MEDICARE PLATINO CONTRACT

APPENDIX C (1) (23)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

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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:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/03/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/03/2022 02:41:09 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:40:45 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:35:44 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:02:59 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03730

PLAN STATUS

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

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SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

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Plan Name:	Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	

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Plan ID:	H4007
Segment ID:	016
Contract Period:	0
Plan Geographic Name:	2023
Is this an Employer-Only plan?	Puerto Rico Island Wide
SECTION A: SECTION A-2	No
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

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

SECTION A: SECTION A-6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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

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

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

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

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

SECTION B: #2 SNF - BASE 1

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

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

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

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

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

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

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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visit for Medicare-covered Benefits:	

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

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

Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

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Medicare-covered Group Sessions:	

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

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

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

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

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

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

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

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

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

SECTION B: #11A DME - BASE 2

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

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

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

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

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

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

Is authorization required?	Yes

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

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

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

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

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

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Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	The plan will provide $0 copayment for adult diapers box up to three (3) every month. Members who meet medical criteria. Brand according to contracted provider. The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00

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

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

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

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

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

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

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and

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	record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: Wigs for Hair Loss Related to Chemotherapy : 14c21: In-Home Support Services*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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

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

Select type of benefit for In-Home Support Services:	Mandatory

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c15: Wigs for Hair Loss Related to Chemotherapy

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

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

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

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

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.
In-Home Support Services Notes:*	Members are connected with individuals that offer assistance with other instrumental activities of daily living. Support may be in person or virtually for up to 60 hours per year (minimum of one hour per visit).. Authorization required for this service.

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

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

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

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome	$0

Visit:	
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No

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

Is a referral required for any Services?	No

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

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

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

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	: 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:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

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SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other	5

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Services:	
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

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Surgery, Other Services:	
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1 per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, bridges up to 1 every 5 years, $2000 maximum benefit per year that only applies to implant services and implant supported prosthetics.

SECTION B: #17A EYE EXAMS - BASE 1

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

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SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	900.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1

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

SECTION B: #18A HEARING EXAMS - BASE 2

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

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Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

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

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

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Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals

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access points of care.	: Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	2970

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

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

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	3072
Expected Number of Enrollees to be engaged and receive Model benefits:	3072

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	600
Select the package level maximum coverage	Every year

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periodicity:	
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and Modifications

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

Notes:	$50 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare	No

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

Notes:	$50 loaded on a prepaid card every month to spend at participating retailers toward the purchase of over-the-counter products from a national network of retailers.

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

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	$50 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

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

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

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

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

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

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

Notes:	$50 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental	: 14c8: Home and Bathroom Safety Devices and

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	75
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

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

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$50 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

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

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

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

Which disease states does this benefit apply? (Select all that apply):	: Congestive Heart Failure (CHF) : Dementia : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Maligent Neoplasm

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Other 2 Description:	Leukemia
Other 3 Description:	Chronic Kidney Disease (CKD) & End Stage Renal Disease (ESRD)
Other 4 Description:	Hepatitis
Other 5 Description:	Pressure Ulcer
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage amount?	No

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

Notes:	Members who are home bound qualify for $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. This amount will not carry forward if unused.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is	No

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unused?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

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Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 018, SEGMENT 0

Module:	PBP
Requested By:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/03/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/03/2022 03:07:50 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:41:16 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:36:08 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:11:25 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03736

PLAN STATUS

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

SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

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Plan Name:	Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	

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Plan ID:	H4007
Segment ID:	018
Contract Period:	0
Plan Geographic Name:	2023
Is this an Employer-Only plan?	Puerto Rico Island Wide
SECTION A: SECTION A-2	No
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

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

SECTION A: SECTION A-6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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

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

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

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

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

SECTION B: #2 SNF - BASE 1

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

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

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

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

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

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

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

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Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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visit for Medicare-covered Benefits:

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

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

Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

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Medicare-covered Group Sessions:	

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

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

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

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

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

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

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

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

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

SECTION B: #11A DME - BASE 2

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

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

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

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

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

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

Is authorization required?	Yes

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

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

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

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

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00

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Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

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

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

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes: Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

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

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

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

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

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

Notes: An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: Wigs for Hair Loss Related to Chemotherapy : 14c21: In-Home Support Services*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

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

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

Select type of benefit for In-Home Support Services:	Mandatory

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c15: Wigs for Hair Loss Related to Chemotherapy

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

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

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Chemotherapy:	
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10	
Is there an enrollee Coinsurance?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14	
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15	
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16	
Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.
In-Home Support Services Notes:*	Members are connected with individuals that offer assistance with other instrumental activities of daily living. Support may be in person or virtually for up to 60 hours per year (minimum of one hour per visit).. Authorization required for this service.
SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2	
Is there an enrollee Deductible?	No

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for	$0

Medicare-covered EKG following Welcome Visit:	
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No

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

Is a referral required for any Services?	No

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

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

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

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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:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics,	5

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Other Oral/Maxillofacial Surgery, Other Services:	
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	6000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

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Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $6000 maximum benefit per year that only applies to crowns.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1 per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, $6000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.

SECTION B: #17A EYE EXAMS - BASE 1

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

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Benefit Coverage amount?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	No
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	900.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

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

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

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

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

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

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No

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Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	4436

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

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

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	4320
Expected Number of Enrollees to be engaged and receive Model benefits:	4320

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

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

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

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	900
Select the package level maximum coverage periodicity:	Every year
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and Modifications

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

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

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

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the purchase of over-the-counter products from a national network of retailers.

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

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	$75 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

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

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee	No

Out-of-Pocket Cost?	

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

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

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

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

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

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

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

Notes:	$75 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	75
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

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

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$75 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

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

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

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

To which chronic condition does this benefit apply? (Select all that apply):	: Chronic alcohol and other drug dependence : Autoimmune disorders

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: Cancer
: Cardiovascular disorders
: Chronic heart failure
: Dementia
: Diabetes
: End-stage liver disease
: End-stage renal disease (ESRD)
: Severe hematologic disorders
: HIV/AIDS
: Chronic lung disorders
: Chronic and disabling mental health conditions
: Neurologic disorders
: Stroke

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

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

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage amount?	No

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

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.

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

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Transportation for Non-Medical Needs

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

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Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan-approved Location
Select type of benefit for Plan-approved Location:	Mandatory
Is this benefit unlimited for number of trips for Plan-approved Location?	No
Indicate number of trips for Plan-approved Location:	36
Select Plan-approved Location Trips periodicity:	Every year
Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	One-way
Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	: Taxi : Van : Medical Transport

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

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

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

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation for Non-Medical Needs?	No
Notes:	Eligible members may receive non-medical related transportation 36 one-way trips to locations that include, but are not limited to, the bank, supermarket, church, pharmacy, beach, post office, or airport. Not limited to a same day appointment.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-	Lower

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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90

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Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 019, SEGMENT 0

Module:	PBP
Requested By:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/01/2022 02:35:55 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:42:17 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:36:34 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:11:25 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03736

PLAN STATUS

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

SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

Plan Name:	Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	

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Plan ID:	H4007
Segment ID:	019
Contract Period:	0
Plan Geographic Name:	2023
Is this an Employer-Only plan?	Puerto Rico Island Wide
SECTION A: SECTION A-2	No
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

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

SECTION A: SECTION A-6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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

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

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

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

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

SECTION B: #2 SNF - BASE 1

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

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

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

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

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

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

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

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Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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visit for Medicare-covered Benefits:	

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

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

Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

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Medicare-covered Group Sessions:	

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

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

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

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

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

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

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

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

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

SECTION B: #11A DME - BASE 2

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

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

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

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

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

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

Is authorization required?	Yes

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

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

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

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

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00

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Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00

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

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes: Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

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

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

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

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

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

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

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

Notes: An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and

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	record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may

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

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

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

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for	$0

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

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays

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Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2

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Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	5
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $2500 maximum benefit per year that only applies to crowns.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1

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	per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, bridges up to 1 every 5 years, $2500 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	No
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes

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Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

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Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

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

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all	Mandatory

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types):	
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status

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Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	2781

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

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

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	2860

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Expected Number of Enrollees to be engaged and receive Model benefits:	2860

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	900
Select the package level maximum coverage periodicity:	Every year
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and Modifications

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

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

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

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the purchase of over-the-counter products from a national network of retailers.

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

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	$75 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

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

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

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

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

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

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

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

Notes:	$75 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	75
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

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

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

Is authorization required?	No

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Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$75 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	1

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 16a1: Oral Exams : 16a2: Prophylaxis (Cleaning) : 16a4: Dental X-Rays : 16b2: Diagnostic Services : 16b3: Restorative Services : 16b4: Endodontics : 16b5: Periodontics : 16b6: Extractions : 16b7: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services : 17a1: Routine Eye Exams : 17b1: Contact Lenses

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	: 17b2: Eyeglasses (lenses and frames) : 18a1: Routine Hearing Exams : 18a2: Fitting/Evaluation for Hearing Aid : 18b1: Hearing Aids (all types)
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	500
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every year
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:	The combined supplemental benefit package maximum amount provides coverage in addition to the maximum amount referenced in the individual benefit category.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30

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

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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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:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/01/2022 02:37:35 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:43:48 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:37:48 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:02:59 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03730

PLAN STATUS

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

SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

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Plan Name:	Humana Gold Plus SNP-DE H4007-022 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s): 40360 - Jayuya, PR
Service Area(s): 40370 - Juana Diaz, PR
Service Area(s): 40380 - Juncos, PR
Service Area(s): 40390 - Lajas, PR
Service Area(s): 40400 - Lares, PR
Service Area(s): 40410 - Las Marias, PR
Service Area(s): 40420 - Las Piedras, PR
Service Area(s): 40430 - Loiza, PR
Service Area(s): 40440 - Luquillo, PR
Service Area(s): 40450 - Manati, PR
Service Area(s): 40460 - Maricao, PR
Service Area(s): 40470 - Maunabo, PR
Service Area(s): 40480 - Mayaguez, PR
Service Area(s): 40490 - Moca, PR
Service Area(s): 40500 - Morovis, PR
Service Area(s): 40510 - Naguabo, PR
Service Area(s): 40520 - Naranjito, PR
Service Area(s): 40530 - Orocovis, PR
Service Area(s): 40540 - Patillas, PR
Service Area(s): 40550 - Penuelas, PR
Service Area(s): 40560 - Ponce, PR
Service Area(s): 40570 - Quebradillas, PR
Service Area(s): 40580 - Rincon, PR
Service Area(s): 40590 - Rio Grande, PR
Service Area(s): 40610 - Sabana Grande, PR
Service Area(s): 40620 - Salinas, PR
Service Area(s): 40630 - San German, PR
Service Area(s): 40640 - San Juan, PR
Service Area(s): 40650 - San Lorenzo, PR
Service Area(s): 40660 - San Sebastian, PR
Service Area(s): 40670 - Santa Isabel, PR
Service Area(s): 40680 - Toa Alta, PR
Service Area(s): 40690 - Toa Baja, PR
Service Area(s): 40700 - Trujillo Alto, PR
Service Area(s): 40710 - Utuado, PR
Service Area(s): 40720 - Vega Alta, PR
Service Area(s): 40730 - Vega Baja, PR
Service Area(s): 40740 - Vieques, PR
Service Area(s): 40750 - Villalba, PR
Service Area(s): 40760 - Yabucoa, PR
Service Area(s): 40770 - Yauco, PR
Contract Number:

	H4007
Plan ID:	022
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

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

SECTION A: SECTION A-6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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

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

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

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

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

SECTION B: #2 SNF - BASE 1

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

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

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

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

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

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

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

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Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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visit for Medicare-covered Benefits:	

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

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

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

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Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

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Medicare-covered Group Sessions:	

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

Is authorization required?	Yes

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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

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

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

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

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

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

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

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SECTION B: #11A DME - BASE 1

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

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Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%

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

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

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

Is authorization required?	Yes

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

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

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

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

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Dialysis Services?	No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00

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Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily

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	systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: Wigs for Hair Loss Related to Chemotherapy
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c15: Wigs for Hair Loss Related to Chemotherapy

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined	No

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Supplemental Benefits?	

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No

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Is authorization required for Medicare-covered EKG following Welcome Visit?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis	No, indicate number

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(Cleaning)?	
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental	Yes

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Items as a supplemental benefit under Part C?	
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	5
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

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Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $2500 maximum benefit per year that only applies to crowns.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1 per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, bridges up to 1 every 5 years, $2500 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	No
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per	$0.00

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Hearing Aid (all types):	
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	1797

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	1934
Expected Number of Enrollees to be engaged and receive Model benefits:	1934

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	600
Select the package level maximum coverage periodicity:	Every year
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and

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	Modifications

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend at participating retailers toward the purchase of over-the-counter products from a

	national network of retailers.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-

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	medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 3: PACKAGE #1

Notes:	$50 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage	75

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amount for Home and Bathroom Safety Devices and Modifications:	
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$50 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

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Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	1

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 16a1: Oral Exams : 16a2: Prophylaxis (Cleaning) : 16a4: Dental X-Rays : 16b2: Diagnostic Services : 16b3: Restorative Services : 16b4: Endodontics : 16b5: Periodontics : 16b6: Extractions : 16b7: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services : 17a1: Routine Eye Exams : 17b1: Contact Lenses : 17b2: Eyeglasses (lenses and frames) : 18a1: Routine Hearing Exams : 18a2: Fitting/Evaluation for Hearing Aid : 18b1: Hearing Aids (all types)
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	500
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every year
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:	The combined supplemental benefit package maximum amount provides coverage in addition to the maximum amount referenced in the individual benefit category.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order

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	: 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

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 026, SEGMENT 0

Module:	PBP
Requested By:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/01/2022 02:40:29 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:45:18 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:39:02 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:11:25 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03736

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

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Plan Name:	Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	

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	H4007
Plan ID:	026
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No

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SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 9

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 10

Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 9

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits per day:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	$0.00
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

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Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per	$0.00

visit for Medicare-covered Benefits:

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee	No

Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	: Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Psychiatric Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for	$0.00

Medicare-covered Group Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Psychiatric Services?	No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes

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Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
SECTION B: #9B ASC SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #9B ASC SERVICES - BASE 2	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

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Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	: Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Dialysis Services?	No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00

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Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily

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	systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: Wigs for Hair Loss Related to Chemotherapy
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c15: Wigs for Hair Loss Related to Chemotherapy

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined	No

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Supplemental Benefits?	

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	
SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3	
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No

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Is authorization required for Medicare-covered EKG following Welcome Visit?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis	No, indicate number

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(Cleaning)?	
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental	Yes

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Items as a supplemental benefit under Part C?	
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	5
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

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Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $2500 maximum benefit per year that only applies to crowns.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1 per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, bridges up to 1 every 5 years, $2500 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	No
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	900.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per	$0.00

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Hearing Aid (all types):	
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	1459

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

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Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	1455
Expected Number of Enrollees to be engaged and receive Model benefits:	1455

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	900
Select the package level maximum coverage periodicity:	Every year
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and

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	Modifications

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend at participating retailers toward the

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	purchase of over-the-counter products from a national network of retailers.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend on general supports for living including

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	rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 3: PACKAGE #1

Notes:	$75 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

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Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	75
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$75 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-	Yes

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of-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?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended	No

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day supply limited to a 1-month supply for the first fill?	

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4007, PLAN 027, SEGMENT 0

Module:	PBP
Requested By:	trcx

PLAN SYSTEM INFORMATION

Last entry Date:	08/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	08/01/2022 02:41:50 PM Eastern Daylight Time
MA BPT Timestamp:	08/03/2022 03:45:49 PM Eastern Daylight Time
PD BPT Timestamp:	07/30/2022 06:39:28 AM Eastern Daylight Time
Last Upload File Creation Timestamp:	08/04/2022 02:11:25 PM Eastern Daylight Time
Upload Status:	08/04/2022 #03736

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	HUMANA HEALTH PLANS OF PUERTO RICO, INC.
Organization Marketing Name:	Humana
Organization Web Site:	www.humana.com/medicare

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Plan Name:	Humana Gold Plus SNP-DE H4007-027 (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR

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Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	

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	H4007
Plan ID:	027
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico Island Wide
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	https://www.humana.com/pharmacy/
Formulary Website Address:	https://www.humana.com/pharmacy/prescription-coverages/medicare-drug-list
Physician Website Address:	https://finder.humana.com/finder/medical
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(800)681-3625
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(866)773-5959
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No

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SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 9

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 10

Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00

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Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 9

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	Yes
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	: Medicare-covered Cardiac Rehabilitation Services : Medicare-covered Intensive Cardiac Rehabilitation Services : Medicare-covered Pulmonary Rehabilitation Services : Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No

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Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage : Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits per day:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	$0.00
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

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Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	: Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per	$0.00

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visit for Medicare-covered Benefits:

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee	No

Out-of-Pocket Cost?	

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	: Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Psychiatric Services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for	$0.00

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Medicare-covered Group Sessions:	

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Psychiatric Services?	No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 4b: Urgently Needed Services : 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7e2: Group Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 7h2: Group Sessions for Psychiatric Services : 9c1: Individual Sessions for Outpatient Substance Abuse : 9c2: Group Sessions for Outpatient Substance Abuse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00

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SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Procedures/Tests : Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

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SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes

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Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	: Medicare-covered Diagnostic Radiological Services : Medicare-covered Therapeutic Radiological Services : Medicare-covered X-Ray Services
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes

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Select which Services have a Copayment (Select all that apply):	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation Services
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	: Medicare-covered Individual Sessions : Medicare-covered Group Sessions

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Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Ground Ambulance Services : Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00

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Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	: Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	: Medicare-covered Diabetes Supplies : Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00

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Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	$0.00

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Dialysis Services?	No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #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:	$0.00

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Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	Up to 14 meals over 7 days after an inpatient stay in a hospital or nursing facility, limited to 4 times per year. Meal delivery must be scheduled within 30 days of discharge from inpatient stay.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 3

Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily

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	systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c15: Wigs for Hair Loss Related to Chemotherapy
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c15: Wigs for Hair Loss Related to Chemotherapy

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined	No

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Supplemental Benefits?	

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Management Training : Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No

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Is authorization required for Medicare-covered EKG following Welcome Visit?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	: Medicare Part B Chemotherapy/Radiation Drugs : Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis	No, indicate number

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(Cleaning)?	
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	8
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	: Oral Exams : Prophylaxis (Cleaning) : Dental X-Rays
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Coinsurance percentage for Oral Exams:	0%
Indicate Maximum Coinsurance percentage for Oral Exams:	0%
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	0%
Indicate Minimum Coinsurance percentage for Dental X-Rays:	0%
Indicate Maximum Coinsurance percentage for Dental X-Rays:	0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Dental X-Rays 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.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental	Yes

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Items as a supplemental benefit under Part C?	
Select enhanced benefits:	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	5
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	: Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	: Medicare-covered Benefits

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $3000 maximum benefit per year that only applies to crowns.
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics (abutment crown) up to 1 per tooth every 5 years, partial dentures and complete dentures up to 1 set(s) every 5 years, bridges up to 1 every 5 years, $3000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Eye Exams
Indicate Minimum Copayment amount for	$0.00

Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	No
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	850.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Contact lenses : Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for	$0.00

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Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Hearing Exams : Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid

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Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per	$0.00

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Hearing Aid (all types):	
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Care Management Program : In-home Assessments : Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses : Other
Expected Number of Beneficiaries to be Engaged Annually:	1556

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	1554
Expected Number of Enrollees to be engaged and receive Model benefits:	1554

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	3180
Select the package level maximum coverage periodicity:	Every year
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13d: Other 1 : 13e: Other 2 : 13f: Other 3 : 14c8: Home and Bathroom Safety Devices and

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	Modifications

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	$265 loaded on a prepaid card every month to spend at participating retailers toward the purchase of food, home supplies, personal wellness care, over-the-counter products from a national network of retailers. Additionally, enrollees may also use the card to pay for non-medical transportation, general supports for living (rent assistance, internet, utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused funds will roll over to the next month and expire at the end of the plan year.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	265
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

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SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	$265 loaded on a prepaid card every month to spend at participating retailers toward the purchase of over-the-counter products from a

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	national network of retailers.

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Healthy Living Products
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	265
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:	$265 loaded on a prepaid card every month to spend on food and produce, home supplies, personal wellness care, indoor air quality equipment and services, and pet care/supplies.

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Living Expense Support
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	265
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13E OTHER 2 - BASE 3: PACKAGE #1

Notes:	$265 loaded on a prepaid card every month to spend on general supports for living including

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	rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 1: PACKAGE #1

Enter name of Service (Optional):	Aging Support and Safety Products
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	265
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No

SECTION B: VBID/UF/SSBCI 19B #13F OTHER 3 - BASE 3: PACKAGE #1

Notes:	$265 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c8: Home and Bathroom Safety Devices and Modifications

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

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Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	265
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	$265 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network	Yes

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Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 1-month supply:	30
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the	No

ADMINISTRACION DE SEGUROS DE SALUD
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EMR

first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

EMR