and Modifications Notes:*

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

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 Nο

Coinsurance?



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

Is there an enrollee

No

Deductible?

Is there an enrollee

Yes

\$0.00

Copayment?

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

Kidney Disease

No

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

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

Is there an enrollee

Copayment?

Yes

\$0

\$0

Select which Services

have a Copayment : Medicare-covered Diabetes Self-Management Training

(Select all that apply):

: Medicare-covered EKG following Welcome Visit

Indicate Minimum Copayment amount for

Medicare-covered

Glaucoma Screening:

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

Copayment amount for Medicare-covered Barium Enemas:

: Medicare-covered Glaucoma Screening

: Medicare-covered Barium Enemas

: Medicare-covered Digital Rectal Exams

\$0



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Indicate Minimum \$0 Copayment amount for Medicare-covered Digital Rectal Exams: Indicate Maximum

\$0

Copayment amount for Medicare-covered Digital Rectal Exams:

Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:

\$0

Indicate Maximum

\$0

Copayment amount for Medicare-covered EKG following Welcome Visit:

Is authorization required for Medicare-covered Glaucoma Screening?

No

Is authorization required for Medicare-covered

No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

No

Barium Enemas? Is authorization required

for Medicare-covered Digital Rectal Exams? Is authorization required

No

for Medicare-covered EKG following

No

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

Is a referral required for

No

any Services?

Welcome Visit?

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

Yes

Copayment?

: Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs

Select which Medicare Part B Rx Drugs have a

Copayment (Select all

that apply):

\$0.00

Indicate Minimum Copayment Amount for

Medicare Part B

Chemotherapy/Radiation

Drugs:

Indicate Maximum \$0.00

Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Minimum

Copayment Amount for other Medicare Part B

\$0.00







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

: Part B to Part B?

from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide

No

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

mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

Yes

Preventive Dental Items

as a supplemental benefit

under Part C?

: Oral Exams

Select enhanced benefits:

: Prophylaxis (Cleaning)

: Dental X-Rays

3

Select type of benefit for

Oral Exams:

Mandatory

Is this benefit unlimited

for Oral Exams?

No, indicate number

Other, Describe

Mandatory

Indicate number of visits

for Oral Exams:

Select the Oral Exams

periodicity:

Select type of benefit for

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

for Dental X-Rays:

Select the Dental X-Rays

Other, Describe

periodicity:

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific

Maximum Enrollee Out-





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of-Pocket Cost?

Is there an enrollee Coinsurance?

Yes

Select which Preventive : Oral Exams

Dental Services have a Coinsurance (Select all : Prophylaxis (Cleaning) : Dental X-Rays

that apply):

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

No

Visit?

0% Indicate Minimum

Coinsurance percentage

for Oral Exams:

Indicate Maximum

0%

0%

0%

0%

Coinsurance percentage

for Oral Exams:

Indicate Minimum

Coinsurance percentage

for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis

0%

(Cleaning):

Indicate Minimum

Coinsurance percentage for Dental X-Rays:

Indicate Maximum

Coinsurance percentage for Dental X-Rays:

SECTION B: #16A PREVENTIVE DENTAL - BASE 4 Is there an enrollee

Deductible?

No No

Is there an enrollee

Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization

No

required? Is a referral required for

Preventive Dental

No

Services?

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

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 Services periodicity:

Other, Describe





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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:

Every year

Select the Periodontics periodicity:

Select type of benefit for

Mandatory

Extractions:

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

Plan-specified amount per period

Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services

periodicity:

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

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Select the Maximum

Plan Benefit Coverage

type:

Indicate Maximum Plan

Benefit Coverage

amount:

Select the Maximum

Every year

1000.00

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

Comprehensive Dental

: Endodontics : Periodontics

Services have a 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







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for Restorative Services:

Indicate Minimum

0%

0%

0%

0%

0%

0%

Coinsurance percentage

for Endodontics:

Indicate Maximum

Coinsurance percentage

for Endodontics:

Indicate Minimum

Coinsurance percentage

for Periodontics:

Indicate Maximum

Coinsurance percentage

for Periodontics:

Indicate Minimum Coinsurance percentage

for Extractions:

Indicate Maximum

Coinsurance percentage

for Extractions:

Indicate Minimum 0%

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

Indicate Maximum

Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

Is there an enrollee

Deductible?

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

Is there an enrollee

Copayment?

Select which : Medicare-covered Benefits

Comprehensive Dental Services have a

Copayment (Select all

that apply):

Indicate Minimum \$0.00

Copayment amount for Medicare-covered

Benefits:

\$0.00 Indicate Maximum

Copayment amount for Medicare-covered

Benefits:

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

No

Is authorization

required?

Is a referral required for

Comprehensive Dental

Services?

Periodontics includes scaling and root planing (deep cleaning) up to 1 per quadrant per year. Notes:

Prosthodontics, Other Oral/Maxillofacial Surgery, other services include adjustments to dentures up to unlimited per year, bridges up to 1 every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years. Restorative services include fillings up to 1 per tooth every 3 years, crown 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?

0%

Surgery, Other Services:

No







Select enhanced benefit:

: Routine Eye Exams

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited for Routine Eye Exams? No, indicate number

Indicate number of

exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

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?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for

Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses?

Yes

Select type of benefit for Eyeglasses (lenses and

Mandatory

frames):

Is this benefit unlimited Yes

for Eyeglasses (lenses

and frames)?







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SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum

Plan-specified amount per period

Plan Benefit Coverage

type:

Do you offer a Yes

Combined Max Plan Benefit Coverage Amount for all Eyewear?

400.00

Indicate Combined Maximum Plan Benefit Coverage amount:

Every year

Select the Combined 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

Deductible?

No

Deductible.

Is there an enrollee

Yes

\$0.00

Copayment?

Select which Eyewear

: Medicare-covered Benefits

Benefits have a

: Contact lenses

Copayment (Select all

: Eyeglasses (lenses and frames)

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

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

Does the plan provide Hearing Exams as a Yes

supplemental benefit





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under Part C?

: Routine Hearing Exams Select enhanced benefits:

Select type of benefit for

Routine Hearing Exams:

Is this benefit unlimited

No, indicate number

Mandatory

for Routine Hearing

Exams?

Indicate number for 1

Routine Hearing Exams:

Select Routine Hearing Every year

Exams 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?

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

Yes

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:

\$0.00 Indicate Minimum

Copayment amount for Routine Hearing Exams:

Indicate Maximum \$0.00

Copayment amount for Routine Hearing Exams: Is authorization

No required? No

Is a referral required for

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

No

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

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 No Supplemental Benefits for the Chronically III?

Are you offering a VBID No







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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

: Cash or Monetary Rebates

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: Advanced Care Planning

No

No

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

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

: Provider/Patient portals : Health Information Exchanges

and/or advance

: Data Warehouses

directives are connected

from your program to access points of care.

Expected Number of

Beneficiaries to be

832

Engaged Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

: Other

Type of Cash or

Monetary Rebates:

: Debit Card/Check

Cash or Monetary

25.00

Rebates amount per

month:

Maximum Annual Cash

300.00

or Monetary Rebates

available:

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

No

Uniformity

Flexibility/SSBCI

benefit offer additional

Part C benefits?

SECTION C: V/T - GENERAL - US







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Do you offer a US No Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network

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 Out-

of-Pocket Cost Amount:

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

apply to the In-Network Maximum Enrollee Out-

of-Pocket cost:

Does the In-Network Yes

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

Medicare-covered plan

services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions

in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

No

Yes

Do you offer Combined Supplemental Benefits with uniform cost

sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug (Part D) benefit?

Select the type of drug

benefit:

apply):

Defined Standard

Describe the components of your pharmacy network (select all that

: Standard Retail : Out-of-Network : Standard Mail-Order : 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

Yes

Does plan utilize ceiling

pricing?

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

Location/supply amount

(s) that apply:







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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-: Out-of-Network Pharmacy - one month supply

Network Pharmacy 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 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?

SECTION RX: MEDICARE RX - NOTES

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

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

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

30

90

31

No

No

: Long-Term Care Pharmacy - 1-month supply

DAINISTRACION Contrato Número