APPENDIX C (1)

Medicare Advantage Plan

Benefit Package PBP

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 016
VBID: Yes - Part C
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 7 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Begin Day Interval 1:	1
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Lifetime Reserve Begin Day Interval 1:	1
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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1a Inpatient Hospital-Acute **Service Category Description** **Benefit Description**	
Question	**Response**

1b Inpatient Hospital-Psychiatric **Service Category Description** **Benefit Description**	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
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

1b Inpatient Hospital-Psychiatric **Service Category Description** **Benefit Description**	
Question	**Response**

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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4a Emergency Services **Service Category Description** **Benefit Description**	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services **Service Category Description** **Benefit Description**	
Question	**Response**

4b Urgently Needed Services **Service Category Description** **Benefit Description**	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

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4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

5 Partial Hospitalization

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

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7a Primary Care Physician Services

Service Category Description

Benefit Description

Question	Response
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
Notes:	N/A

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

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7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

7f Podiatry Services **Service Category Description** **Benefit Description**	
Question	**Response**
Notes:	N/A

7g Other Health Care Professional Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

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7h Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

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Question	Response
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response
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
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

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per unit for Medicare-covered Benefits:	$0.00

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9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount per unit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location

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10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	48
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Rideshare Services; Van; Other, Describe
Description:	Car, wheelchair access vehicle
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
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
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

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13a Acupuncture

Service Category Description

Benefit Description

Question	Response
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
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

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13b Over-the-Counter (OTC) Items Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	480.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
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
Notes:	The plan will provide $0 copayment for adult diapers (briefs, pull-ups) box up to two (2) every month. Members who meet medical criteria. Brand according to contracted provider. The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
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
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.

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

14d Kidney Disease Education Services

Service Category Description

Benefit Description

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

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14d Kidney Disease Education Services

Service Category Description

Benefit Description

Question	Response
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	Medicare-covered Glaucoma Screening; Medicare-covered Diabetes Self-Management Training; Medicare-covered Barium Enemas; Medicare-covered Digital Rectal Exams; Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No

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14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

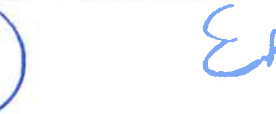
Question	Response
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
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
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No



16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	4
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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
Description:	Dental X-Rays services 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.
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?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
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%
Is there an enrollee Deductible?	No

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray Notes:	Dental X-Rays services 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	4
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select the Restorative Services periodicity:	Other, Describe
Description:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $3,000 maximum benefit per year that only applies to crowns.
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:	2
Select the Periodontics periodicity:	Other, Describe
Description:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	9
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Adjustments to dentures unlim/yr. Bridges, complete/partial dentures, or reline,1/5 yr. Complete /partial denture repair 3/yr. Implant svcs 1/tooth/lifetime, implant supported prosthetics 1/tooth/5 yr
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	**Response**
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No
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
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Restorative Services Notes:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $3,000 maximum benefit per year that only applies to crowns.
Endodontics Notes:	N/A

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Periodontics Notes:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Extractions Notes:	N/A
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Adjustments to dentures unlim/yr. Bridges, complete/partial dentures, or reline,1/5 yr. Complete /partial denture repair 3/yr. Implant svcs 1/tooth/lifetime, implant supported prosthetics 1/tooth/5 yr

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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
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:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00

17b Eyewear

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

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18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
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
Notes:	N/A
Notes:	N/A
Notes:	N/A

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

19a Reduced Cost Sharing for VBID/UF/SSBCI

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

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	1786
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI

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

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	1786
		Expected Number of Enrollees to be engaged and receive Model benefits:	1786
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount:	480
		Select the package level maximum coverage periodicity:	Every year
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Notes:	$40 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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is 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.
		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

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Notes:	$40 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.
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Healthy Living Products
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$40 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.
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	Enter name of Service (Optional):	Living Expense Support
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Notes:	$40 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$40 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications*

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
		Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications
		Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	40.00
		Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	Yes
		Is a referral required for Other Defined Supplemental Benefits?	No
		Home and Bathroom Safety Devices and Modifications Notes:*	$40 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

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PBP Section	Category	Question	Response
19b Additional Benefits for VBID/UF/SSBCI - UF Package 2			
Disease States: Congestive Heart Failure (CHF); Dementia; Other 1; Other 2; Other 3; Other 4; Other 5			
Service Category Description			
Benefit Description			
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Congestive Heart Failure (CHF); Dementia; Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Maligent Neoplasm
		Other 2 Description:	Leukemia
		Other 3 Description:	Chronic Kidney Disease (CKD) & End Stage Renal Disease (ESRD)
		Other 4 Description:	Hepatitis
		Other 5 Description:	Pressure Ulcer
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No
		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
		Notes:	Members who are home bound qualify for $200 maximum benefit coverage amount per month for underpads, disposable gloves, wipes, creams and lotions to prevent dry/cracked skin and decrease risk of ulcers, nutritional drinks through contracted provider. This amount will not carry forward if unused.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	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

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19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Congestive Heart Failure (CHF); Dementia; Other 1; Other 2; Other 3; Other 4; Other 5 Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	200.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
		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

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 018
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
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

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

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3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

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4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

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4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

5 Partial Hospitalization

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Notes:	N/A

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

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7h Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

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8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
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

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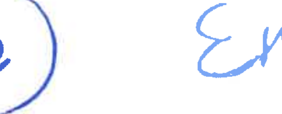

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Observation Services copayment is charged:	Per stay
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

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9d Outpatient Blood Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services

Service Category Description

Benefit Description

Question	Response
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Locatio[n]
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No

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10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Indicate number of trips for Plan Approved Health-related Location:	36
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Van; Other, Describe
Description:	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.
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	$0.00

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11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

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13a Acupuncture

Service Category Description

Benefit Description

Question	Response
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
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

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13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes

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13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Is a referral required for the Meal Benefit?	No
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.

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No

14b Annual Physical Exam

Service Category Description

Benefit Description

Question	Response
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	Medicare-covered Glaucoma Screening; Medicare-covered Diabetes Self-Management Training; Medicare-covered Barium Enemas; Medicare-covered Digital Rectal Exams; Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	**Response**
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	No
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	4
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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
Description:	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.
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?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
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%
Is there an enrollee Deductible?	No

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	4
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Description:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $3000 maximum benefit per year that only applies to crowns.
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Every year
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	5
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Prosths, Oral/Maxillo Surgery, bridges-crown up to 1 every 5 years, bridges-pontic up to 1 every 5 years, occlusal adjustment up to 1 every 3 years, oral surgery up to 2 per year. Dentures unlimited
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
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
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
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	N/A
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $3000 maximum benefit per year that only applies to crowns.
Endodontics Notes:	N/A
Periodontics Notes:	Periodontics includes scaling and root planing (deep cleaning) per quadrant up to 1 per year.
Extractions Notes:	N/A

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
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, $3000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, partial dentures, bridges, implant services, and implant supported prosthetics.

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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
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:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A
Notes:	N/A
Notes:	N/A

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	2986
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool; North Carolina Department of Health and Human Services Healthy Opportunities Program's Social Determinants of Health (SDOH) Screening Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	2986
		Expected Number of Enrollees to be engaged and receive Model benefits:	2986
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount:	720.00
		Select the package level maximum coverage periodicity:	Every year
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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
		Notes:	$60 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.

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	720.00
		Select Maximum Plan Benefit Coverage periodicity:	Every year
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
		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
		Notes:	$60 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.
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Healthy Living Products
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$60 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.
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	Enter name of Service (Optional):	Living Expense Support
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Notes:	$60 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$60 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications*
		Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
		Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications
		Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	60.00
		Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	Yes
		Is a referral required for Other Defined Supplemental Benefits?	No
		Home and Bathroom Safety Devices and Modifications Notes:*	$60 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 019
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Begin Day Interval 1:	1
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Lifetime Reserve Begin Day Interval 1:	1
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
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

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 34-001

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

EMR

4a Emergency Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

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4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7a Primary Care Physician Services

Service Category Description

Benefit Description

Question	Response
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
Notes:	N/A

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

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EMR

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Notes:	N/A

7g Other Health Care Professional Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services

Service Category Description

Benefit Description

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Question	Response
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
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

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9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response
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
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

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9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No

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10b Transportation Services

Service Category Description

Benefit Description

Question	**Response**
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Van; Other, Describe
Description:	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.
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
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
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	No

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13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	No
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.

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Benefit Description

Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response
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

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
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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14d Kidney Disease Education Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
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
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Coinsurance for Insulin?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	4
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Description:	Dental X-Rays services 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.
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?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
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%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray Notes:	Dental X-Rays services 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	4
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe
Description:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to crowns.
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:	2
Select the Periodontics periodicity:	Other, Describe
Description:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per 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

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
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:	9
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services services include adjustments to dentures up to unlimited per year, bridges, complete dentures, complete or partial denture reline and p
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Restorative Services Notes:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to crowns.
Endodontics Notes:	N/A
Periodontics Notes:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Extractions Notes:	N/A
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services services include adjustments to dentures up to unlimited per year, bridges, complete dentures, complete or partial denture reline and partial dentures up to 1 every 5 years, complete or partial denture repair up to 3 per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, partial dentures, implant services and implant supported prosthetics.

17a Eye Exams

Service Category Description

Benefit Description

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

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes

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17b Eyewear

Service Category Description

Benefit Description

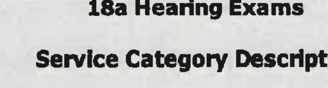
Question	Response
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
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
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
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response



18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
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
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:	0.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	522
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	522
		Expected Number of Enrollees to be engaged and receive Model benefits:	522
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Specify the maximum benefit amount:	60.00
		Select the package level maximum coverage periodicity:	Every month
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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
		Notes:	$60 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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is 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.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	$60 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.
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Healthy Living Products
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$60 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.
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	Enter name of Service (Optional):	Living Expense Support
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Notes:	$60 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	60.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$60 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications*

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
		Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications
		Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	60.00
		Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	Yes
		Is a referral required for Other Defined Supplemental Benefits?	No
		Home and Bathroom Safety Devices and Modifications Notes:*	$60 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 026
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-026 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services

Question	Response
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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
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

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

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3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

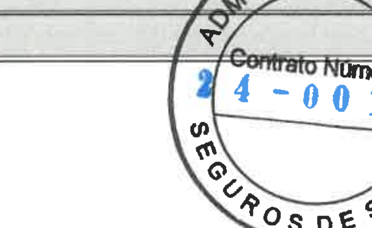
Question	Response
Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):	Medicare-covered Cardiac Rehabilitation Services; Medicare-covered Intensive Cardiac Rehabilitation Services; Medicare-covered Pulmonary Rehabilitation Services; Medicare-covered Supervised 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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response



4a Emergency Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

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4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

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5 Partial Hospitalization

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Notes:	N/A

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

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7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes

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7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

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8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

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8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response
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
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

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

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9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

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9d Outpatient Blood Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services

Service Category Description

Benefit Description

Question	Response
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No

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10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Indicate number of trips for Plan Approved Health-related Location:	36
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Van; Other, Describe
Description:	$0 copayment for plan approved location up to 36 one-way trip(s) per year by car, van, wheelchair access vehicle.
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

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13a Acupuncture

Service Category Description

Benefit Description

Question	Response
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
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

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13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Is a referral required for the Meal Benefit?	No
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.

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

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14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No

EMR

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	Medicare-covered Glaucoma Screening; Medicare-covered Diabetes Self-Management Training; Medicare-covered Barium Enemas; Medicare-covered Digital Rectal Exams; Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

EMR

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	Yes
Indicate Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Every year
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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

EMR

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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:	1
Select the Dental X-Rays 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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Oral Exams:	$0.00
Indicate Maximum Copayment amount for Oral Exams:	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning):	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning):	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Indicate Minimum Copayment amount for Dental X-Rays:	$0.00
Indicate Maximum Copayment amount for Dental X-Rays:	$0.00
Is authorization required?	No

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray Notes:	N/A

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every three years
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
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 three years
Select type of benefit for Extractions:	Mandatory

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
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:	5000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	Medicare-covered Benefits; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	Yes
Select which Comprehensive Dental Services have a Copayment (Select all that apply):	Medicare-covered Benefits; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
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 Diagnostic Services:	$0.00
Indicate Maximum Copayment amount for Diagnostic Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	N/A
Restorative Services Notes:	N/A
Endodontics Notes:	N/A
Periodontics Notes:	N/A
Extractions Notes:	N/A
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	N/A

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17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear

Service Category Description

Benefit Description

Question	Response
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

17b Eyewear

Service Category Description

Benefit Description

Question	Response
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
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:	700.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response

EMR

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

18b Hearing Aids

Service Category Description

Benefit Description

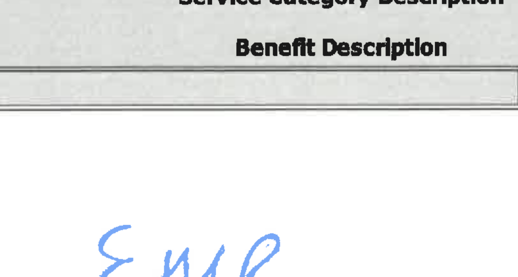
Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response



20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	4370
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	4370
		Expected Number of Enrollees to be engaged and receive Model benefits:	4370
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Specify the maximum benefit amount:	780.00
		Select the package level maximum coverage periodicity:	Every year
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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
		Notes:	$65 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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
		Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	N/A
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 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?	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
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	N/A
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	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?	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
		Is there an enrollee Copayment?	No
		Notes:	N/A
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		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
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	N/A
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications*
		Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	Yes
		Is a referral required for Other Defined Supplemental Benefits?	No

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Home and Bathroom Safety Devices and Modifications Notes:*	N/A

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 027
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-027 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
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

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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4a Emergency Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

5 Partial Hospitalization

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

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7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Notes:	N/A

7g Other Health Care Professional Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

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7h Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
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

9a Outpatient Hospital Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services **Service Category Description** **Benefit Description**	
Question	**Response**

9b Ambulatory Surgical Center (ASC) Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

9d Outpatient Blood Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services

Service Category Description

Benefit Description

Question	Response
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

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10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Van; Other, Describe
Description:	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.
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts **Service Category Description** **Benefit Description**	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
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

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13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
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
Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Is a referral required for the Meal Benefit?	No
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.

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

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14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.

14d Kidney Disease Education Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Services have a Copayment (Select all that apply):	Medicare-covered Glaucoma Screening; Medicare-covered Diabetes Self-Management Training; Medicare-covered Barium Enemas; Medicare-covered Digital Rectal Exams; Medicare-covered EKG following Welcome Visit
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	$0.00
Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	$0.00
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?
Notes:	n/a
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	4
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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
Description:	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.
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?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
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%
Is there an enrollee Deductible?	No

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	10
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select the Restorative Services periodicity:	Other, Describe
Description:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $3000 maximum benefit per year that only applies to crowns.
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:	8
Select the Periodontics periodicity:	Other, Describe
Description:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	8
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Denture adj unlimited/year, bridges, comp./partial dentures, comp./partial denture reline, 1/5 years, comp./partial denture repair 3/year, implant svcs 1/tooth/life, implant prost. 1/tooth/5 years
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No
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
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	"Diagnostic Services - Diagnostic Services services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Restorative Services Notes:	Restorative services include fillings 0% up to 1 per tooth every 3 years, crown 0% up to 1 per tooth every 5 years, $3000 maximum benefit per year that only applies to crowns.
Endodontics Notes:	N/A
Periodontics Notes:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Extractions Notes:	N/A
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services services include adjustments to dentures up to unlimited per year, bridges, complete dentures, complete or partial denture reline and partial dentures up to 1 every 5 years, complete or partial denture repair up to 3 per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics up to 1 per tooth every 5 years, $3,000 maximum benefit per year that only applies to adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, partial dentures, implant services and implant supported prosthetics.

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear

Service Category Description

Benefit Description

Question	Response
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
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:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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

18a Hearing Exams

Service Category Description

Benefit Description

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

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
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
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

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	Yes
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	1279
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	1279
		Expected Number of Enrollees to be engaged and receive Model benefits:	1279
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount:	3180
		Select the package level maximum coverage periodicity:	Every year
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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
		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.

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	265
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
		Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
		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
		Notes:	$265 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.
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Healthy Living Products
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	265
		Select Maximum Plan Benefit Coverage periodicity:	Every month

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		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.
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	Enter name of Service (Optional):	Living Expense Support
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	265
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Notes:	$265 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	265
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$265 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications*
		Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
		Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications
		Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	265
		Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		Home and Bathroom Safety Devices and Modifications Notes:*	$265 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

Bid Reports 2024

PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 030
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Kansas City
Lead Marketing Region:	Kansas City
Org. Marketing Name:	Humana
Plan Name:	Humana Gold Plus SNP-DE H4007-030 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024491
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
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
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	No
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Begin Day Interval 1:	1
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Lifetime Reserve Begin Day Interval 1:	1
Indicate the number of day intervals for Additional Days:	Zero (No Copayment per Day)
Begin Day Interval 1:	90
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Copayment amount for the Medicare-covered stay:	$0.00
Indicate the number of day intervals for the Medicare-covered stay:	Zero (No Copayment per Day)
Begin Day Interval 1:	1
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Zero (No Copayment per Day)
Lifetime Reserve Begin Day Interval 1:	1
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

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	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
Is there an enrollee Copayment?	Yes

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3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A
Notes:	N/A

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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 the Copayment for Medicare-covered Benefits waived if admitted to hospital?	Yes
Select either Days or Hours within which admission must occur for waiver:	Hours
Enter number of Days or Hours:	24
Does the Emergency Services cost sharing count towards any plan-level deductible?	No
Notes:	N/A

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	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
Does the Urgently Needed Services cost sharing count towards any plan-level deductible?	No
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	No
Notes:	N/A

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Select type of benefit for Worldwide Emergency Transportation:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	Yes
Is there an enrollee Deductible?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

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5 Partial Hospitalization

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits 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
Notes:	N/A

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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
Notes:	N/A

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes
Notes:	N/A

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No
Notes:	N/A

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
Notes:	N/A

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

EMR

7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Mental Health Specialty Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No

EMR

7f Podiatry Services **Service Category Description** **Benefit Description**	
Question	**Response**
Notes:	N/A

7g Other Health Care Professional Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	No
Notes:	N/A

7h Psychiatric Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Select which Psychiatric Services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

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7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No
Notes:	N/A
Notes:	N/A

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	N/A

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
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
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
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No
Notes:	N/A

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
Notes:	N/A

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
Diagnostic Procedures/Tests Notes:	N/A
Lab Services Notes:	N/A

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	Yes
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No
X-Ray Services Notes:	N/A
Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	N/A
Therapeutic Radiological Services Notes:	N/A

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
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

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9a Outpatient Hospital Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Notes:	N/A
9a1 Outpatient Hospital Services Notes:	N/A
9a2 Observation Services Notes:	N/A

9a Outpatient Hospital Services **Service Category Description** **Benefit Description**	
Question	**Response**

9b Ambulatory Surgical Center (ASC) Services **Service Category Description** **Benefit Description**	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	N/A

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

Question	Response
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
Select which Outpatient Substance Abuse services have a Copayment (Select all that apply):	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Select which Services have a Copayment (Select all that apply):	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is this Copayment waived if admitted to hospital?	No
Is authorization required for non-emergency Medicare services?	Yes
Notes:	N/A
Notes:	N/A

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10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No

10b Transportation Services

Service Category Description

Benefit Description

Question	**Response**
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Van; Other, Describe
Description:	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.
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
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per trip:	$0.00
Indicate Maximum Copayment amount per trip:	$0.00
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Services arranged by the plan's transportation provider to approved locations by means of car, van, or wheelchair access vehicle that provide members access to health benefits.

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	N/A

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):	Medicare-covered Medical Supplies
Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	$0.00
Is authorization required?	Yes
Notes:	N/A
Notes:	N/A

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
Notes:	N/A
Notes:	N/A

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	**Response**
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per treatment:	$0.00
Indicate Maximum Copayment amount per treatment:	$0.00
Is authorization required?	Yes
Is a referral required for Acupuncture?	No
Notes:	N/A

13a Acupuncture

Service Category Description

Benefit Description

Question	**Response**

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	**Response**
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

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13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria

13c Meal Benefit

Service Category Description

Benefit Description

Question	Response
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount:	$0.00
Indicate Maximum Copayment amount:	$0.00
Is authorization required?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Is a referral required for the Meal Benefit?	No
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.

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	Yes
Select type of benefit for the Annual Physical Exam:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for each Annual Physical Exam:	$0.00
Indicate Maximum Copayment amount for each Annual Physical Exam:	$0.00
Is authorization required?	No
Is a referral required for the Annual Physical Exam?	No

14b Annual Physical Exam

Service Category Description

Benefit Description

Question	Response
Notes:	An examination performed by a primary care physician that collects health information and measures different bodily systems as a baseline reading. The Routine Physical Exam includes a more comprehensive examination than an annual wellness visit. Services in a Routine Physical Exam will include the following: 1. Bodily systems examinations, such as heart, lung, head and neck, and neurological. 2. Measure and record vital signs, such as blood pressure, heart rate and respiratory rate 3. Complete prescription medication review. 4. Review of any recent hospitalization

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*; 14c15: Wigs for Hair Loss Related to Chemotherapy
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	4
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	Physical Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory
Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c15: Wigs for Hair Loss Related to Chemotherapy
Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:	500.00
Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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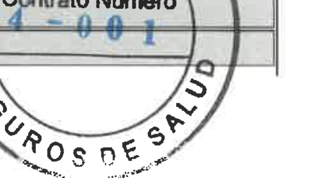
14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:	$0.00
Indicate Maximum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:	$0.00
Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	No authorization required for this service.
Fitness Benefit Notes:*	Fitness benefit includes a health and wellness program which has the goal of helping older adults live healthy active lifestyles by providing access to partner fitness facilities and may include classes specifically for older adults. These classes are focused on physical activity. In addition, this program may include a specialized at-home package to support fitness and exercise at home for those unable to take a class at the fitness center.No authorization required for this service.
Home and Bathroom Safety Devices and Modifications Notes:*	The plan will provide 1 bath chair every 5 years.Authorization is required for this service.
Wigs for Hair Loss Related to Chemotherapy Notes:	Authorization is required for this service.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**



14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
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
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Attestation:	I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
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
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:	$0.00
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No

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15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?
Notes:	N/A
Notes:	N/A
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	2
Select the Oral Exams periodicity:	Every year
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	2
Select the Prophylaxis (Cleaning) periodicity:	Every year
Select type of benefit for Fluoride Treatment:	Mandatory
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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Description:	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.
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?	Yes
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Oral Exams; Prophylaxis (Cleaning); Dental X-Rays
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%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is there a combination of services included in a single cost per Office Visit?	No
Indicate Minimum Copayment amount for Fluoride Treatment:	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment:	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Oral Exam Notes:	N/A
Prophylaxis (Cleaning) Notes:	N/A
Dental X-Ray 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	4
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Diagnostic Services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	2
Select the Restorative Services periodicity:	Other, Describe
Description:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to crowns.
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:	2
Select the Periodontics periodicity:	Other, Describe
Description:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	8
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Adjustments to dentures unlim/yr. Bridges, complete/partial dentures, or reline,1/5 yr. Complete /partial denture repair 3/yr. Implant svcs 1/tooth/lifetime, implant supported prosthetics 1/tooth/5 yr
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):	Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Indicate Minimum Coinsurance percentage for Diagnostic Services:	0%
Indicate Maximum Coinsurance percentage for Diagnostic Services:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	0%
Indicate Maximum Coinsurance percentage for Restorative Services:	0%
Indicate Minimum Coinsurance percentage for Endodontics:	0%
Indicate Maximum Coinsurance percentage for Endodontics:	0%
Indicate Minimum Coinsurance percentage for Periodontics:	0%
Indicate Maximum Coinsurance percentage for Periodontics:	0%
Indicate Minimum Coinsurance percentage for Extractions:	0%
Indicate Maximum Coinsurance percentage for Extractions:	0%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Is there an enrollee Deductible?	No

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
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
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Diagnostic Services Notes:	Diagnostic Services include comprehensive oral exam and cone beam CT imaging up to 1 every 3 years, pulp vitality test up to 2 per quadrant per year.
Restorative Services Notes:	Restorative services include amalgam or composite filling up to 1 per tooth every 3 years, crown up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to crowns.
Endodontics Notes:	Endodontics services include root canal up to unlimited per year.
Periodontics Notes:	Periodontics services include periodontal surgery up to 1 per quadrant every 3 years, scaling and root planing (deep cleaning) up to 1 per quadrant per year.
Extractions Notes:	Extractions services include extractions up to unlimited per year.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services services include adjustments to dentures up to unlimited per year, bridges, complete dentures, complete or partial denture reline and partial dentures up to 1 every 5 years, complete or partial denture repair up to 3 per year, implant services up to 1 per tooth per lifetime, implant supported prosthetics up to 1 per tooth every 5 years, $2,000 maximum benefit per year that only applies to adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, partial dentures, implant services and implant supported prosthetics.

17a Eye Exams

Service Category Description

Benefit Description

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

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Eye Exams have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Eye Exams
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	N/A
Notes:	N/A

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes

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17b Eyewear

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
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
Select which Eyewear Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Contact lenses:	$0.00
Indicate Maximum Copayment amount for Contact lenses:	$0.00
Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	N/A
Notes:	N/A

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response

EMR

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
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
Is there an enrollee Copayment?	Yes
Select which Hearing Exam Benefits have a Copayment (Select all that apply):	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No
Notes:	N/A
Notes:	N/A
Notes:	N/A

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18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Indicate Minimum Copayment amount per Hearing Aid (all types):	$0.00
Indicate Maximum Copayment amount per Hearing Aid (all types):	$0.00
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	Yes
Is authorization required?	No
Is a referral required for Hearing Aids?	No
Notes:	N/A

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Care Management Program; In-home Assessments; Other Program
Specify Other Program:	Humana will offer all members access to digital advance care planning tool integrated with Humana's online member portals
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses; Other
Expected Number of Beneficiaries to be Engaged Annually:	4966
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Caregiver feedback; Provider feedback; Patient/caregiver/community health needs assessment
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply):	Accountable Health Communities (AHC) HRSN Screening Tool; Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		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:	4966
		Expected Number of Enrollees to be engaged and receive Model benefits:	4966
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		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; 14c8: Home and Bathroom Safety Devices and Modifications
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Specify the maximum benefit amount:	1500.00
		Select the package level maximum coverage periodicity:	Every year
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		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
		Notes:	$125 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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	125.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is 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.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No

PBP Section	Category	Question	Response
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 **Disease States:** **Service Category Description** **Benefit Description**			
		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
		Notes:	$125 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.
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Healthy Living Products
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	125.00
		Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$125 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.
19b - 13e	Additional Benefits for VBID/UF/SSBCI - Other 2	Enter name of Service (Optional):	Living Expense Support
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	125.00
		Select Maximum Plan Benefit Coverage periodicity:	Other, Describe

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		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?	No
		Notes:	$125 loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, pest control, non-medical transportation, disaster relief kits, utilities, internet service payments, and social needs, including social organization membership fees and activity expenses.
19b - 13f	Additional Benefits for VBID/UF/SSBCI - Other 3	Enter name of Service (Optional):	Aging Support and Safety Products
		Select type of benefit for Other 3:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	125.00
		Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
		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?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	$125 loaded on a prepaid card every month to spend on robotic pets, speech/language assistive devices, and weighted mugs and utensils.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		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
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
		Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	14c8: Home and Bathroom Safety Devices and Modifications
		Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	125.00
		Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Indicate Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Indicate Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications:	$0.00
		Is authorization required?	Yes
		Is a referral required for Other Defined Supplemental Benefits?	No
		Home and Bathroom Safety Devices and Modifications Notes:*	$125 loaded on a prepaid card every month to spend on bathroom safety devices and equipment.

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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