MEDICARE PLATINO CONTRACT

APPENDIX C (1) (23)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

EMR

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 08/03/2022 03:40:45 PM Eastern Daylight Time

MA BPT Timestamp:

07/30/2022 06:35:44 AM Eastern Daylight Time

PD BPT Timestamp:
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 Section B5 Status

Completed Completed

Section B6 Status

Completed

Section B7 Status Section B8 Status

Completed Completed

Section B9 Status Section B10 Status Completed Completed

Section B11 Status Section B12 Status Section B13 Status

Completed Completed

Section B13 Status
Section B14 Status

Completed Completed

Section B15 Status Section B16 Status

Completed

Section B17 Status Section B18 Status Completed Completed

Section B18 Status Section B19 Status Section C Status Completed Completed

Section C Status Section D Status Completed Completed

Section Mrx Status

Completed

RICO, INC.

SECTION A: SECTION A-1

Organization Legal Name:

HUMANA HEALTH PLANS OF PUERTO

Organization Marketing Name:

Humana

Organization Web Site:

www.humana.com/medicare

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Plan Name:
Organization Type:
Plan Type:
Enrollee Type:
Service Area(s):

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

40320 - Hatillo, PR

40330 - Hormigueros, PR

40340 - Humacao, PR

40350 - Isabela, PR



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Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):
Service Area(s):
~

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



Contract Number:

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 (800)681-3625 Contrato Número
SECTION A: SECTION A-4	ALL OF
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(800)681-3625

(711)-

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Beneficiaries:

Customer Service Contact TTY for Current

Medicare Beneficiaries:

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	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-A	CUTE - BASE 2
	Is there a service-specific Maximum Enrollee	No
	Out of Pookst Cost?	

Is there an enrollee Coinsurance? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

No

No

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an

care?

Out-of-Pocket Cost?

enrollee obtains care?



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\$0.00

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment amount for the Medicare-

covered stay:

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

Medicare-covered stay:

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

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

Medicare-covered Lifetime Reserve Days:

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

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

Additional Days:

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay

period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an

enrollee obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

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

MR

inpatient facility.)

Indicate Copayment amount for the Medicare-\$0.00

covered stay:

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No

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Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stav

benefit period?

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

 \mathbb{C} ?

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Yes Zero

No

Indicate the Number of Hospital Days

Required Prior to SNF Admission (0-2):

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

No

Is there an enrollee Coinsurance?

No

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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

No

Is there an enrollee Coinsurance?

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 PULMONA	ARY REHABILITATION SERVICES - BASE 4
is authorization reduited:	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
SECTION B: #4A EMERGENCY SERVICES	S - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No No Contrato Número
Is there an enrollee Coinsurance?	No Romero

Yes

\$0.00

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Is there an enrollee Copayment?

Indicate Minimum Copayment amount for

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

Medicare-covered Benefits:

Is the Copayment for Medicare-covered

Benefits waived if admitted to hospital?

Select either Days or Hours within which

admission must occur for waiver:

Enter number of Days or Hours:

Does the Emergency Services cost sharing

count towards any plan-level deductible?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Yes

\$0.00

\$0.00

No

\$0.00

Yes

Hours

24

No

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

Is there an enrollee Copayment?

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

Medicare-covered Benefits:

Does the Urgently Needed Services cost

sharing count towards any plan-level

deductible?

Is the Copayment for Medicare-covered

Benefits waived if admitted to hospital?

No

Yes

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?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide

Emergency Coverage:

Select type of benefit for Worldwide Urgent

Coverage:

Select type of benefit for Worldwide

Emergency Transportation:

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

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Out-of-Pocket Cost?

Mandatory

Mandatory

Mandatory

No

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	No	

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Hospitalization?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? Yes

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Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits.

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

\$0.00

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

a supplemental benefit under Part C?

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

\$0.00

Medicare-covered Benefits:

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

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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 No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

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 Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

: Medicare-covered Individual Sessions Select which Mental Health Specialty Services : Medicare-covered Group Sessions have a Copayment (Select all that apply):

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 \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Group Sessions:

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee No

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No

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Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible? No

Is there an enrollee Copayment? Yes

Select which Podiatry Services have a : Medicare-covered Podiatry Services

No

Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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?

Is there an enrollee Coinsurance? No

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

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

Is authorization required? No

Is a referral required for Other Health Care No

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

Select which Psychiatric Services have a : Medicare-covered Individual Sessions Copayment (Select all that apply): : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

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

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 No

Is a referral required for Physical Therapy and Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

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: #7.J 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 \$0.00 visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

\$0.00

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about:blank 8/5/2022 SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

No

Telehealth Services?

Is a referral required for Additional Telehealth

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

: Medicare-covered Diagnostic Procedures/Tests

Services have a Copayment (Select all that

: Medicare-covered Lab Services

apply):

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Lab Services:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Lab Services:

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If a member receives multiple services at the same location on the same day, does only the

Yes

maximum copay apply?

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

Is authorization required?

Yes

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No

Is a referral required for Outpatient Diagnostic Yes

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

: Medicare-covered Therapeutic Radiological

Services

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

: Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Copayment amount for

other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Minimum Copayment amount for

Medicare-covered Therapeutic Radiological

Indicate Maximum Copayment amount for

Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum Copayment amount for

Medicare-covered X-Ray Services:

Indicate Maximum Copayment amount for

Medicare-covered X-Ray Services:

If a member receives multiple services at the

same location on the same day, does only the

maximum copay apply?

\$0.00 Yes

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 DHINISTRACION Contrato Número

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: Medicare-covered Outpatient Hospital Services Select which Services have a Copayment : Medicare-covered Observation Services (Select all that apply): Indicate Minimum Copayment amount per \$0.00 visit for Medicare-covered Outpatient Hospital Services: \$0.00 Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: Indicate Minimum Copayment amount for \$0.00 Medicare-covered Observation Services: Indicate Maximum Copayment amount for \$0.00 Medicare-covered Observation Services: Observation Services copayment is charged: Per stay Is authorization required for Medicare-covered Yes **Outpatient Hospital Services?** Is authorization required for Medicare-covered Yes Observation Services? Is a referral required for Medicare-covered No **Outpatient Hospital Services?** Is a referral required for Medicare-covered No **Observation Services? SECTION B: #9B ASC SERVICES - BASE 1** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #9B ASC SERVICES - BASE 2** Is there an enrollee Deductible? No Yes Is there an enrollee Copayment? Indicate Minimum Copayment amount per \$0.00 visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per \$0.00 visit for Medicare-covered Benefits: Yes Is authorization required? ONINISTRACION Is a referral required for Ambulatory Surgical No Center Services? SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1 Contrato Número Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Yes Is there an enrollee Copayment?

apply):
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Select which Outpatient Substance Abuse

services have a Copayment (Select all that

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: Medicare-covered Individual Sessions : Medicare-covered Group Sessions PBP Data Report Page 18 of 43

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

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

\$0.00

\$0.00

Indicate the Minimum Copayment amount for \$0.00

Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for

Medicare-covered Air Ambulance Services:

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Yes

Yes

Yes

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

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?

One-way

Select Type of Transportation for Plan Approved Health-related Location:

Select Mode of Transportation for Plan : Van

: Other, Describe Approved Health-related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 \$0.00 Indicate Minimum Copayment amount per trip:

Indicate Maximum Copayment amount per

\$0.00

Yes

No

Is authorization required?

No

Is a referral required for Transportation

Services?

Notes:

trip:

Services arranged by the plan's transportation

provider to approved locations by means of car, van, or wheelchair access vehicle that provide

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members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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Indicate Minimum Copayment amount per

\$0.00

item for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

item for Medicare-covered Benefits:

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

No

Durable Medical Equipment (DME)?

Is authorization required?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

: Medicare-covered Prosthetic Devices

have a Copayment (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per

\$0.00

item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per

\$0.00

item for Medicare-covered Prosthetic Devices:

Indicate Minimum Copayment amount per

\$0.00

\$0.00

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

item for Medicare-covered Medical Supplies:

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

Is authorization required?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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?

Select which Diabetic Supplies and Services

: Medicare-covered Diabetes Supplies

have a Copayment (Select all that apply):

: 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

\$0.00

item for Medicare-covered Diabetic

Therapeutic Shoes or Inserts:

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\$0.00

Yes

No

\$0.00 Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Do you limit Diabetic Supplies and Services to Yes those from specified manufacturers? Is authorization required? No **SECTION B: #12 DIALYSIS SERVICES - BASE 1** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? Yes Indicate Minimum Copayment amount per \$0.00 session for Medicare-covered Benefits: Indicate Maximum Copayment amount per \$0.00 session for Medicare-covered Benefits: SECTION B: #12 DIALYSIS SERVICES - BASE 2 Is authorization required? No Is a referral required for Dialysis Services? No **SECTION B: #13A ACUPUNCTURE - BASE 1** Does the plan provide Acupuncture as a Yes supplemental benefit under Part C? : Number of Treatments Select enhanced benefit: Select type of benefit for Number of Mandatory Treatments: Is this benefit unlimited for Number of No Treatments? 20 Indicate limit for Number of Treatments: Indicate Number of Treatments periodicity: Every year Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #13A ACUPUNCTURE - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? Yes \$0.00 Indicate Minimum Copayment amount per treatment:

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SECTION B: #13B OTC ITEMS - BASE 1

Is authorization required?

treatment:

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Indicate Maximum Copayment amount per

Is a referral required for Acupuncture?

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Yes

No

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

Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Are you offering Nicotine Replacement No Therapy (NRT) as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

So.00

Does this cover all of the OTC list which may

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

Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: The plan will provide \$0 copayment for adult

Yes

No

No

No

hospitilization

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

: Immediately following surgery or inpatient

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.

Select type of benefit for Meals: Mandatory

Select the type of primarily health related

meals benefit offered:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Jul-01-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

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

Indicate Minimum Copayment amount:

Is there an enrollee Coinsurance?

\$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 : I attest that there is no coinsurance, copayment,

Services Attestation 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 Yes

Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical Mandatory

Exam:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount for

\$0.00

each Annual Physical Exam:

Indicate Maximum Copayment amount for \$0.00

each Annual Physical Exam:

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

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

Exam?

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

measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and

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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

Yes

Supplemental Benefits as a benefit under Part

 \mathbb{C} ?

Select enhanced benefit (Select all that apply):

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c15: Wigs for Hair Loss Related to

Chemotherapy

: 14c21: In-Home Support Services*

Select type of benefit for Additional Sessions

of Smoking and Tobacco Cessation

Mandatory

Counseling:

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

Mandatory

Related to Chemotherapy:

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

Select type of benefit for In-Home Support

Mandatory

Services:

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

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c15: Wigs for Hair Loss Related to

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Benefits have a Maximum Plan Benefit Chemotherapy

Coverage amount (Select all that apply):

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to

Chemotherapy:

Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Every year

500.00

Chemotherapy:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

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

No

Supplemental Benefits?

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:

In-Home Support Services Notes:*

Authorization is required for this service.

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-COV	VERED 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-COV	ERED PREVENTIVE SERVICES - BASE 2
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #14E OTHER MEDICARE-COV	ERED 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 \$0 Contrato Número
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome	\$0

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Visit:

Is authorization required for Medicare-covered

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

No

No

No

No

No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

Yes

No

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

Is there an enrollee Copayment?

Select which Medicare Part B Rx Drugs have a

Copayment (Select all that apply):

: Medicare Part B Chemotherapy/Radiation

: Other Medicare Part B Drugs \$0.00

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Maximum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for

other Medicare Part B Drugs:

Is there an enrollee Deductible?

Is Authorization Required?

Does the plan offer step therapy?

Does the benefit step from (select all that

\$0.00

\$0.00

\$0.00

No

Yes Yes

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

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

No

Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits:

: Oral Exams



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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: Select the Oral Exams periodicity: Every year Select type of benefit for Prophylaxis Mandatory (Cleaning): Is this benefit unlimited for Prophylaxis No, indicate number (Cleaning)? 2 Indicate number of visits for Prophylaxis (Cleaning): Select the Prophylaxis (Cleaning) periodicity: Every year **SECTION B: #16A PREVENTIVE DENTAL - BASE 2** Select type of benefit for Dental X-Rays: Mandatory No, indicate number Is this benefit unlimited for Dental X-Rays? Indicate number of visits for Dental X-Rays: Other, Describe Select the Dental X-Rays periodicity: Is there a service-specific Maximum Plan No Benefit Coverage amount? **SECTION B: #16A PREVENTIVE DENTAL - BASE 3** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? Yes Select which Preventive Dental Services have a : Oral Exams : Prophylaxis (Cleaning) Coinsurance (Select all that apply): : Dental X-Rays Is there a combination of services included in a No single cost per Office Visit? 0% Indicate Minimum Coinsurance percentage for Oral Exams: 0% Indicate Maximum Coinsurance percentage for Oral Exams: Indicate Minimum Coinsurance percentage for 0% Prophylaxis (Cleaning): Indicate Maximum Coinsurance percentage for 0% Prophylaxis (Cleaning): Indicate Minimum Coinsurance percentage for 0% Dental X-Rays: Indicate Maximum Coinsurance percentage for 0% Dental X-Rays: SECTION B: #16A PREVENTIVE DENTAL - BASE 4



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Is there an enrollee Deductible?

Is there an enrollee Copayment?

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No

No

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SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required? No
Is a referral required for Preventive Dental No

Services?

Dental X-Rays Notes: Dental X-Rays include bitewing x-rays up to 1

Yes

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?

tems as a supplemental benefit under Part C?

Select enhanced benefits: : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

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Surgery, Other Services

No, indicate number

No, indicate number

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic

Services?

Indicate number of visits for Diagnostic 1

Services:

Select the Diagnostic Services periodicity: Every three years

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative 2

Services:

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:

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:

Is this benefit unlimited for Prosthodontics, No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

5

Mandatory

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Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

2000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance? Yes

Select which Comprehensive Dental Services : Diagnostic Services

have a Coinsurance (Select all that apply): : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate Minimum Coinsurance percentage for

Diagnostic Services:

0%

Indicate Maximum Coinsurance percentage for

Diagnostic Services:

0%

Indicate Minimum Coinsurance percentage for

0%

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:

Indicate Maximum Coinsurance percentage for

0%

Periodontics:

Indicate Minimum Coinsurance percentage for

0%

Extractions:

0%

Indicate Maximum Coinsurance percentage for Extractions:

Indicate Minimum Coinsurance percentage for

MR

0%

Prosthodontics, Other Oral/Maxillofacial

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0%

Surgery, Other Services:

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

No Is there an enrollee Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

Select which Comprehensive Dental Services

have a Copayment (Select all that apply):

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

Medicare-covered Benefits:

: Medicare-covered Benefits

\$0.00

\$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes No

Is a referral required for Comprehensive Dental

Services?

Restorative services include fillings 0% up to 1 Restorative Services Notes:

per tooth every 3 years, crown 0% up to 1 per

tooth every 5 years.

Periodontics includes scaling and root planing Periodontics Notes:

(deep cleaning) per quadrant up to 1 per year.

Prosthodontics, Other Oral/Maxillofacial Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes: 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 Eve Exams as a supplemental benefit under Part C?

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Yes

: Routine Eye Exams

Mandatory

No, indicate number

Every year

No

1

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 : Medicare-covered Benefits

(Select all that apply): : Routine Eye Exams

Indicate Minimum Copayment amount for \$0.00 Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00 Medicare-covered Benefits:

Indicate Minimum Copayment amount for \$0.00

Routine Eye Exams:
Indicate Maximum Consyment amount for \$0.00

Indicate Maximum Copayment amount for \$0.00 Routine Eye Exams:

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits: : Contact lenses : Eyeglasses (lenses and frames)

Select type of benefit for Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses? Yes
Select type of benefit for Eyeglasses (lenses
Mandatory

and frames):

Is this benefit unlimited for Eyeglasses (lenses Yes

and frames)?
SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

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

type:
Do you offer a Combined Max Plan Benefit Yes

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit 900.00

Coverage amount: 900.00

Select the Combined Maximum Plan Benefit Every year Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

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

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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\$0.00

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

Select which Evewear Benefits have a : Medicare-covered Benefits

Copayment (Select all that apply): : Contact lenses

: Eyeglasses (lenses and frames)

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

\$0.00 Indicate Minimum Copayment amount for

Contact lenses:

Indicate Maximum Copayment amount for \$0.00

Contact lenses:

Indicate Minimum Copayment amount for \$0.00

Eyeglasses (lenses and frames):

Indicate Maximum Copayment amount for \$0.00

Eyeglasses (lenses and frames):

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?

Select enhanced benefits: . Routine Hearing Exams

Fitting/Evaluation for Hearing Aid

Yes

Mandatory

Select type of benefit for Routine Hearing

Exams:

Is this benefit unlimited for Routine Hearing No, indicate number

Exams?

Indicate number for Routine Hearing Exams: 1

Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

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

for Hearing Aid?

1 Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

No Is there an enrollee Deductible? No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?



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Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3 Is there an enrollee Copayment? Yes Select which Hearing Exam Benefits have a : Medicare-covered Benefits Copayment (Select all that apply): : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid \$0.00 Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for \$0.00 Medicare-covered Benefits: Indicate Minimum Copayment amount for \$0.00 Routine Hearing Exams: Indicate Maximum Copayment amount for \$0.00 Routine Hearing Exams: Indicate Minimum Copayment amount for \$0.00 Fitting/Evaluation for Hearing Aid: \$0.00 Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: No Is authorization required? Is a referral required for Hearing Exams? No **SECTION B: #18B HEARING AIDS - BASE 1** Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? Select enhanced benefits: : Hearing Aids (all types) Select type of benefit for Hearing Aids (all Mandatory types): Is this benefit unlimited for Hearing Aids (all No, indicate number types)? Indicate quantity for Hearing Aids (all types): Select Hearing Aids (all types) periodicity: Every year **SECTION B: #18B HEARING AIDS - BASE 2** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Per ear Amount apply per ear or for both ears combined? Select the Maximum Plan Benefit Coverage Plan-specified amount per period

No

SECTION B: #18B HEARING AIDS - BASE 3

Indicate Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

FUR

2000.00

Every year

type:

amount:

periodicity:

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No

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? Yes

\$0.00 Indicate Minimum Copayment amount per

Hearing Aid (all types):

Indicate Maximum Copayment amount per \$0.00

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 Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

Are you offering a VBID Hospice Benefit? No Yes

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

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

Value-Based Insurance Design Attestation

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: 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

Humana will offer all members access to digital Specify Other Program:

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?

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

Program Connectedness: Please check the way

that advance care plans and/or advance directives are connected from your program to No

No

: Electronic Health Records/Electronic Medical

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: Provider/Patient portals

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: Health Information Exchanges access points of care.

: 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 No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

2

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 3072

and receive Model benefits:

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

Is there a prerequisite for any additional

No

benefits for this package?

Select all the Non-Medicare-covered additional

: 13b: Over-the-Counter (OTC) Items

: 13d: Other 1 benefits offered in this package: : 13e: Other 2

: 13f: Other 3

: 14c: Other Defined Supplemental Benefits

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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 No

deductible?

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

MR

Every year

about:blank

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 nonmedical 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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50

Select Maximum Plan Benefit Coverage

periodicity:

amount:

Every month

Does vour 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?

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

: 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

MR



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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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Yes

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

D C. C

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

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?

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, nonmedical 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?

50

No

Yes

amount:

Select Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

periodicity:

Other, Describe

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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 perspend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

-MR

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

Modifications

Coverage amount (Select all that apply):

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

Indicate Maximum Plan Benefit Coverage

75

amount for Home and Bathroom Safety

Devices and Modifications:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

No

Supplemental Benefits?

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

Home and Bathroom Safety Devices and

\$50 loaded on a prepaid card every month to

Modifications Notes:*

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

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

Which disease states does this benefit apply?

: Congestive Heart Failure (CHF)

(Select all that apply):

: Dementia

: Other 1

: Other 2

Other 3

Other 4

Other 5

Other 1 Description:

Maligent Neoplasm

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No

Leukemia Other 2 Description:

Chronic Kidney Disease (CKD) & End Stage Other 3 Description:

Renal Disease (ESRD)

Hepatitis Other 4 Description: Other 5 Description: Pressure Ulcer

Does the enrollee need to have all diseases

selected to qualify?

Does the enrollee need to have a combination No of diseases selected to qualify? If yes, describe

in notes.

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

Is there a prerequisite for any additional No

benefits for this package?

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

Members who are home bound qualify for \$200 Notes:

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

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POSDE

unused.

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

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

Part C?

Mandatory Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

amount:

Indicate Maximum Plan Benefit Coverage

Select Maximum Plan Benefit Coverage

periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is 200.00

Every month

No

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No

No

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement

Therapy (NRT) as a Part C OTC benefit?

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 No

be found in Chapter 4 of the Medicare

Managed Care Manual?

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 Yes

Out-of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Lower

Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-3400.00

of-Pocket Cost Amount:

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

Yes

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No SECTION D: COMBINED BENEFITS - GENERAL

Do vou offer Combined Supplemental Benefits No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription Yes

drug (Part D) benefit?

Defined Standard Select the type of drug benefit:

: Standard Retail Describe the components of your pharmacy

Out-of-Network network (select all that apply): Standard Mail-Order

: Long-Term Care

OSDES

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

423,154. 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

30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

: Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply: Enter number of days for Out-of-Network

30

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

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

Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order

30

Cost Sharing 1-month supply:

Enter number of days for Standard Mail-Order

90

Cost Sharing 3-month supply:

: Long-Term Care Pharmacy - 1-month supply

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

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

No

31

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

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

No

SECTION RX: VBID - GENERAL

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

Model?

No

EMR



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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: trex

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 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.

Contrato Número

Organization Marketing Name: Humana

EMR

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:	НМО
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):	40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR
Service Area(s):	40320 - Hatillo, PR

40330 - Hormigueros, PR

40340 - Humacao, PR

40350 - Isabela, PR

Service Area(s):

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Service Area(s):

Service Area(s):

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



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

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 No Continuation Area?

Do you intend to participate in the PLATINO Yes program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible Is this D-SNP plan a Medicare zero-dollar cost No

sharing plan (this does not apply to Part D Services)?

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

SECTION A: SECTION A-3

Participating Pharmacy Website Address: https://www.humana.com/pharmacy/

Formulary Website Address: https://www.humana.com/pharmacy/prescription-

No

coverages/medicare-drug-list Physician Website Address:

https://finder.humana.com/finder/medical Customer Service Contact Phone Number for

(866)773-5959 Current Medicare Beneficiaries:

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 (800)681-3625 Beneficiaries:

Customer Service Contact Phone Number for (866)773-5959 Current Part D Medicare Beneficiaries:

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

Customer Service Contact Phone Number for (800)681-3625 Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

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

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:	e (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-A	CUTE DACE 4
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	A Jatur
Select type of benefit for Additional Days:	: Additional Days
Is this benefit unlimited for Additional Days?	Mandatory
SECTION B: #1A INPATIENT HOSPITAL-A	Yes
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

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

No

No

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care?

enrollee obtains care?

Is there an enrollee Coinsurance?

Does this plan's Additional Days cost sharing

vary by hospital(s) in which an enrollee obtains

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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

No

shares? (These are the total charges for all

services provided to the enrollee in the

inpatient facility.)

\$0.00

Indicate Copayment amount for the Medicarecovered stay:

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

Indicate the number of day intervals for

Zero (No Copayment per Day)

Additional Days:

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an

enrollee obtains care?

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

No

shares? (These are the total charges for all

services provided to the enrollee in the

inpatient facility.)

Indicate Copayment amount for the Medicare-

\$0.00

covered stay:

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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

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part

No

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Yes

Zero

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

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

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental No

benefit under Part C?

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance?

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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? Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):

Yes

: 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 \$0.00

Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:

Indicate Maximum Copayment amount per

service for Medicare-covered Cardiac Rehabilitation Services:

Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:

Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:

Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:

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

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

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

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

Is authorization required?

Yes

Is a referral required for Cardiac and

No

Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

\$0.00

Medicare-covered Benefits:

Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?

Yes

Select either Days or Hours within which

Hours

admission must occur for waiver:

Enter number of Days or Hours: Does the Emergency Services cost sharing

24 No

count towards any plan-level deductible?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Does the Urgently Needed Services cost

No

sharing count towards any plan-level

deductible?

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

Yes

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

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide

Emergency Coverage:

Mandatory

Select type of benefit for Worldwide Urgent Coverage:

Mandatory

Select type of benefit for Worldwide

Mandatory

Emergency Transportation: Is there a Maximum Plan Benefit Coverage

No

amount for Worldwide Emergency/Urgent

Coverage?

No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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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
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	: Worldwide Emergency Transportation \$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 HOSPITALIZA	TION - DAGE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #5 PARTIAL HOSPITALIZAT	TION - 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 SERVICE	S-RASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No Contrato Nún
Is there an enrollee Coinsurance?	No No
SECTION B: #6 HOME HEALTH SERVICE	
Is there an enrollee Deductible?	S - BASE 2

No

Yes



Is there an enrollee Deductible?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as No

a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Chiropractic Services

\$0.00

Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

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:

Indicate Maximum Copayment amount per \$0.00

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\$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 No

Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Individual Sessions have a Copayment (Select all that apply): : Medicare-covered Group Sessions

\$0.00

\$0.00

\$0.00

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for

Medicare-covered Group Sessions:

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

No

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 : Medicare-covered Podiatry Services Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

Select which Psychiatric Services have a : Medicare-covered Individual Sessions Copayment (Select all that apply): : Medicare-covered Group Sessions

\$0.00

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

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

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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 No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

\$0.00

Yes

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

Is authorization required? Yes Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

: 4b: Urgently Needed Services have Additional Telehealth Benefits available: : 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 \$0.00 visit for Medicare-covered Benefits:

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

No

Telehealth Services?

Is a referral required for Additional Telehealth

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment? Indicate Minimum Copayment amount for

Yes \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Select which Outpatient Diag Procs/Tests/Lab

: Medicare-covered Diagnostic Procedures/Tests

Services have a Copayment (Select all that apply):

: Medicare-covered Lab Services

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Lab Services:

\$0.00

Indicate Maximum Copayment amount for

Medicare-covered Lab Services:

If a member receives multiple services at the same location on the same day, does only the

Yes

maximum copay apply?

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

s authorization required?

Yes

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Is a referral required for Outpatient Diagnostic

Yes

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes : Medicare-covered Diagnostic Radiological

Select which Outpatient Diag/Therapeutic Rad

Services

Services have a Copayment (Select all that apply):

: Medicare-covered Therapeutic Radiological

Services : Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for

\$0.00

other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Copayment amount for

\$0.00

other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Therapeutic Radiological

Services:

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

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

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? SECTION B: #9B ASC SERVICES - BASE 2	No
Is there an enrollee Deductible?	NT.
Is there an enrollee Copayment?	No 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
10.0 #04=	

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

Is there a service-specific Maximum Enrollee No

Is a referral required for Ambulatory Surgical

Out-of-Pocket Cost?

Center Services?

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?

Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):

Yes
: Medicare-covered Individual Sessions

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

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

 \mathbb{C} ?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Ground Ambulance Services (Select all that apply): : Medicare-covered Air Ambulance Services

Indicate the Minimum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance Services:

Indicate Minimum Copayment amount for

Medicare-covered Air Ambulance Services:

\$0.00

\$0.00

\$0.00

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Indicate Maximum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

No

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No

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?

Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location Every year

Trips periodicity:

Select Type of Transportation for Plan One-way

Approved Health-related Location:

Select Mode of Transportation for Plan : Van

Approved Health-related Location: : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 \$0.00

trip:

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

Services?

Notes: Services arranged by the plan's transportation

> provider to approved locations by means of car, van, or wheelchair access vehicle that provide

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members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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\$0.00

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per
\$0.00

item for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

item for Medicare-covered Benefits:

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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 : Medicare-covered Prosthetic Devices have a Copayment (Select all that apply): : Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per \$0.00

item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Prosthetic Devices:

Indicate Minimum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No.

Out-of-Pocket Cost?

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 : Medicare-covered Diabetes Supplies

have a Copayment (Select all that apply): : Medicare-covered Diabetic Therapeutic Shoes

or Inserts

\$0.00

Indicate Minimum Copayment amount per \$0.00

item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per

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item for Medicare-covered Diabetes Supplies:

about:blank

Indicate Minimum Copayment amount per item for Medicare-covered Diabetic	\$0.00	
Therapeutic Shoes or Inserts:		
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	\$0.00	
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes	
Is authorization required?	No	
SECTION B: #12 DIALYSIS SERVICES - I	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 - B	ASE 2	
Is authorization required?	No	
Is a referral required for Dialysis Services?	No	
SECTION B: #13A ACUPUNCTURE - BASE	7 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	Mandatory	
Treatments:	wandatory	
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	No	
Benefit Coverage amount?	140	
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?	- · •	
Is there an enrollee Copayment?	No Voc	
Indicate Minimum Copayment amount per	Yes	
treatment:	\$0.00	

\$0.00

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Indicate Maximum Copayment amount per

treatment:

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?

Select type of benefit for OTC Items: Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

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

Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Mandatory

No

No

No

No No Yes

\$0.00 \$0.00

No

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.

Select type of benefit for Meals:

Select the type of primarily health related meals benefit offered:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

Yes

: Immediately following surgery or inpatient hospitilization

No

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: Indicate Maximum Copayment amount:

\$0.00 \$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?

Is a referral required?

No No

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

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical

Exam:

Mandatory

Is there a service-specific 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? Is there an enrollee Copayment?

No Yes

Indicate Minimum Copayment amount for

\$0.00

each Annual Physical Exam:

\$0.00

Indicate Maximum Copayment amount for each Annual Physical Exam:

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

Is authorization required?

No

Is a referral required for the Annual Physical

No

Exam?

Notes:

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

Exam will include the following: 1. Bodily

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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

Yes

Supplemental Benefits as a benefit under Part

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:

Indicate type of Fitness Benefit offered (Select all that apply):

Mandatory

: 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

Mandatory

Services:

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

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

: 14c15: Wigs for Hair Loss Related to

Chemotherapy

Coverage amount (Select all that apply):

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

about:blank 8/5/2022 Chemotherapy:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

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

No

Supplemental Benefits?

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

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No

Out-of-Pocket Cost?

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?	N	
	Is a referral required for Kidney Disease	No	
	Education Services?	No	
	SECTION B: #14E OTHER MEDICARE- Is there a service-specific Maximum Enrolled	OVERED PREVENTIVE SERVICES	
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No	BASE 1
	SECTION B: #14E OTHER MEDICARE-O	OVEDED DREVENORS	
	Is there an enrollee Coinsurance?	No	BASE 2
	Is there an enrollee Deductible?	No	
	SECTION B: #14E OTHER MEDICARE-O	OVEDED DDEVENOVER CO.	
	copayment;	Yes	BASE 3
	Select which Services have a Congarment		
	(Select all that apply):	: Medicare-covered Glaucoma Screening : Medicare-covered Diabetes Self-Manag	3
		Training	gement
		: Medicare-covered Barium Enemas	
		: Medicare-covered Digital Rectal Exam:	S
	T. P Sm .	: Medicare-covered EKG following Weld Visit	come
	Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0	
	Indicate Maximum Congress amount for	\$0	
	Medicare-covered Glaucoma Screening:		
	Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0	
	Indicate Maximum Consyment amount for	\$0	
	Training:	Ψ	
	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	C/0
	Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0 \$0 Contrate 1	ON ON
	Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0	0 0 1
)	Indicate Maximum Copayment amount for	\$0	DESP

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Medicare-covered EKG following Welcome

Visit:

Is authorization required for Medicare-covered No

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?

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

No

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?

Is there an enrollee Coinsurance?

No

No

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

Is there an enrollee Copayment?

Select which Medicare Part B Rx Drugs have a

Copayment (Select all that apply):

: Medicare Part B Chemotherapy/Radiation

: Other Medicare Part B Drugs

\$0.00

\$0.00

\$0.00

\$0.00

No

Yes

No

Yes

Yes

Indicate Minimum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Maximum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for

other Medicare Part B Drugs:

Is there an enrollee Deductible?

Is Authorization Required?

Does the plan offer step therapy?

Does the benefit step from (select all that apply):

Yes

: 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?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

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as a supplemental benefit under Part C?

about:blank



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Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning)
Select type of benefit for Oral Exams:	: Dental X-Rays
Is this benefit unlimited for Oral Exams?	Mandatory
Indicate number of visits for Oral Exams:	No, indicate number
Select the Oral Exams periodicity:	2
Select type of benefit for Prophylaxis (Cleaning):	Every year 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 DENTA	L. RASE 2
Select type of benefit for Dental X-Rays:	
Is this benefit unlimited for Dental X-Rays?	Mandatory
Indicate number of visits for Dental X-Rays:	No, indicate number
Select the Dental X-Rays periodicity:	
Is there a service-specific Maximum Plan	Other, Describe No
Benefit Coverage amount?	-
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	: Oral Exams
Coinsurance (Select all that apply):	: Prophylaxis (Cleaning)
In them 1:	: 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 -	RASE A
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

No

Services?

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:

Is this benefit unlimited for Diagnostic

Services?

Mandatory

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:

Is this benefit unlimited for Restorative

Mandatory

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:

Select the Periodontics periodicity:

Every year

Select type of benefit for Extractions: Is this benefit unlimited for Extractions?

Mandatory

Yes

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

No, indicate number

Services?

Indicate number of visits for Prosthodontics,

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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?

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

0%

Restorative Services:

0%

Indicate Maximum Coinsurance percentage for Restorative Services:

0%

Indicate Minimum Coinsurance percentage for **Endodontics:**

Indicate Maximum Coinsurance percentage for

0%

Endodontics:

0%

Indicate Minimum Coinsurance percentage for Periodontics:

0%

Indicate Maximum Coinsurance percentage for Periodontics:

0%

Indicate Minimum Coinsurance percentage for Extractions:

Indicate Maximum Coinsurance percentage for Extractions:

0%

Indicate Minimum Coinsurance percentage for

0%

EMR



Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is there an enrollee Deductible?

No

0%

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?

Restorative Services Notes:

No

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:

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

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

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, 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?

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Is there a service-specific Maximum Plan

SMR

Yes

: Routine Eye Exams

Mandatory

No, indicate number

1

Every year

No



В	enetit	Coverage	amount?	
т	4.1			

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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):

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Eye Exams:

Indicate Maximum Copayment amount for

Routine Eye Exams:

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Select type of benefit for Eyeglasses (lenses and frames):

Is this benefit unlimited for Eyeglasses (lenses and frames)?

SECTION B: #17B EYEWEAR - BASE 3

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

Select the Maximum Plan Benefit Coverage type:

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit Coverage amount:

Select the Combined Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

No

: Medicare-covered Benefits

: Routine Eye Exams

\$0.00

\$0.00

\$0.00

\$0.00

No

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Yes

Mandatory

Yes

Yes

Plan-specified amount per period

Yes

900.00

Every year

No

MR



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 : Medicare-covered Benefits

Copayment (Select all that apply): : Contact lenses

: Eyeglasses (lenses and frames)

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Indicate Minimum Copayment amount for \$0.00

Contact lenses:

Indicate Maximum Copayment amount for \$0.00

Contact lenses:

Indicate Minimum Copayment amount for \$0.00

Eveglasses (lenses and frames):

Indicate Maximum Copayment amount for \$0.00

Eyeglasses (lenses and frames):

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No

Is a referral required for Eyewear?

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Yes

1

No

Mandatory

No, indicate number

Select type of benefit for Routine Hearing

Exams:

Is this benefit unlimited for Routine Hearing No, indicate number

Exams?

Indicate number for Routine Hearing Exams:

1

Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

EMR

Is there a service-specific Maximum Plan

Benefit Coverage amount?



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

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?

Select which Hearing Exam Benefits have a : Medicare-covered Benefits Copayment (Select all that apply): : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

No

No, indicate number

Plan-specified amount per period

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Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits: Indicate Minimum Copayment amount for \$0.00

Routine Hearing Exams:

Indicate Maximum Copayment amount for \$0.00

Routine Hearing Exams: Indicate Minimum Copayment amount for \$0.00

Fitting/Evaluation for Hearing Aid: Indicate Maximum Copayment amount for \$0.00

Fitting/Evaluation for Hearing Aid: Is authorization required? No

SECTION B: #18B HEARING AIDS - BASE 1

Is a referral required for Hearing Exams?

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

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all Mandatory types):

Is this benefit unlimited for Hearing Aids (all types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

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

Does the Maximum Plan Benefit Coverage

combined?

Per ear Amount apply per ear or for both ears

Select the Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage 2000.00 amount:

Indicate Maximum Plan Benefit Coverage Every year

periodicity:

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SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? Yes

Indicate Minimum Copayment amount per \$0.00

Hearing Aid (all types):

Indicate Maximum Copayment amount per \$0.00

Hearing Aid (all types):

Is there an enrollee Deductible?

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 No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

Yes

No

Yes

Select what type of benefit your SSBCI

includes:

Additional Benefits

Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness 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): Ann

: 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.

Records

: Provider/Patient portals : Health Information Exchanges

: Electronic Health Records/Electronic Medical

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

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 4320 Expected Number of Enrollees to be engaged 4320

and receive Model benefits:

Select LIS reduction level:

4320

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

Is there a prerequisite for any additional

No

benefits for this package?

Select all the Non-Medicare-covered additional

: 13b: Over-the-Counter (OTC) Items

benefits offered in this package:

: 13d: Other 1 : 13e: Other 2

: 13f: Other 3

: 14c: Other Defined Supplemental Ben

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

SMR

No

deductible?

about:blank

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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?

900

Yes

Specify the maximum benefit amount:

Select the package level maximum coverage

periodicity:

Every year

Select the Non-Medicare-covered benefits that

: 13b: Over-the-Counter (OTC) Items apply to the package level maximum coverage: : 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 nonmedical 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:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

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

Yes

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Yes

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

Nicotine Replacement Therapy (NRT)

Attestation:

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

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POSDE

or formulary drugs.

SMR

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

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

be found in Chapter 4 of the Medicare

Managed Care Manual?

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

Notes: \$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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 75

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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.

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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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 75

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

s there a service-specific Maximum

Sur R

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Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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, nonmedical 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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

periodicity.

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Other, Describe

75

No

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

Is there an enrollee Coinsurance?

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

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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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POSDE

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

Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

Coverage amount (Select all that apply):

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

75

Indicate Maximum Plan Benefit Coverage

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**

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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 No

Supplemental Benefits?

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

Home and Bathroom Safety Devices and \$75 loaded on a prepaid card every month to

spend on bathroom safety devices and Modifications Notes:*

equipment.

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

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

To which chronic condition does this benefit

: Chronic alcohol and other drug dependence

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pply? (Select all that apply):

: 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

: 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

Select all the Non-Medicare-covered additional

deductible?

benefits offered in this package:

No

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

Is there a package level maximum coverage

No

amount?

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.

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?

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

Yes

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-: Taxi Medical Need for Plan-approved Location: : Van

: Medical Transport

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

Is there a service-specific Maximum Plan

Benefit Coverage amount?

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**

No Is there an enrollee Copayment? 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

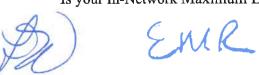
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Yes

Out-of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Lower



about:blank



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Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-

of-Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Medicare-covered plan services?

: In-Network Medicare-covered benefits

Yes

3400.00

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? **SECTION D: COMBINED BENEFITS - GENERAL**

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit: Defined Standard : Standard Retail

Describe the components of your pharmacy

network (select all that apply):

: 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 : Standard Retail Cost Sharing - 1 month Supply Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

90

30

Sharing 3-month supply: 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:

Enter number of days for Standard Mail-Order

Cost Sharing 1-month supply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

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

30

90

SMR

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about:blank

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:

00/01/00

MA BPT Timestamp: PD BPT Timestamp:

08/01/2022 02:35:55 PM Eastern Daylight Time 08/03/2022 03:42:17 PM Eastern Daylight Time

Last Upload File Creation Timestamp:

07/30/2022 06:36:34 AM Eastern Daylight Time 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 Completed

Section B3 Status Section B4 Status

Completed

Section B5 Status Section B6 Status

Completed
Completed

Section B7 Status Section B8 Status Completed Completed

Section B9 Status Section B10 Status Section B11 Status

Completed Completed Completed

Section B13 Status
Section B14 Status

Section B12 Status

Completed Completed

Section B15 Status Section B16 Status

Completed Completed

Section B17 Status Section B18 Status Section B19 Status

Completed Completed

Section C Status Section D Status Completed Completed

Section Mrx Status

Completed Completed

SECTION A: SECTION A-1 Organization Legal Name:

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization Marketing Name:

MR

Humana

Organization Web Site:

www.humana.com/medicare

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Pla	n N	am	e:
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Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

Service Area(s): Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

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Service Area(s):

Service Area(s):

MR

Humana Gold Plus SNP-DE H4007-019 (HMO

D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

40330 - Hormigueros, PR

40340 - Humacao, PR

40350 - Isabela, PR



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

Plan ID:	H4007
Segment ID:	019
Contract Period:	0
Plan Geographic Name	2023
Tan Geographic Name.	_

Plan Geographic Name: Puerto Rico Island Wide Is this an Employer-Only plan?

SECTION A: SECTION A-2

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

Do you intend to participate in the PLATINO program?

Is this a Special Needs Plan? Special Needs Plan Type:

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

Services)?

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

SECTION A: SECTION A-3

Participating Pharmacy Website Address:

Formulary Website Address:

Physician Website Address: Customer Service Contact Phone Number for Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:

Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:

Customer Service Contact TTY for Current

SMR

No

Yes

Yes

Dual-Eligible

No

No

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

https://www.humana.com/pharmacy/prescriptioncoverages/medicare-drug-list

https://finder.humana.com/finder/medical

(866)773-5959

(866)773-5959

(800)681-3625

(800)681-3625

(866)773-5959

(866)773-5959

(800)681-3625

(800)681-3625

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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
CECTION D. 41 A INDATED TO COLUMN	ACTION

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

Does the plan provide Inpatient Hospital-Acute Yes Services as a supplemental benefit under Part C?

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 No

Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost No

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

Is there an enrollee Coinsurance?

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

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains

care?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment? Yes

Do you charge the Medicare-defined cost No

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

inpatient facility.)

Indicate Copayment amount for the Medicare- \$0.00

covered stay:

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

No

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

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

Additional Days:

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay

period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost No

sharing vary by hospital(s) in which an

enrollee obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

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

SMR

inpatient facility.)

Indicate Copayment amount for the Medicare- \$0.00

covered stay:

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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

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part

No

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Yes

Zero

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

No

which an enrollee obtains care? 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

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

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Copayment? ac and Pulmonary ices have a Copayment y): : 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 copayment amount per \$0.00 covered Cardiac ces:
Copayment amount per \$0.00 -covered Cardiac ees:
opayment amount per \$0.00 -covered Intensive Cardiac es:
opayment amount per \$0.00 covered Intensive Cardiac es:
opayment amount per \$0.00 covered Pulmonary
opayment amount per \$0.00 covered Pulmonary
payment amount per \$0.00 covered Supervised (a) for Symptomatic asse (PAD) Services:
payment amount per \$0.00 overed Supervised T) for Symptomatic ase (PAD) Services:
DIAC AND PULMONARY REHABILITATION CHARLES
Y AC
r Cardiac and No on Services?
ERGENCY SERVICES DAGE 1
ic Maximum Enrollee No
covered Intensive Cardiac es: opayment amount per \$0.00 covered Intensive Cardiac es: opayment amount per \$0.00 covered Pulmonary es: opayment amount per \$0.00 covered Pulmonary es: opayment amount per \$0.00 covered Supervised I) for Symptomatic ase (PAD) Services: payment amount per \$0.00 overed Supervised I) for Symptomatic ase (PAD) Services: payment amount per \$0.00 overed Supervised I) for Symptomatic ase (PAD) Services: covered Supervised I) for Symptomatic ase (PAD) Services: covered Supervised I) for Symptomatic ase (PAD) Services: covered Supervised II for Symptomatic ase (PAD) Services: covered Supe

No

Yes

\$0.00

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Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount for

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SECTION B: #4A EMERGENCY SERVICES - BASE 2

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Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?

Yes

Select either Days or Hours within which

Hours

admission must occur for waiver:

24

Enter number of Days or Hours:

No

Does the Emergency Services cost sharing count towards any plan-level deductible?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Does the Urgently Needed Services cost

No

sharing count towards any plan-level

deductible?

Is the Copayment for Medicare-covered

No

Benefits waived if admitted to hospital?

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide

Emergency 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

No

Coverage?

Is there a service-specific Maximum Enrollee

SMR

No

Out-of-Pocket Cost?

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
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	: Worldwide Emergency Transportation \$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?	
SECTION B: #5 PARTIAL HOSPITALIZA	No
is there a service-specific Maximum Enrolled	No
Out-of-rocket Cost?	140
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #5 PARTIAL HOSPITALIZAT	TION - BASE 2
is there all emotiee 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	S_DACE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No No No PASE 2 Contrato No
Is there an enrollee Coinsurance?	No OHIM
SECTION B: #6 HOME HEALTH SERVICES	S - BASE 2 Contrato Nó
Is there an enrollee Deductible?	O DASE 2
Is there an enrollee Copayment?	110
)	Yes

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Indicate Minimum Copayment amount per

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Is a referral required for Home Health

Services?

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

\$0.00

Yes

No

\$0.00

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

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Indicate Maximum Copayment amount per \$0.00 Contrato Número 0 0

visit for Medicare-covered Benefits:

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

Is authorization required?

Yes

Is a referral required for Occupational Therapy

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Indicate Minimum Copayment amount per

Yes

visit for Medicare-covered Benefits:

\$0.00

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

\$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Group Sessions:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

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

Is authorization required?

No

Is a referral required for Mental Health

No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

No

supplemental benefit under Part C?

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 : Medicare-covered Podiatry Services

Select which Podiatry Services have a

Copayment (Select all that apply):

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: #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

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Other Health Care

No

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Select which Psychiatric Services have a

: Medicare-covered Individual Sessions

Copayment (Select all that apply):

: Medicare-covered Group Sessions

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

\$0.00

Indicate Minimum Copayment amount for

Medicare-covered Group Sessions:

\$0.00

Indicate Maximum Copayment amount for

\$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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

Is authorization required?

Yes

Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

Yes

for Part B services?

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? Is there an enrollee Deductible?

No 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:

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

Is authorization required for Additional

No

Telehealth Services?

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

No

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

: Medicare-covered Diagnostic Procedures/Tests

apply):

: Medicare-covered Lab Services

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Lab Services:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Lab Services:

If a member receives multiple services at the same location on the same day, does only the

SMR

Yes

maximum copay apply?

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?

Is there an enrollee Coinsurance?

No

No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that

apply):

No Yes

: Medicare-covered Diagnostic Radiological

Services

: Medicare-covered Therapeutic Radiological

Services

: Medicare-covered X-Ray Services \$0.00

Indicate Minimum Copayment amount for other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic

Radiological Services (e.g., ČT, MRI, etc):

Indicate Minimum Copayment amount for

Medicare-covered Therapeutic Radiological Services:

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum Copayment amount for

Medicare-covered X-Ray Services: Indicate Maximum Copayment amount for

Medicare-covered X-Ray Services:

If a member receives multiple services at the same location on the same day, does only the

maximum copay apply?

\$0.00

\$0.00

\$0.00

\$0.00

\$0.00

Yes

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

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Yes

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Select which Services have a Copayment (Select all that apply): Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	: Medicare-covered Outpatient Hospital Services : Medicare-covered Observation 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?

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

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OUROS DE Select which Outpatient Substance Abuse Medicare-covered Individual Sessions services have a Copayment (Select all that : Medicare-covered Group Sessions

apply):

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Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

Is authorization required?

No
Is a referral required for Outpatient Substance

No

Abuse?

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

Does the plan provide Outpatient Blood Yes Services as a supplemental benefit under Part

 \mathbb{C} ?

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

No

No

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

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

\$0.00

\$0.00

Indicate the Minimum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

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Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved

Mandatory

Health-related Location:

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

: Van

Approved Health-related Location:

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

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

\$0.00

trin

Is authorization required?

Yes

Is a referral required for Transportation

Ma

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

EMR

No

Out-of-Pocket Cost?

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

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

Indicate Maximum Copayment amount per

item for Medicare-covered Benefits:

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required?

Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

\$0.00

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 : Medicare-covered Prosthetic Devices have a Copayment (Select all that apply):

: Medicare-covered Medical Supplies Indicate Minimum Copayment amount per \$0.00

item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Prosthetic Devices:

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

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

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

Is authorization required?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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?

Select which Diabetic Supplies and Services

have a Copayment (Select all that apply):

Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:

: Medicare-covered Diabetes Supplies

: Medicare-covered Diabetic Therapeutic Shoes

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or Inserts

\$0.00

\$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 - B	RASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Ma
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per	Yes
session for Medicare-covered Benefits:	\$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	\$0.00
SECTION B: #12 DIALYSIS SERVICES - BA	ACE 2
Is authorization required?	
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE	No
Does the plan provide Acupuncture as a	
supplemental benefit under Part C?	Yes
Select enhanced benefit:	· No1 cm
Select type of benefit for Number of	: Number of Treatments
Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	20
Indicate Number of Treatments periodicity:	20
Is there a service-specific Maximum Plan	Every year
Benefit Coverage amount?	No
Is there a service-specific Maximum Enrolled	No
out-or-rocket Cost?	
SECTION B: #13A ACUPUNCTURE - BASE 2	2
Is there an enrollee Coinsurance?	No
Is there an enrolled Dad will a	410

No

Yes

\$0.00

\$0.00

treatment: about:blank

treatment:

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount per

Indicate Maximum Copayment amount per

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Is authorization required? Is a referral required for Acupuncture?

Yes

No

Yes

No

No

No

No

\$0.00

\$0.00

No

Yes

Mandatory

hospitilization

Mandatory

SECTION B: #13B OTC ITEMS - BASE 1

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

Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No Is there an enrollee Copayment? Yes

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

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

Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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

: Immediately following surgery or inpatient

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for Meals:

Select the type of primarily health related

meals benefit offered:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance? No

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

Indicate Minimum Copayment amount:

\$0.00

No

No



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?

Is a referral required?

No

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

Mandatory

Exam:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

\$0.00

each Annual Physical Exam:

Indicate Maximum Copayment amount for

\$0.00

each Annual Physical Exam:

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

Is authorization required?

No

Is a referral required for the Annual Physical

Exam? Notes:

No

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

Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and

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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

Yes

Supplemental Benefits as a benefit under Part

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*

Mandatory

Select type of benefit for Additional Sessions

of Smoking and Tobacco Cessation

Counseling:

4

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness

all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4 No

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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?

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

Is there an enrollee Coinsurance?

No

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

No

Supplemental Benefits?

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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0.0

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?

Is there an enrollee Coinsurance?

No

No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Is authorization required?

No

Is a referral required for Kidney Disease

No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1 No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-

covered Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

Select which Services have a Copayment

(Select all that apply):

: Medicare-covered Glaucoma Screening

: Medicare-covered Diabetes Self-Management

Training

: Medicare-covered Barium Enemas

: Medicare-covered Digital Rectal Exams

: Medicare-covered EKG following Welcome

Visit

Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:

Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for

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\$0

\$0

\$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?		
Is a referral required for any Services?	No	
SECTION B: #15 MEDICARE PART B RX D	DIGG DIGG	
Is there a Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	Ma	
SECTION B: #15 MEDICARE PART B RX DI	No	
Is there an enrollee Copayment?		
Select which Medicare Part B Rx Drugs have a	Yes	
Copayment (Select all that apply):	: Medicare Part B Chemotherapy/Radiation Drugs	
Indicate Minimum Copayment Amount for	: Other Medicare Part B Drugs	
Medicare Part B Chemotherapy/Radiation	\$0.00	
Drugs:	INISTRACIO.	

\$0.00

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Drugs:

Indicate Maximum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

PUROSDE

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

\$0.00

Indicate Maximum Copayment Amount for

\$0.00

other Medicare Part B Drugs:

No

Is there an enrollee Deductible? Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

No

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Oral Exams

: Prophylaxis (Cleaning)

: Dental X-Rays

Select type of benefit for Oral Exams:

Is this benefit unlimited for Oral Exams?

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Select type of benefit for Prophylaxis

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Indicate number of visits for Prophylaxis

No, indicate number 2

Mandatory

Every year

Mandatory

No, indicate number

2 (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

SECTION B: #16A PREVENTIVE DENTAL - BASE 2 Select type of benefit for Dental X-Rays:

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Every year

Mandatory

No, indicate number

Other, Describe

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?

Select which Preventive Dental Services have a

Coinsurance (Select all that apply):

Yes

: 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	- RASE A
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
SECTION B: #16B COMPREHENSIVE DENT	

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Diagnostic Services:

Is this benefit unlimited for Diagnostic

Services?

Indicate number of visits for Diagnostic

Services:

Select the Diagnostic Services periodicity:

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative Services?

Indicate number of visits for Restorative

Services:

Mandatory

No, indicate number

Every three years

Mandatory

No, indicate number

2

1



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

No, indicate number

Indicate number of visits for Periodontics:

Select the Periodontics periodicity:

Every year

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

5

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

Other, Describe

Plan-specified amount per period

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage

2500.00

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

0%

Diagnostic Services:

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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 DENT	TAT 1	ľ

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

Select which Comprehensive Dental Services

have a Copayment (Select all that apply):

: Medicare-covered Benefits

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes No

Is a referral required for Comprehensive Dental

Services?

Restorative Services Notes:

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

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services include adjustments to dentures up to unlimited per year, implant services up to 1 per tooth per lifetime, implant

supported prosthetics (abutment crown) up to 1

Periodontics Notes:

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



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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?

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Select which Eye Exams have a Copayment (Select all that apply):

Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

Medicare-covered Benefits:

Indicate Minimum Copayment amount for

Routine Eye Exams:

Indicate Maximum Copayment amount for

Routine Eye Exams:

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Yes

: Routine Eye Exams

Mandatory

No, indicate number

1

Every year

No

No

No

Yes

: Medicare-covered Benefits

: Routine Eye Exams

\$0.00

\$0.00

\$0.00

\$0.00

No

No

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

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	110
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 : Eveglasses (lenses and forms)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	: Eyeglasses (lenses and frames) \$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 EDANISTRACION DE
SECTION B: #17B EYEWEAR - BASE 6	Contrato Número
Is authorization required?	No (23 - 001)
Is a referral required for Eyewear?	(4)
SECTION B: #18A HEARING EXAMS - BASI	No E1
Does the plan provide Hearing Exams as a	Vos.
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:	
Select type of benefit for Fitting/Evaluation for	Every year
Hearing Aid:	•
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 - BA	ASE 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 - BA	SF 2
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	: Medicare-covered Benefits : Routine Hearing Exams
Indicate Minimum Copayment amount for	: Fitting/Evaluation for Hearing Aid
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 \$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	\$0.00 Contrato Número
Is authorization required?	No (23 - 001)
Is a referral required for Hearing Exams?	No.
SECTION B: #18B HEARING AIDS - BASE 1	Yes Yes
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes Yes
Select enhanced benefits:	: Hearing Aids (all trees)
Select type of benefit for Hearing Aids (all	: Hearing Aids (all types) Mandatory

types):

Is this benefit unlimited for Hearing Aids (all

types)?

No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

2

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):

Indicate Maximum Copayment amount per \$0.00

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

No

No

Do you offer Special Supplemental Benefits for the Chronically Ill?

Are you offering a VBID Hospice Benefit? Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

No Yes

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

- MR

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?

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

No

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?

How many packages do your Additional

Benefits contain? (1-15)

1

Yes

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

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

No

benefits for this package?

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

No

deductible?

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 : 13b: Over-the-Counter (OTC) Items

apply to the package level maximum coverage: : 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?

Select type of benefit for OTC Items:

FMR

Yes

Mandatory

about:blank

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Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

75

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Does vour 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

Yes

Benefit Coverage amount?

75

Indicate Maximum Plan Benefit Coverage

Select Maximum Plan Benefit Coverage

periodicity:

amount:

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



about:blank

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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage amount:

75

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

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? Is there an enrollee Deductible?

No

No No

Is there an enrollee Copayment?

No

Is authorization required?

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, nonmedical 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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

75

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

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

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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 Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c8: Home and Bathroom Safety Devices and

Modifications*

Mandatory

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

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

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit Modifications

Coverage amount (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS

BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage 75

amount for Home and Bathroom Safety

Devices and Modifications:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS

BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

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?

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Is a referral required for Other Defined

No

Supplemental Benefits?

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

Lower

Is your In-Network Maximum Enrollee Out-of-

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:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

: In-Network Medicare-covered benefits

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Yes

1

Yes

Select the number of Combined Supplemental

Benefit packages you are offering?

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?

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

500

No

Max Plan Benefit Amount:

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:

Describe the components of your pharmacy

network (select all that apply):

Defined Standard : 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

No

program?

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

: Out-of-Network Pharmacy - one month supply

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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:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

30

about:blank

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

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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 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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Humana Gold Plus SNP-DE H4007-022 (HMO Plan Name: D-SNP) Local CCP Organization Type: **HMO** Plan Type: Part A and Part B Enrollee Type: 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 - Barranguitas, PR Service Area(s): 40110 - Bayamon, PR Service Area(s): 40120 - Cabo Rojo, PR Service Area(s): Service Area(s): 40130 - Caguas, PR Service Area(s): 40140 - Camuy, PR 40145 - Canovanas, PR Service Area(s): 40150 - Carolina, PR Service Area(s): 40160 - Catano, PR Service Area(s): Service Area(s): 40170 - Cayey, PR 40180 - Ceiba, PR Service Area(s): 40190 - Ciales, PR Service Area(s): Service Area(s): 40200 - Cidra, PR 40210 - Coamo, PR Service Area(s): Service Area(s): 40220 - Comerio, PR Service Area(s): 40230 - Corozal, PR 40240 - Culebra, PR Service Area(s): 40250 - Dorado, PR Service Area(s): 40260 - Fajardo, PR Service Area(s): Service Area(s): 40265 - Florida, PR Contrato Número 40270 - Guanica, PR Service Area(s): 40280 - Guayama, PR Service Area(s): 40290 - Guayanilla, PR Service Area(s): 40300 - Guaynabo, PR Service Area(s): ROSD 40310 - Gurabo, PR Service Area(s): 40320 - Hatillo, PR Service Area(s):

> 40330 - Hormigueros, PR 40340 - Humacao, PR

40350 - Isabela, PR

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

40730 - Vega Baja, PR

40740 - Vieques, PR

40750 - Villalba, PR

40760 - Yabucoa, PR

40770 - Yauco, PR



Contract Number:

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H4007 022 Plan ID: Segment ID: 2023 Contract Period: Puerto Rico Island Wide Plan Geographic Name: Is this an Employer-Only plan? **SECTION A: SECTION A-2** Does this Plan have a CMS-approved No Continuation Area? Do you intend to participate in the PLATINO Yes program? Is this a Special Needs Plan? Yes Dual-Eligible Special Needs Plan Type: 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? **SECTION A: SECTION A-3** Participating Pharmacy Website Address: https://www.humana.com/pharmacy/ https://www.humana.com/pharmacy/prescription-Formulary Website Address: coverages/medicare-drug-list https://finder.humana.com/finder/medical Physician Website Address: Customer Service Contact Phone Number for (866)773-5959 Current Medicare Beneficiaries: Customer Service Contact Local Phone (866)773-5959 Number for Current Medicare Beneficiaries: Customer Service Contact Phone Number for (800)681-3625 Prospective Medicare Beneficiaries: Customer Service Contact Local Phone (800)681-3625 Number for Prospective Medicare Beneficiaries: Customer Service Contact Phone Number for (866)773-5959 Current Part D Medicare Beneficiaries: Customer Service Contact Local Phone (866)773-5959 Number for Current Part D Medicare Beneficiaries: Customer Service Contact Phone Number for (800)681-3625 Prospective Part D Medicare Beneficiaries: **SECTION A: SECTION A-4** Customer Service Contact Local Phone (800)681-3625 Number for Prospective Part D Medicare Beneficiaries: 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-A	CUTE - 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-A	CUTE - 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-A	CUTE - BASE 5
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No



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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes No

Do you charge the Medicare-defined cost

shares? (These are the total charges for all

services provided to the enrollee in the

inpatient facility.)

Indicate Copayment amount for the Medicare-

\$0.00

covered stay:

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

Indicate the number of day intervals for

Zero (No Copayment per Day)

Additional Days:

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an

enrollee obtains care?

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 No

Do you charge the Medicare-defined cost

shares? (These are the total charges for all

services provided to the enrollee in the

inpatient facility.)

Indicate Copayment amount for the Medicarecovered 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

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

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

No

which an enrollee obtains care? 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

No

Rehabilitation Services as a supplemental

MR

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Deductible?

No

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Is there an enrollee Copayment? Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	Yes : 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
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	Disease (PAD) 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 PULMONAL	RY REHABILITATION SERVICES
Is authorization required?	Yes Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

Pulmonary Rehabilitation Services? SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

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

\$0.00

Medicare-covered Benefits:

Is the Copayment for Medicare-covered

Yes

Benefits waived if admitted to hospital?

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Does the Urgently Needed Services cost

No

sharing count towards any plan-level

deductible?

Is the Copayment for Medicare-covered

No

Benefits waived if admitted to hospital?

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide

Emergency Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Select type of benefit for Worldwide

Emergency Transportation:

Mandatory

No

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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Is there an enrollee Copayment?	W.
Select which Worldwide Services have a	Yes
Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	: Worldwide Emergency Transportation \$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
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?	_
SECTION B: #5 PARTIAL HOGBER	No
SECTION B: #5 PARTIAL HOSPITALIZAT	FION - 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 HOSPITALIZAT	No
Is there an enrollee Copayment?	
Indicate Minimum Copayment amount for	Yes
rredicare-covered Benefits per day:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:	\$0.00
Is authorization required?	Vac
Is a referral required for Partial Hospitalization?	Yes No
SECTION D. 4CHOLES	

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health

No

No

Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No Is there an enrollee Deductible? No

Is there an enrollee Copayment? Indicate Minimum Copayment amount per

Yes \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

No

No

a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

\$0.00

Medicare-covered Benefits:

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

\$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for

\$0.00

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:

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

Is authorization required?

No

Is a referral required for Mental Health

No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

No

supplemental benefit under Part C?

No

Is there a service-specific Maximum Enrollee MR

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Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Select which Podiatry Services have a : Medicare-covered Podiatry Services

Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per
\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Select which Psychiatric Services have a : Medicare-covered Individual Sessions Copayment (Select all that apply): : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

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\$0.00

Yes

Medicare-covered Group Sessions:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

No Is authorization required? 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?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? Nο Yes Is there an enrollee Copayment? \$0.00

Indicate Minimum Copayment amount per

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

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

Is authorization required? Yes Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-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

: 7h2: Group Sessions for Psychiatric Services

: 9c1: Individual Sessions for Outpatient

Substance Abuse

: 9c2: Group Sessions for Outpatient Substance

Abuse

No

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

SECTION B: #7.I ADDITIONAL TELEHEALTH SERVICES - BASE 2

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

\$0.00

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No

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

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee N

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

Select which Outpatient Diag Procs/Tests/Lab
Services have a Copayment (Select all that

Services have a Copayment (Select all that

Services have a Copayment (Select all that

apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Lab Services:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Lab Services:

If a member receives multiple services at the Same location on the same day, does only the

maximum copay apply?

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

Yes

Is authorization required?

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Is a referral required for Outpatient Diagnostic

Procedures/Test/Lab Services?

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

Yes

Services

\$0.00

\$0.00

\$0.00

Yes

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Diagnostic Radiological

Services have a Copayment (Select all that apply):

: Medicare-covered Therapeutic Radiological Services

: Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for \$0.00 other Medicare-covered Diagnostic

Radiological Services (e.g., ČT, MRI, etc):

Indicate Maximum Copayment amount for \$0.00 other Medicare-covered Diagnostic

Radiological Services (e.g., ČT, MRI, etc):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Therapeutic Radiological Services:

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:

Indicate Maximum Copayment amount for

Medicare-covered X-Ray Services:

If a member receives multiple services at the same location on the same day, does only the

maximum copay apply?

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

MR



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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 SUBSTANC	E ABUSE - BASE 1

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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Select which Outpatient Substance Abuse : Medicare-covered Individual Sessions services have a Copayment (Select all that : Medicare-covered Group Sessions

apply):

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Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

No

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

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

\$0.00

\$0.00

(Select all that apply): : Medicare-covered Air Ambulance Services

Indicate the Minimum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

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Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to

No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C? Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved

Mandatory

Health-related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

No

Indicate number of trips for Plan Approved

24

Health-related Location:

Select Plan Approved Health-related Location

Every year

Trips periodicity:

Select Type of Transportation for Plan

Approved Health-related Location:

One-way

Select Mode of Transportation for Plan

: Van

Approved Health-related Location:

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? 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

\$0.00

trip: 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

EMR

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

10%

Medicare-covered Benefits:

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

No

Durable Medical Equipment (DME)?

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

: Medicare-covered Prosthetic Devices

have a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

10%

10%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Select which Prosthetics/Medical Supplies

have a Copayment (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per

item for Medicare-covered Medical Supplies:

\$0.00

Indicate Maximum Copayment amount per

\$0.00

item for Medicare-covered Medical Supplies:

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

Is authorization required?

Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1 Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

Yes

Select which Diabetic Supplies and Services

: Medicare-covered Diabetes Supplies

have a Copayment (Select all that apply):

: 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 - E	RACE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Ma
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per	Yes
session for Medicare-covered Benefits:	\$0.00
Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	\$0.00
SECTION B: #12 DIALYSIS SERVICES - B.	ASE 2
Is authorization required?	No
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE	21
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:	
Is there a service-specific Maximum Plan	Every year
Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	2.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	
Is there an enrollee Copayment?	No
Indicate Minimum Co	Yes

\$0.00





Indicate Minimum Copayment amount per

Indicate Maximum Copayment amount per \$0.00 treatment: 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 Yes (OTC) Items as a supplemental benefit under Part C? Select type of benefit for OTC Items: Mandatory Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Are you offering Nicotine Replacement No Therapy (NRT) as a Part C OTC benefit? 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 No be found in Chapter 4 of the Medicare Managed Care Manual? SECTION B: #13B OTC ITEMS - BASE 3 Notes: The plan will provide 1 blood pressure

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:

Select the type of primarily health related meals benefit offered.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

: Immediately following surgery or inpatient hospitilization

monitoring unit every 5 years for members who

meet the medical criteria

No

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

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Is there an enrollee Deductible?

No

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 : I attest that there is no coinsurance, copayment,

Services Attestation 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 Yes

Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical Mandatory

Exam:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 \$0.00

each Annual Physical Exam:

Indicate Maximum Copayment amount for \$0.00

each Annual Physical Exam:

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

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

Exam?

Notes: An examination performed by a primary care

physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical

Exam will include the following: 1. Bodily

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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

Yes

Supplemental Benefits as a benefit under Part **C**?

Select enhanced benefit (Select all that apply):

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c15: Wigs for Hair Loss Related to

Chemotherapy

Select type of benefit for Additional Sessions

of Smoking and Tobacco Cessation

Mandatory

Counseling:

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

Mandatory

Related to Chemotherapy:

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

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c15: Wigs for Hair Loss Related to

Benefits have a Maximum Plan Benefit

Chemotherapy

Coverage amount (Select all that apply):

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to

500.00

Chemotherapy: Select Maximum Plan Benefit Coverage

periodicity for Wigs for Hair Loss Related to

Every year

Chemotherapy:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

- MR

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Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No 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 No

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco

Cessation Counseling Notes:

Fitness Benefit Notes:*

No authorization required for this service.

Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. No authorization required for this

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service.

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

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

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

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

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Is authorization required? No Is a referral required for Kidney Disease No

Education Services?

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

Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost for Other Medicarecovered Preventive Services?

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?

Select which Services have a Copayment : Medicare-covered Glaucoma Screening

: Medicare-covered Diabetes Self-Management (Select all that apply):

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:

Indicate Maximum Copayment amount for

Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management

Training:

Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:

Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:

Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:

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

Indicate Maximum Copayment amount for

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

Medicare-covered EKG following Welcome

Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome

Is authorization required for Medicare-covered

Glaucoma Screening?

Is authorization required for Medicare-covered Diabetes Self-Management Training?

Is authorization required for Medicare-covered **Barium Enemas?**

Is authorization required for Medicare-covered

FMR

Digital Rectal Exams?

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

No

No

No

No



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Is authorization required for Medicare-covered No

EKG following Welcome Visit?

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

No

\$0.00

\$0.00

\$0.00

\$0.00

No

Yes

: Part B to Part B?

: Medicare Part B Chemotherapy/Radiation

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?

Is there an enrollee Coinsurance?

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):

: Other Medicare Part B Drugs

Indicate Minimum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Maximum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for

other Medicare Part B Drugs:

Is there an enrollee Deductible?

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

Prophylaxis (Cleaning)

: Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams? No, indicate number

Indicate number of visits for Oral Exams: 2

Select the Oral Exams periodicity: Every year Select type of benefit for Prophylaxis Mandatory

(Cleaning):

is this benefit unlimited for Prophylaxis No, indicate number

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(Cleaning)?

Indicate number of visits for Prophylaxis 2

(Cleaning):

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 No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Select which Preventive Dental Services have a : Oral Exams

Coinsurance (Select all that apply): : Prophylaxis (Cleaning)

: Dental X-Rays

No

0%

0%

Is there a combination of services included in a

single cost per Office Visit?

Indicate Minimum Coinsurance percentage for 0%

Oral Exams:

Indicate Maximum Coinsurance percentage for 0%

Oral Exams:

Indicate Minimum Coinsurance percentage for 0%

Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for

Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for

Dental X-Rays:

Indicate Maximum Coinsurance percentage for 0%

Dental X-Rays:

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 No

Services?

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.

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SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Yes

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1

2

Mandatory

5

No, indicate number

Other, Describe

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

No, indicate number

No, indicate number

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic

Services?

Indicate number of visits for Diagnostic

Services:

Select the Diagnostic Services periodicity: Every three years

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Yes Is this benefit unlimited for Endodontics?

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? No, indicate number

Indicate number of visits for Periodontics:

Select the Periodontics periodicity: Every year Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

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Yes

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2500.00

amount: Select the Maximum Plan Benefit Coverage Every year periodicity: Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4 Is there an enrollee Coinsurance? Select which Comprehensive Dental Services : Diagnostic Services Restorative Services have a Coinsurance (Select all that apply): · Endodontics : Periodontics : Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate Minimum Coinsurance percentage for Diagnostic Services: Indicate Maximum Coinsurance percentage for 0% Diagnostic Services: Indicate Minimum Coinsurance percentage for 0% Restorative Services: Indicate Maximum Coinsurance percentage for 0% Restorative Services: Indicate Minimum Coinsurance percentage for 0% **Endodontics:** Indicate Maximum Coinsurance percentage for 0% **Endodontics:** 0% Indicate Minimum Coinsurance percentage for Periodontics: Indicate Maximum Coinsurance percentage for 0% Periodontics: Indicate Minimum Coinsurance percentage for 0% Extractions: Indicate Maximum Coinsurance percentage for 0% Extractions: Indicate Minimum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Is there an enrollee Deductible? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

Select which Comprehensive Dental Services

have a Copayment (Select all that apply):

- XUR

Indicate Maximum Plan Benefit Coverage

: Medicare-covered Benefits



about:blank 8/5/2022 Indicate Minimum Copayment amount for

Medicare-covered Benefits:

\$0.00

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Benefits:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

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?

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Select the Routine Eye Exams periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Copayment?

Select which Eye Exams have a Copayment

(Select all that apply):

Indicate Minimum Copayment amount for

Yes

: Routine Eye Exams

Mandatory

No, indicate number

Every year

No

1

No

No Yes

: Medicare-covered Benefits

: Routine Eye Exams

\$0.00



- XUR

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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:	No Every year
SECTION B: #17B EYEWEAR - BASE 4	No. R.
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No Contrato Número 23 - 00 1
Is there an enrollee Coinsurance?	No O
SECTION B: #17B EYEWEAR - BASE 5	(m)
Is there an enrollee Deductible?	No Van
Is there an enrollee Copayment?	res
Select which Eyewear Benefits have a	: Medicare-covered Benefits
Copayment (Select all that apply):	: 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	
CECTION D. 410A HEADING EVAMS DAGE 1		

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing

Exams:

Mandatory

Yes

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 Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

1

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Benefits Copayment (Select all that apply): : 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 No Contento Número
	Is there an enrollee Coinsurance?	No Som Con
	SECTION B: #18B HEARING AIDS - BASE 4	CONTAIN NAMES
	Is there an enrollee Copayment?	Yes 23 - 00 1
	Indicate Minimum Copayment amount per Hearing Aid (all types):	\$0.00 \$0.00
1	Indicate Maximum Copayment amount per	\$0.00

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No

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?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

Are you offering a VBID Hospice Benefit? No Are you offering Part C benefits under the Yes

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning, what other interventions have you

been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

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

No

Does your organization offer provider incentives for offering or engaging

beneficiaries in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance directives are connected from your program to

SMR

access points of care.

: Electronic Health Records/Electronic Medical Records

Contrato Número

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

: Other 1797

Expected Number of Beneficiaries to be

Engaged Annually:

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

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No

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional 1

Benefits contain? (1-15)

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

: Socioeconomic Status

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

Select LIS reduction level: : Dual-Eligible Status (for territories)

1934 Expected Number of Enrollees to be Targeted: Expected Number of Enrollees to be engaged 1934

and receive Model benefits:

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM

Yes

No

INFO): PACKAGE #1

Is there a prerequisite for any additional

benefits for this package?

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

deductible?

Are any benefits exempt from the plan-level No

AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage

amount?

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) Item

: 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?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

Mandatory

Yes

50

Every month

-

Yes

No

Yes

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

Contrato Número

or formulary drugs.

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

Is there an enrollee Coinsurance?

Is there an enrollee 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?

EMR

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

about:blank 8/5/2022

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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50

No

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

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:

\$50 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-

EMR

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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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

\$50 loaded on a prepaid card every month to Notes:

spend on robotic pets, speech/language assistive

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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 Yes

Supplemental Benefits as a benefit under Part

C?

: 14c8: Home and Bathroom Safety Devices and Select enhanced benefit (Select all that apply):

Modifications*

Mandatory Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

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

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

SMR

Supplemental Benefits?

Select which Other Defined Supplemental : 14c8: Home and Bathroom Safety Devices and

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

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

Other, Describe

Devices and Modifications:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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 No

Supplemental Benefits?

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

BASE 15: PACKAGE #1

\$50 loaded on a prepaid card every month to Home and Bathroom Safety Devices and

Modifications Notes:* 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 Yes

Out-of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Lower

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

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ROSD

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

SMR

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Do you offer Reductions in Cost Sharing? No SECTION D: COMBINED BENEFITS - GENERAL

Do vou offer Combined Supplemental Benefits Yes

with uniform cost sharing?

Select the number of Combined Supplemental

Benefit packages you are offering?

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

The combined supplemental benefit package

: 18b1: Hearing Aids (all types)

: Debit Card

No

Yes

500

No

Every year

What is your combined supplemental benefits

mode of delivery?

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Max Plan Benefit Amount:

Select Maximum Plan Benefit Coverage

Amount Periodicity:

Do you offer Combined Supplemental Benefits

with a shared visit limit?

SECTION D: NOTES

Notes:

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?

Select the type of drug benefit:

Describe the components of your pharmacy

SMR

network (select all that apply):

Yes

Defined Standard

: 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 : Standard Retail Cost Sharing - 1 month Supply

Location/supply amount(s) that apply: : Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost 90

Sharing 3-month supply:

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

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network 30

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 1-month supply

Location/supply amount(s) that apply: : Standard Mail-Order - 3-month supply

Enter number of days for Standard Mail-Order

Cost Sharing 1-month supply:

Enter number of days for Standard Mail-Order 90

Cost Sharing 3-month supply:

Select the Long-Term Care Pharmacy one Long-Term Care Pharmacy - 1-month supply

30

31

No

month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary No available with an extended day supply?

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

first fill?

SECTION RX: 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 B18 Status Completed
Section B19 Status Completed
Section C Status Completed
Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1

Section B17 Status

Organization Legal Name: HUMANA HEALTH PLANS OF PUERTO

RICO, INC.

Completed

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Organization Marketing Name: Humana

SMR

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):	40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR 23 - 001
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR 40290 - Guayanilla, 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):

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Service Area(s):

Service Area(s):

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40330 - Hormigueros, PR

40340 - Humacao, PR 40350 - Isabela, PR PBP Data Report Page 3 of 42

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
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40760 - Yabucoa, PR 40770 - Yauco, PR

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Service Area(s):

Service Area(s): 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 Strike STRAC/OAD
SECTION A: SECTION A-4	$\begin{bmatrix} 23 - 0 & 0 & 1 \end{bmatrix}$
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 Yes Services as a supplemental benefit under Part C?

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 No Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost

Does this plants Medicare-covered benefit cost

sharing vary by hospital(s) in which an

enrollee obtains care?

Is there an enrollee Coinsurance?

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

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains

care?

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No

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\$0.00

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

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

inpatient facility.)

Indicate Copayment amount for the Medicare-

covered stay:

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

Medicare-covered stay:

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)

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

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

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay

period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost No

sharing vary by hospital(s) in which an

enrollee obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Indicate Copayment amount for the Medicare-

covered stay:

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\$0.00

No

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Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

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benefit period?

Do you charge cost sharing on the day of

No

discharge?

Yes Is authorization required?

No

Is a referral required for Inpatient Psychiatric **Hospital Services?**

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days

Zero

Required Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee 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

Yes Is authorization required?

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

EMR

benefit under Part C?

No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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 : Medicare-covered Cardiac Rehabilitation Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment Services (Select all that apply): : 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 \$0.00 service for Medicare-covered Cardiac Rehabilitation Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Cardiac Rehabilitation Services: Indicate Minimum Copayment amount per \$0.00 service for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Minimum Copayment amount per \$0.00 service for Medicare-covered Pulmonary Rehabilitation Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Pulmonary Rehabilitation Services: Indicate Minimum Copayment amount per \$0.00 service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

Is there an enrollee Coinsurance? No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment? Yes \$0.00

Indicate Minimum Copayment amount for

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Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Is the Copayment for Medicare-covered Yes

Benefits waived if admitted to hospital?

Select either Days or Hours within which Hours

admission must occur for waiver:

24 Enter number of Days or Hours: Does the Emergency Services cost sharing No

count towards any plan-level deductible?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Does the Urgently Needed Services cost No

sharing count towards any plan-level

deductible?

Is the Copayment for Medicare-covered No

Benefits waived if admitted to hospital?

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

Does the plan provide Worldwide Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

: Worldwide Emergency Coverage Select enhanced benefit:

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide Mandatory

Emergency Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Select type of benefit for Worldwide Mandatory

Emergency Transportation:

Is there a Maximum Plan Benefit Coverage No

amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Worldwide Emergency Coverage Select which Worldwide Services have a : Worldwide Urgent Coverage Copayment (Select all that apply): : Worldwide Emergency Transportation \$0.00 Indicate Minimum Copayment amount for Worldwide Emergency Coverage: Indicate Maximum Copayment amount for \$0.00 Worldwide Emergency Coverage: Is this Copayment waived for Worldwide Yes Emergency Coverage if admitted to hospital? Indicate Minimum Copayment amount for \$0.00 Worldwide Urgent Coverage: Indicate Maximum Copayment amount for \$0.00 Worldwide Urgent Coverage: Is this Copayment waived for Worldwide Yes Urgent Coverage if admitted to hospital? Indicate Minimum Copayment amount for \$0.00 Worldwide Emergency Transportation: Indicate Maximum Copayment amount for \$0.00 Worldwide Emergency Transportation: Is this Copayment waived for Worldwide Yes Emergency Transportation if admitted to hospital?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

No

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

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

Is there an enrollee Deductible?

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 \$0.00 Medicare-covered Benefits per day:

Is authorization required?

Is a referral required for Partial

Hospitalization?

Yes

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible? No Yes



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\$0.00

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as No

a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 : Medicare-covered Chiropractic Services

Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

\$0.00





visit for Medicare-covered Benefits:

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

Is authorization required?

Yes No

Is a referral required for Occupational Therapy

Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Yes Is there an enrollee Copayment? \$0.00

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

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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

Is authorization required?

No Yes

Is a referral required for Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Select which Mental Health Specialty Services : Medicare-covered Individual Sessions have a Copayment (Select all that apply):

Indicate Minimum Copayment amount for

Medicare-covered Individual Sessions:

: Medicare-covered Group Sessions

\$0.00

Indicate Maximum Copayment amount for

Medicare-covered Individual Sessions:

\$0.00

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Group Sessions:

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

Is authorization required? No Is a referral required for Mental Health No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Is there a service-specific Maximum Enrollee

supplemental benefit under Part C?

No

No







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Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Yes

Select which Podiatry Services have a : Medicare-covered Podiatry Services

Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Select which Psychiatric Services have a : Medicare-covered Individual Sessions Copayment (Select all that apply): : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No No

Is there an enrollee Deductible? Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

SECTION B: #71 PT AND SP SERVICES - BASE 2

Is authorization required?

Yes

Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

Yes

for Part B services?

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: #7.I ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No Yes

Is there an enrollee Copayment? Indicate Minimum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

\$0.00

visit for Medicare-covered Benefits:

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No

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

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 Yes Is there an enrollee Copayment?

: Medicare-covered Diagnostic Procedures/Tests Select which Outpatient Diag Procs/Tests/Lab : Medicare-covered Lab Services

Services have a Copayment (Select all that

apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Lab Services:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Lab Services:

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

maximum copay apply?

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

Yes Is authorization required?

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Yes

No

Is a referral required for Outpatient Diagnostic

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

\$0.00

\$0.00

\$0.00

: Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for

other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Copayment amount for

other Medicare-covered Diagnostic

Radiological Services (e.g., CT, MRI, etc):

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological

Services:

Indicate Minimum Copayment amount for

Medicare-covered X-Ray Services:

Indicate Maximum Copayment amount for

Medicare-covered X-Ray Services:

If a member receives multiple services at the same location on the same day, does only the

maximum copay apply?

\$0.00

\$0.00

\$0.00

Yes

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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?	Yes No TE ARUSE - BASE 1 Contrato Número
SECTION B: #9C OUTPATIENT SUBSTANC	Contains 1
Is there a service-specific Maximum Enrollee	No 23-00

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Select which Outpatient Substance Abuse services have a Copayment (Select all that : Medicare-covered Group Sessions

apply):

Out-of-Pocket Cost?

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Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

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

(Select all that apply): : Medicare-covered Air Ambulance Services

\$0.00

\$0.00

Indicate the Minimum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate the Maximum Copayment amount for

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

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\$0.00

Yes

No

Every year

Indicate Maximum Copayment amount for

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Mandatory

Health-related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved 24

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan

One-way

Approved Health-related Location:

Select Mode of Transportation for Plan : Van

Approved Health-related Location: : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 \$0.00

trip:

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

Services?

Notes: Services arranged by the plan's transportation

provider to approved locations by means of car, van, or wheelchair access vehicle that provide

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members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No.

Out-of-Pocket Cost?

No



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Is there an enrollee Coinsurance? Yes Indicate Minimum Coinsurance percentage for 10%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

have a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for 10%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Prosthetic Devices:

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 : Medicare-covered Medical Supplies have a Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 : Medicare-covered Diabetes Supplies

have a Copayment (Select all that apply): : Medicare-covered Diabetic Therapeutic Shoes

or Inserts

\$0.00

Indicate Minimum Copayment amount per

item for Medicare-covered Diabetes Supplies:

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overed Diabetes Supplies:

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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 - BAS	SE 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 - BAS	SE 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	No

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SECTION B: #13A ACUPUNCTURE - BASE 2

Indicate limit for Number of Treatments:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Out-of-Pocket Cost?

Indicate Number of Treatments periodicity:

Is there a service-specific Maximum Enrollee

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per

\$0.00

treatment:

Treatments?

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No

No

Every year

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No

No

Indicate Maximum Copayment amount per \$0.00 treatment: Yes Is authorization required? Is a referral required for Acupuncture? No **SECTION B: #13B OTC ITEMS - BASE 1** Does the plan provide Over-The-Counter Yes (OTC) Items as a supplemental benefit under Part C? Select type of benefit for OTC Items: Mandatory Is there a service-specific Maximum Plan No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

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?

Benefit Coverage amount?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: The plan will provide 1 blood pressure

Yes

monitoring unit every 5 years for members who

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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.

Select type of benefit for Meals: Mandatory

Select the type of primarily health related : Immediately following surgery or inpatient

meals benefit offered: hospitilization

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

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

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No

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Is there an enrollee Copayment?

Indicate Minimum Copayment amount:

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 : I attest that there is no coinsurance, copayment,

Services Attestation 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 Yes

Exam as a supplemental benefit under Part C?

Select type of benefit for the Annual Physical Mandatory

Exam:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount for

\$0.00

each Annual Physical Exam:

Indicate Maximum Copayment amount for \$0.00

each Annual Physical Exam:

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

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

Exam?

Notes: An examination performed by a primary care

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

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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?

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

Mandatory

Counseling:

Indicate number of visits offered in addition to

4

Medicare:

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

Mandatory

Related to Chemotherapy:

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

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c15: Wigs for Hair Loss Related to

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Benefits have a Maximum Plan Benefit

Chemotherapy

Coverage amount (Select all that apply):

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

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

Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to

500.00

Chemotherapy:

Every year

Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to

Chemotherapy:

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?

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 No

Supplemental Benefits?

Additional Sessions of Smoking and Tobacco

Cessation Counseling Notes:

Fitness Benefit Notes:*

No authorization required for this service.

Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. No authorization required for this service.

No

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.

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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?

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 \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Is authorization required? No Is a referral required for Kidney Disease No

Education Services?



Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost for Other Medicarecovered Preventive Services?

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

: Medicare-covered Glaucoma Screening Select which Services have a Copayment

: Medicare-covered Diabetes Self-Management (Select all that apply):

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:

Indicate Maximum Copayment amount for

Medicare-covered Glaucoma Screening: Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management

Training:

Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:

Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:

Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:

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

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

Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome

Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome

Is authorization required for Medicare-covered Glaucoma Screening?

Is authorization required for Medicare-covered Diabetes Self-Management Training?

Is authorization required for Medicare-covered **Barium Enemas?**

Is authorization required for Medicare-covered

EMR

Digital Rectal Exams?

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

\$0

No

No

No





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No

No

Is authorization required for Medicare-covered

EKG following Welcome Visit?

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

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? Yes

Select which Medicare Part B Rx Drugs have a

Copayment (Select all that apply):

: Medicare Part B Chemotherapy/Radiation

\$0.00

\$0.00

\$0.00

\$0.00

Yes

: Other Medicare Part B Drugs

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Maximum Copayment Amount for

Drugs:

Medicare Part B Chemotherapy/Radiation

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for

other Medicare Part B Drugs:

Is there an enrollee Deductible? No Is Authorization Required? Yes

Does the plan offer step therapy?

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?

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

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Select the Oral Exams periodicity: Every year Select type of benefit for Prophylaxis Mandatory

(Cleaning):

s this benefit unlimited for Prophylaxis No, indicate number Contrato Número

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(Cleaning)?

Indicate number of visits for Prophylaxis 2

(Cleaning):

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 No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Select which Preventive Dental Services have a : Oral Exams

Coinsurance (Select all that apply): : Prophylaxis (Cleaning)

: Dental X-Rays

No

0%

0%

Is there a combination of services included in a

single cost per Office Visit?

Indicate Minimum Coinsurance percentage for 0%

Oral Exams:

Indicate Maximum Coinsurance percentage for 0%

Oral Exams:

Indicate Minimum Coinsurance percentage for 0%

Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for

Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for

Dental X-Rays:

Indicate Maximum Coinsurance percentage for 0%

Dental X-Rays:

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 No
Services?

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.

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SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Yes

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1

2

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

No, indicate number

Services?

Indicate number of visits for Diagnostic

Services:

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:

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?

5

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

Services:

Select the Prosthodontics/Other

Other, Describe

No, indicate number

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:



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Indicate Maximum Plan Benefit Coverage 2500.00 amount: Select the Maximum Plan Benefit Coverage Every year periodicity: Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4 Is there an enrollee Coinsurance? Select which Comprehensive Dental Services : Diagnostic Services : Restorative Services have a Coinsurance (Select all that apply): : Endodontics Periodontics : Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate Minimum Coinsurance percentage for 0% Diagnostic Services: Indicate Maximum Coinsurance percentage for 0% Diagnostic Services: 0% Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Maximum Coinsurance percentage for 0% Restorative Services: 0% Indicate Minimum Coinsurance percentage for **Endodontics:** Indicate Maximum Coinsurance percentage for 0% **Endodontics:** Indicate Minimum Coinsurance percentage for 0% Periodontics: Indicate Maximum Coinsurance percentage for 0% Periodontics: 0% Indicate Minimum Coinsurance percentage for Extractions: 0% Indicate Maximum Coinsurance percentage for **Extractions:** Indicate Minimum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

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):

Is there an enrollee Deductible?

: Medicare-covered Benefits

No

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Indicate Minimum Copayment amount for

Medicare-covered Benefits:

\$0.00

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Benefits:

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.

Yes

SECTION B: #17A EYE EXAMS - BASE 1

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

Select enhanced benefit:

Mandatory

Select type of benefit for Routine Eye Exams:

: Routine Eye Exams

Is this benefit unlimited for Routine Eye

No, indicate number

Every year

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

No

1

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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

: Routine Eye Exams

: Medicare-covered Benefits

(Select all that apply):

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 RAMINISTRACION ON ON
	Is there an enrollee Coinsurance?	No Contrato Número
	SECTION B: #17B EYEWEAR - BASE 5	(23 - 00)
	Is there an enrollee Deductible?	No On On
	Is there an enrollee Copayment?	Yes Con Chy
	Select which Eyewear Benefits have a	Yes : Medicare-covered Benefits Contact I was a series of the series of
	Copayment (Select all that apply):	: Contact lenses: Eyeglasses (lenses and frames)
1	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	

periodicity:

Indicate number for Fitting/Evaluation for

Select Fitting/Evaluation for Hearing Aid

Is there a service-specific Maximum Plan

SECTION B: #18A HEARING EXAMS - BASE 2

Benefit Coverage amount? No

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Hearing Aid:

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 : Medicare-covered Benefits Copayment (Select all that apply): : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

1

No

Every year

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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 8
SECTION B: #18B HEARING AIDS - BASE 4	(

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Yes

\$0.00

\$0.00

Is there an enrollee Copayment?

Hearing Aid (all types):

Indicate Minimum Copayment amount per

Indicate Maximum Copayment amount per

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No

No

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?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

No Are you offering a VBID Hospice Benefit? Are you offering Part C benefits under the Yes

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning, what other interventions have you

been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

: Annual Wellness Visit WHP Program Type (choose one or more):

> : Care Management Program : In-home Assessments

: Other Program

Humana will offer all members access to digital Specify Other Program:

advance care planning tool integrated with

Humana's online member portals

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person : Web-Based

No

No

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

Does your organization offer provider incentives for offering or engaging

beneficiaries in WHP activities?

Program Connectedness: 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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No

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

VBID

: Socioeconomic Status

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 1455 Expected Number of Enrollees to be engaged 1455

and receive Model benefits:

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

INFO): PACKAGE #1

Is there a prerequisite for any additional

benefits for this package?

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

Yes

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

Is there a package level maximum coverage

is there a package rever maximum coverage

amount?

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) Ite : 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 nonmedical 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?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

Mandatory

Yes

75

Every month

Yes

No

Yes

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

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or formulary drugs.

ONINISTRACION 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 No

be found in Chapter 4 of the Medicare

Managed Care Manual?

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

\$75 loaded on a prepaid card every month to spend at participating retailers toward the

Notes:

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Yes

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?

Indicate Maximum Plan Benefit Coverage 75

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Yes

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?

Indicate Maximum Plan Benefit Coverage 75

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

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?

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 #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, nonmedical 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

Yes

Benefit Coverage amount?

1 68

- 11 - 3 - 5 - 5 - 5 - 5

Indicate Maximum Plan Benefit Coverage

75

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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 #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

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c8: Home and Bathroom Safety Devices and

Modifications*

Select type of benefit for Home and Bathroom

Mandatory

Safety Devices and Modifications:

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

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

- MR

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

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75

Other, Describe

Indicate Maximum Plan Benefit Coverage

amount for Home and Bathroom Safety

Devices and Modifications:

Select Maximum Plan Benefit Coverage

periodicity for Home and Bathroom Safety

Devices and Modifications:

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

BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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 No

Supplemental Benefits?

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 Yes

Out-of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-

of-Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

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Does the In-Network Maximum Enrollee Out-

3400.00

Lower

: In-Network Medicare-covered benefits

Yes

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No

Yes

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?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Defined Standard

: Long-Term Care

Select the type of drug benefit: Describe the components of your pharmacy : Standard Retail

network (select all that apply): : Out-of-Network : Standard Mail-Order

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 No (OTCs) under the utilization management

program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

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

90

30

30

90

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 1-month supply : Standard Mail-Order - 3-month supply Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 1-month supply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

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

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

Are any of the drugs available at an extended

: Long-Term Care Pharmacy - 1-month supply

31

No

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 No Rewards and Incentives under the VBID Model?



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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 D 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 B14 Status

Section B15 Status

Completed
Section B16 Status

Completed
Section B17 Status

Completed
Section B18 Status

Completed
Section B19 Status

Completed
Section C Status

Completed
Section C Status

Section Mrx Status

SMR

SECTION A: SECTION A-1

Organization Legal Name: HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Completed

Completed

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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):	40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, 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



40760 - Yabucoa, PR

40770 - Yauco, PR

Contract Number:

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Service Area(s):

Service Area(s):

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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 Contrato Número
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	$(800)681-3625 \qquad \qquad 23 - 001$
SECTION A: SECTION A-4	10
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 - BASI		CUTE - BASE 1
	Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
	Select enhanced benefits:	: Additional Day
	Select type of benefit for Additional Days:	Mandatory

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Days

Yes

No

No

No

No

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care? EMR

Is there an enrollee Coinsurance?

Is this benefit unlimited for Additional Days?

Is there a service-specific Maximum Enrollee

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an

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

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

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Out-of-Pocket Cost?

enrollee obtains care?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Yes

Do you charge the Medicare-defined cost

No

shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

inpatient facility.)

Indicate Copayment amount for the Medicare- \$0.00

covered stay:

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

Medicare-covered stay:

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

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)

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

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

Additional Days:

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay

period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost No

sharing vary by hospital(s) in which an

enrollee obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

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

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inpatient facility.)

Indicate Copayment amount for the Medicare-\$0.00

covered stay:



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Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered stay:

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

Indicate the number of day intervals for the

Zero (No Copayment per Day)

Medicare-covered Lifetime Reserve Days:

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost 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

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

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SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Original Medicare

Yes Is authorization required? 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

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Deductible?

No

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Yes Is there an enrollee Copayment? : Medicare-covered Cardiac Rehabilitation Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment Services : Medicare-covered Intensive Cardiac (Select all that apply): 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 \$0.00 service for Medicare-covered Cardiac Rehabilitation Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Cardiac Rehabilitation Services: Indicate Minimum Copayment amount per \$0.00 service for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Minimum Copayment amount per \$0.00 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: Indicate Maximum Copayment amount per \$0.00 service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

No

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

Is there an enrollee Coinsurance?

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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:

Is the Copayment for Medicare-covered

Benefits waived if admitted to hospital?

Select either Days or Hours within which

admission must occur for waiver:

Enter number of Davs or Hours:

Does the Emergency Services cost sharing

count towards any plan-level deductible?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

\$0.00

Yes

Hours

24

No

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

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

Does the Urgently Needed Services cost

sharing count towards any plan-level

deductible?

No

No

Is the Copayment for Medicare-covered

Benefits waived if admitted to hospital?

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

: Worldwide Emergency Transportation

Select type of benefit for Worldwide

Emergency Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Select type of benefit for Worldwide

Mandatory

Emergency Transportation:

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

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 : Worldwide Emergency Coverage : Worldwide Urgent Coverage Copayment (Select all that apply): : Worldwide Emergency Transportation Indicate Minimum Copayment amount for \$0.00 Worldwide Emergency Coverage: Indicate Maximum Copayment amount for \$0.00 Worldwide Emergency Coverage: Is this Copayment waived for Worldwide Yes Emergency Coverage if admitted to hospital? Indicate Minimum Copayment amount for \$0.00 Worldwide Urgent Coverage: Indicate Maximum Copayment amount for \$0.00 Worldwide Urgent Coverage: Is this Copayment waived for Worldwide Yes Urgent Coverage if admitted to hospital? Indicate Minimum Copayment amount for \$0.00 Worldwide Emergency Transportation: Indicate Maximum Copayment amount for \$0.00 Worldwide Emergency Transportation: Is this Copayment waived for Worldwide Yes Emergency Transportation if admitted to hospital?

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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 \$0.00 Medicare-covered Benefits per day:

\$0.00 Indicate Maximum Copayment amount for

Medicare-covered Benefits per day:

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

Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

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 OHINISTRACION PORINISTRACION Contrato Número

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\$0.00 Indicate Minimum Copayment amount per

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

\$0.00

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as No

a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

Select which Chiropractic Services have a : Medicare-covered Chiropractic Services

Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

No Is there an enrollee Deductible? 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 No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

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 No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

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

Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Select which Mental Health Specialty Services : Medicare-covered Individual Sessions have a Copayment (Select all that apply): : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for

Medicare-covered Group Sessions:

\$0.00 \$0.00

\$0.00

\$0.00

No

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Is there a service-specific 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 : Medicare-covered Podiatry Services

Copayment (Select all that apply):

Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount per
\$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes

Select which Psychiatric Services have a : Medicare-covered Individual Sessions Copayment (Select all that apply): : Medicare-covered Group Sessions

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Individual Sessions:

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Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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 No

Is a referral required for Psychiatric Services?

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No Is there an enrollee Copayment? Yes Indicate Minimum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per \$0.00

visit for Medicare-covered Benefits:

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

Is authorization required? Yes Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may : 4b: Urgently Needed Services have Additional Telehealth Benefits available: : 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

No

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

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 \$0.00

visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per

visit for Medicare-covered Benefits:

\$0.00





about:blank 8/5/2022 SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

\$0.00

Medicare-covered Benefits:

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

: Medicare-covered Diagnostic Procedures/Tests

: Medicare-covered Lab Services

apply):

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Diagnostic

Procedures/Tests:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Lab Services:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Lab Services:

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

SMR

maximum copay apply?

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?

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

Is there a service-specific Maximum Enrollee

No

Yes

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

No

Is there an enrollee Copayment?

Yes

Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that

: Medicare-covered Diagnostic Radiological

: Medicare-covered Therapeutic Radiological

Services : Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for

\$0.00

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:

apply):

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological

Indicate Minimum Copayment amount for

Services:

\$0.00

Medicare-covered X-Ray Services:

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?

Is a referral required for Outpatient

Yes No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

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





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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 SUBSTANC	CE ABUSE - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SHIMISTRACION
SECTION B: #9C OUTPATIENT SUBSTANC	CE ABUSE - BASE 2 Contrato Número
Is there an enrollee Coinsurance?	No (2.3 = 0.0.1)
Is there an enrollee Deductible?	No vo
	10,1

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Select which Outpatient Substance Abuse

services have a Copayment (Select all that

Is there an enrollee Copayment?

apply):

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

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

Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Group Sessions:

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

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

No

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible? Nο Is there an enrollee Copayment?

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

\$0.00

Indicate the Minimum Copayment amount for

Medicare-covered Ground Ambulance

Indicate the Maximum Copayment amount for \$0.00

Medicare-covered Ground Ambulance

Services:

Indicate Minimum Copayment amount for \$0.00

Medicare-covered Air Ambulance Services:

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\$0.00

Indicate Maximum Copayment amount for

Medicare-covered Air Ambulance Services:

Is this Copayment waived if admitted to No

hospital?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved

Health-related Location:

Select enhanced benefit:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

24

No

Yes

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

Approved Health-related Location:

One-way

: Van

Select Mode of Transportation for Plan

Approved Health-related Location: : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 \$0.00 Indicate Minimum Copayment amount per trip: \$0.00 Indicate Maximum Copayment amount per

trip:

Is authorization required? Yes No

Is a referral required for Transportation

Services?

Notes:

Services arranged by the plan's transportation

provider to approved locations by means of car, van, or wheelchair access vehicle that provide

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members access to health benefits.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

SMR

Out-of-Pocket Cost?

No

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No

10%

10%

\$0.00

Is there an enrollee Coinsurance? Yes Indicate Minimum Coinsurance percentage for 10%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

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)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance?

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

have a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

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

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

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

have a Copayment (Select all that apply): Indicate Minimum Copayment amount per

item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per \$0.00

item for Medicare-covered Medical Supplies:

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

Is authorization required?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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?

Select which Diabetic Supplies and Services : Medicare-covered Diabetes Supplies

have a Copayment (Select all that apply): : 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 - BA	ASE 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 - BA	ASE 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	\$0.00

treatment:

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Indicate Maximum Copayment amount per \$0.00 treatment: Yes Is authorization required? Is a referral required for Acupuncture? No **SECTION B: #13B OTC ITEMS - BASE 1** Does the plan provide Over-The-Counter Yes (OTC) Items as a supplemental benefit under Part C? Select type of benefit for OTC Items: Mandatory Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Are you offering Nicotine Replacement No Therapy (NRT) as a Part C OTC benefit? **SECTION B: #13B OTC ITEMS - BASE 2** No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No Yes Is there an enrollee Copayment? **Indicate Minimum Copayment amount:** \$0.00 **Indicate Maximum Copayment amount:** \$0.00 Does this cover all of the OTC list which may No be found in Chapter 4 of the Medicare Managed Care Manual? SECTION B: #13B OTC ITEMS - BASE 3 The plan will provide 1 blood pressure Notes: monitoring unit every 5 years for members who meet the medical criteria SECTION B: #13C MEAL BENEFIT - BASE 1 Does the plan provide a limited duration Meal Yes Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section. Select type of benefit for Meals: Mandatory Select the type of primarily health related : Immediately following surgery or inpatient meals benefit offered: hospitilization

SECTION B: #13C MEAL BENEFIT - BASE 2

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Is there a service-specific Maximum Plan

Is there a service-specific Maximum Enrollee

Benefit Coverage amount?

Out-of-Pocket Cost?

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

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No

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?

Select type of benefit for the Annual Physical

Exam:

No

Mandatory

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

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?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

Yes
Indicate Minimum Copayment amount for

\$0.00

each Annual Physical Exam:

Indicate Maximum Copayment amount for \$0.00

each Annual Physical Exam:

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

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

Exam?

Notes: An examination performed by a primary care

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

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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

Yes

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c15: Wigs for Hair Loss Related to

Chemotherapy

Mandatory

Select type of benefit for Additional Sessions

of Smoking and Tobacco Cessation

Counseling:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

4

: Physical Fitness

Mandatory

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

Select type of benefit for Wigs for Hair Loss

Related to Chemotherapy:

Mandatory

Yes

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply):

: 14c15: Wigs for Hair Loss Related to

SHINISTRACION

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Chemotherapy

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

Indicate Maximum Plan Benefit Coverage

amount for Wigs for Hair Loss Related to

Chemotherapy:

Select Maximum Plan Benefit Coverage

periodicity for Wigs for Hair Loss Related to

Chemotherapy:

Every year

500.00

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?

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 No

Supplemental Benefits?

Fitness Benefit Notes:*

Additional Sessions of Smoking and Tobacco

Cessation Counseling Notes:

No authorization required for this service.

Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center. No authorization required for this

service.

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

Home and Bathroom Safety Devices and 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 Authorization is required for this service.

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Yes

Indicate Minimum Copayment amount for

\$0.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$0.00

Medicare-covered Benefits:

Is authorization required? No
Is a referral required for Kidney Disease No

Education Services?

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

Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost for Other Medicarecovered 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 : Medicare-covered Glaucoma Screening (Select all that apply):

: Medicare-covered Diabetes Self-Management

Training

: Medicare-covered Barium Enemas : Medicare-covered Digital Rectal Exams : Medicare-covered EKG following Welcome

Visit

\$0

\$0

\$0

\$0

\$0

No

No

Indicate Minimum Copayment amount for \$0 Medicare-covered Glaucoma Screening:

Indicate Maximum Copayment amount for \$0 Medicare-covered Glaucoma Screening:

Indicate Minimum Copayment amount for \$0

Medicare-covered Diabetes Self-Management Training:

Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management

Training:

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

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

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

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

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

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

Is authorization required for Medicare-covered No Glaucoma Screening?

Is authorization required for Medicare-covered No Diabetes Self-Management Training?

Is authorization required for Medicare-covered **Barium Enemas?**

Is authorization required for Medicare-covered Digital Rectal Exams?

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No

No

Is authorization required for Medicare-covered

EKG following Welcome Visit?

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

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee 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

\$0.00

\$0.00

Indicate Minimum Copayment Amount for \$0.00

Medicare Part B Chemotherapy/Radiation

Indicate Maximum Copayment Amount for

Medicare Part B Chemotherapy/Radiation

Drugs:

Indicate Minimum Copayment Amount for

other Medicare Part B Drugs:

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 : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

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

No

Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

: Prophylaxis (Cleaning)

: Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

No, indicate number Is this benefit unlimited for Oral Exams?

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity: Every year Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis

No, indicate number

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2

(Cleaning)?

Indicate number of visits for Prophylaxis

Select the Prophylaxis (Cleaning) periodicity:

(Cleaning):

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:

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

0%

Dental X-Rays: Indicate Maximum Coinsurance percentage for

Dental X-Rays:

0%

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

No Is authorization required? Is a referral required for Preventive Dental No

Dental X-Rays Notes:

Services?

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:

Every three years

Select the Diagnostic Services periodicity: 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:

1

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:

Select the Periodontics periodicity: Every year Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions?

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Yes

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

Yes

Benefit Coverage amount?

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

type:

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Indicate Maximum Plan Benefit Coverage 3000.00 amount: Select the Maximum Plan Benefit Coverage Every year periodicity: Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4 Is there an enrollee Coinsurance? Yes Select which Comprehensive Dental Services : Diagnostic Services : Restorative Services have a Coinsurance (Select all that apply): : Endodontics : Periodontics Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate Minimum Coinsurance percentage for 0% Diagnostic Services: Indicate Maximum Coinsurance percentage for 0% Diagnostic Services: Indicate Minimum Coinsurance percentage for 0% Restorative Services: Indicate Maximum Coinsurance percentage for 0% Restorative Services: 0% Indicate Minimum Coinsurance percentage for **Endodontics:** Indicate Maximum Coinsurance percentage for 0% Endodontics: Indicate Minimum Coinsurance percentage for 0% Periodontics: Indicate Maximum Coinsurance percentage for 0% Periodontics: Indicate Minimum Coinsurance percentage for 0% **Extractions:** Indicate Maximum Coinsurance percentage for 0% **Extractions:** Indicate Minimum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for 0% Prosthodontics, Other Oral/Maxillofacial Contrato Número

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? Yes

Select which Comprehensive Dental Services : Medicare-cov

have a Copayment (Select all that apply):

Surgery, Other Services:

about:blank

Is there an enrollee Deductible?

: Medicare-covered Benefits

No

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Indicate Minimum Copayment amount for

Medicare-covered Benefits:

Indicate Maximum Copayment amount for

Medicare-covered Benefits:

\$0.00

Yes

No

\$0.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Is a referral required for Comprehensive Dental

Services?

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

vear 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.

Yes

SECTION B: #17A EYE EXAMS - BASE 1

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

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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):

Indicate Minimum Copayment amount for

: Routine Eye Exams

Mandatory

No. indicate number

Every year

No

1

No



: Medicare-covered Benefits

: Routine Eye Exams

\$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:	850.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	STRAC/OA
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No Ontrato Número
Is there an enrollee Coinsurance?	No (23 - 0 0 1)
SECTION B: #17B EYEWEAR - BASE 5	3/
Is there an enrollee Deductible?	13/
Is there an enrollee Copayment?	Yes Yes
Select which Eyewear Benefits have a	: Medicare-covered Benefits
Copayment (Select all that apply):	: Contact lenses: Eyeglasses (lenses and frames)
	# 0.00

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\$0.00

Indicate Minimum Copayment amount for

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Yes

Mandatory

No, indicate number

Medicare-covered Benefits: Indicate Maximum Copayment amount for \$0.00 Medicare-covered Benefits: Indicate Minimum Copayment amount for \$0.00 Contact lenses: Indicate Maximum Copayment amount for \$0.00 Contact lenses: Indicate Minimum Copayment amount for \$0.00 Eyeglasses (lenses and frames): Indicate Maximum Copayment amount for \$0.00 Eyeglasses (lenses and frames): 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?

Select enhanced benefits: : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing

Exams:

Is this benefit unlimited for Routine Hearing No, indicate number

Exams?

Indicate number for Routine Hearing Exams: 1

Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for 1

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible?

No
Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? Yes

Select which Hearing Exam Benefits have a : Medicare-covered Benefits Copayment (Select all that apply): : Routine Hearing Exams

Fitting/Evaluation for Hearing Aid

: 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
T 4 11 0 1	7.

No

Yes

\$0.00

\$0.00

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Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Hearing Aid (all types):

SECTION B: #18B HEARING AIDS - BASE 4

Indicate Minimum Copayment amount per

Indicate Maximum Copayment amount per

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No

No

Yes

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?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

No Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness 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

: Annual Wellness Visit WHP Program Type (choose one or more):

: Care Management Program : In-home Assessments

: Other Program

Humana will offer all members access to digital Specify Other Program:

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

No

No

WHP Services?

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

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

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Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C No

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

1

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

Select LIS reduction level:

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

1554

Expected Number of Enrollees to be engaged

1554

and receive Model benefits:

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

INFO): PACKAGE #1

Is there a prerequisite for any additional

No

benefits for this package?

Select all the Non-Medicare-covered additional

: 13b: Over-the-Counter (OTC) Items

benefits offered in this package:

: 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

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM

AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage

Yes

amount?

Specify the maximum benefit amount:

3180

Select the package level maximum coverage

Every year

periodicity:

Select the Non-Medicare-covered benefits that

: 13b: Over-the-Counter (OTC) Items

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apply to the package level maximum coverage:

: 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

Yes

Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Mandatory

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?

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

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

No

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

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or formulary drugs.

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

Is there an enrollee Coinsurance?

Is there an enrollee 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?

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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

265

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee 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

Yes

Benefit Coverage amount?

265

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage

Is a referral required for Other Services?

Other, Describe

periodicity:

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

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, nonmedical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.

> > DHIMISTRACION

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POSDE

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

Aging Support and Safety Products Enter name of Service (Optional):

Mandatory Select type of benefit for Other 3:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Other, Describe

No

Yes

265

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

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

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

: 14c8: Home and Bathroom Safety Devices and Select enhanced benefit (Select all that apply):

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**

Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

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: 14c8: Home and Bathroom Safety Devices and

Modifications

Coverage amount (Select all that apply):

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

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Indicate Maximum Plan Benefit Coverage

265

amount for Home and Bathroom Safety

Devices and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Other, Describe

Devices and Modifications:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Nο

Supplemental Benefits?

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

Home and Bathroom Safety Devices and

\$265 loaded on a prepaid card every month to

Modifications Notes:*

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

Yes

Out-of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Lower

Pocket (MOOP) Cost at the Lower,

Intermediate or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-

3400.00

of-Pocket Cost Amount:

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

of-Pocket Cost apply to all In-Network

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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?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription Yes

drug (Part D) benefit?

Defined Standard Select the type of drug benefit:

Describe the components of your pharmacy : Standard Retail

network (select all that apply): : Out-of-Network : Standard Mail-Order

Long-Term Care

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

423,154. 423.154.

SECTION RX: MEDICARE RX GENERAL 2

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

program?

about:blank

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Location/supply amount(s) that apply: 30

Enter number of days for Standard Retail Cost Sharing 1-month supply:

Enter number of days for Standard Retail Cost 90 Sharing 3-month supply:

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

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network 30

Pharmacy 1-month supply:

: Standard Mail-Order - 1-month supply Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 3-month supply Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order 30

Cost Sharing 1-month supply:

90 Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply: Long-Term Care Pharmacy - 1-month supply Select the Long-Term Care Pharmacy one

month Location/supply amount(s) that apply: WINISTRACION OF THE PROPERTY O Enter number of days for Long-Term Care 31

Pharmacy 1-month supply: No 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

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first fill?

SECTION RX: VBID - GENERAL

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

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