APPENDIX C (1)
Medicare Advantage Plan Benefit Package PBP

Bid Reports 2025

ADMINISTRACION DE SEGUROS DE SALUD

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PBP Benefits Report

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 016
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 2 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare-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?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$50.00

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,10b1 Transportation Services - Plan Approved Health-related Location,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c6 Implant Services,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

Tiered Cost sharing for Part B Services	
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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

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5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Enhanced benefits (7b)	Routine Care
Type of benefit for Routine Care	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Number of visits for Routine Care	12
Routine Care periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services; Routine Care
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount per visit for Routine Care	$0.00
Maximum Copayment amount per visit for Routine Care	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

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9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

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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
Enhanced benefit (10b)	Plan Approved Health-related Location
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
Number of trips for Plan Approved Health-related Location	24
Plan Approved Health-related Location Trips periodicity	Every year
Type of Transportation for Plan Approved Health-related Location	One-way
Mode of Transportation for Plan Approved Health-related Location	Rideshare Services; Van; Other, Describe
Mode of Transportation for Plan Approved Health-related Location description	Car, wheelchair access vehicle
Is there a service specific maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (10b)	This benefit offers unlimited miles per trip.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Prosthetic Devices	$0.00
Maximum Copayment amount per item for Medicare-covered Prosthetic Devices	$0.00
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Are you offering Naloxone coverage as a Part C OTC benefit?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Notes (14b)	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

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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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
Type of benefit for Fitness Benefit	Mandatory
Type of Fitness Benefit offered	Physical Fitness
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Fitness Benefit	$0.00
Maximum Copayment amount for Fitness Benefit	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Fitness Benefit Notes (14c4):*	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.
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	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 (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs.

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	2000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$2,000 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c4)	$2,000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Implant Services	Mandatory
Is this benefit unlimited for Implant Services?	No
Number of visits for Implant Services	2
Implant Services periodicity	Other, Describe
Implant Services periodicity description	implant supported prosthetics 1/tooth/5 yrs, implant svcs 1/tooth/lifetime
Is there a coinsurance?	Yes
Coinsurance percentage for Implant Services	0%
Minimum Coinsurance percentage for Implant Services	0%
Maximum Coinsurance percentage for Implant Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c6)	$2,000 maximum benefit per year that only applies to implant services and implant supported prosthetics
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c7)	$2,000 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Enhanced benefits (17b)	Contact lenses; Eyeglasses (lenses and frames)
Type of benefit for Contact lenses	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Type of benefit for Eyeglasses (lenses and frames)	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	500.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1
Routine Hearing Exams periodicity	Every year
Type of benefit for Fitting/Evaluation for Hearing Aid	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Number for Fitting/Evaluation for Hearing Aid	1
Fitting/Evaluation for Hearing Aid periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Minimum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Maximum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	Yes
Enhanced benefits (18b)	Hearing Aids (all types)
Type of benefit for Prescription Hearing Aids (all types)	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Quantity for Hearing Aids (all types)	2
Hearing Aids (all types) periodicity	Every year
Service maximum plan benefit coverage	Yes
Select Coverage	Per ear
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	1000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a copayment ?	Yes
Minimum Copayment amount per Hearing Aid (all types)	$0.00
Maximum Copayment amount per Hearing Aid (all types)	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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18c OTC Hearing Aids 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 this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Does this plan offer Special Supplemental Benefits for Chronically Ill?	No
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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)	1

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 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**
19b	Additional Benefits for VBID/UF/SSBCI	Type of Package	MA Uniformity Flexibility
		Disease state - Please choose one or more	Congestive Heart Failure (CHF); Dementia; Other 1; Other 2; Other 3; Other 4; Other 5
		Chronic Conditions -Other1	Malignant Neoplasm
		Chronic Conditions -Other2	Leukemia
		Chronic Conditions -Other3	Chronic Kidney Disease (CKD) & End Stage
		Chronic Conditions -Other4	Hepatitis
		Chronic Conditions -Other5	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?	No
		Prerequisite for any additional benefits for this package?	No
		Non-Medicare-covered additional benefits offered in this package: (Maximum of 30 service categories can be added to a 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?	Yes
		Specify the maximum benefit amount	125.00
		Package level maximum coverage periodicity	Every month
		Mode of delivery for maximum coverage amount	Other
		Other mode of delivery description	When purchased through contracted provider
		Non-Medicare-covered benefits that apply to the package level maximum coverage	13b: Over-the-Counter (OTC) Items
		B19b Notes	Members who are home bound and in nursing home facilities qualify for the maximum benefit coverage amount.
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
		Type of benefit for OTC Items	Mandatory

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 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 maximum plan benefit coverage amount?	Yes
		Maximum plan benefit coverage amount	125.00
		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
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
		Are you offering Naloxone coverage as a Part C OTC benefit?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
		Notes (13b)	Members who are home bound and in nursing home facilities qualify for $125.00 maximum benefit coverage amount per month for adult diapers (briefs, pull-up), underpads, disposable gloves, wipes, creams and lotions to prevent dry/cracked skin and decrease risk of ulcers, nutritional drinks through contracted provider.

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HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 018
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 1 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare-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?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$100.00

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,10b1 Transportation Services - Plan Approved Health-related Location,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c6 Implant Services,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

Tiered Cost sharing for Part B Services	
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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No

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2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No

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4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

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5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

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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
Enhanced benefit (10b)	Plan Approved Health-related Location
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
Number of trips for Plan Approved Health-related Location	24
Plan Approved Health-related Location Trips periodicity	Every year
Type of Transportation for Plan Approved Health-related Location	One-way
Mode of Transportation for Plan Approved Health-related Location	Rideshare Services; Van; Other, Describe
Mode of Transportation for Plan Approved Health-related Location description	Car, wheelchair access vehicle
Is there a service specific maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (10b)	This benefit offers unlimited miles per trip.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Prosthetic Devices	$0.00
Maximum Copayment amount per item for Medicare-covered Prosthetic Devices	$0.00
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Are you offering Naloxone coverage as a Part C OTC benefit?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

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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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Notes (14b)	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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
Type of benefit for Fitness Benefit	Mandatory
Type of Fitness Benefit offered	Physical Fitness
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Fitness Benefit	$0.00
Maximum Copayment amount for Fitness Benefit	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Fitness Benefit Notes (14c4):*	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.
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	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 (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs.

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	2500.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$2,500 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c4)	$2,500 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Implant Services	Mandatory
Is this benefit unlimited for Implant Services?	No
Number of visits for Implant Services	2
Implant Services periodicity	Other, Describe
Implant Services periodicity description	implant supported prosthetics 1/tooth/5 yrs, implant svcs 1/tooth/lifetime
Is there a coinsurance?	Yes
Coinsurance percentage for Implant Services	0%
Minimum Coinsurance percentage for Implant Services	0%
Maximum Coinsurance percentage for Implant Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c6)	$2,500 maximum benefit per year that only applies to implant services and implant supported prosthetics
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c7)	$2,500 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Enhanced benefits (17b)	Contact lenses; Eyeglasses (lenses and frames)
Type of benefit for Contact lenses	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Type of benefit for Eyeglasses (lenses and frames)	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	500.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1
Routine Hearing Exams periodicity	Every year
Type of benefit for Fitting/Evaluation for Hearing Aid	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Number for Fitting/Evaluation for Hearing Aid	1
Fitting/Evaluation for Hearing Aid periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Minimum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Maximum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	Yes
Enhanced benefits (18b)	Hearing Aids (all types)
Type of benefit for Prescription Hearing Aids (all types)	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Quantity for Hearing Aids (all types)	2
Hearing Aids (all types) periodicity	Every year
Service maximum plan benefit coverage	Yes
Select Coverage	Per ear
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	1000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

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18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a copayment ?	Yes
Minimum Copayment amount per Hearing Aid (all types)	$0.00
Maximum Copayment amount per Hearing Aid (all types)	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

18c OTC Hearing Aids Service Category Description Benefit Description	
Question	**Response**

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

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PBP Benefits Report

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HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 026
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 1 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
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**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$174.70

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,10b1 Transportation Services - Plan Approved Health-related Location,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c6 Implant Services,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

Tiered Cost sharing for Part B Services	
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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

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5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

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7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

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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
Enhanced benefit (10b)	Plan Approved Health-related Location
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
Number of trips for Plan Approved Health-related Location	24
Plan Approved Health-related Location Trips periodicity	Every year
Type of Transportation for Plan Approved Health-related Location	One-way
Mode of Transportation for Plan Approved Health-related Location	Rideshare Services; Van; Other, Describe
Mode of Transportation for Plan Approved Health-related Location description	Car, wheelchair access vehicle
Is there a service specific maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (10b)	This benefit offers unlimited miles per trip.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Minimum coinsurance	10%
Maximum coinsurance	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes
Notes (11a MC)	10% Continuous Glucose Monitor - DME Prov $0 Continuous Glucose Monitor - Pharmacy 10% DME - DME Prov 10% DME - Pharmacy

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Which Prosthetics/Medical Supplies have a Coinsurance	Medicare-covered Prosthetic Devices
Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	No
Are you offering Naloxone coverage as a Part C OTC benefit?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

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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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Notes (14b)	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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
Type of benefit for Fitness Benefit	Mandatory
Type of Fitness Benefit offered	Physical Fitness
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Fitness Benefit	$0.00
Maximum Copayment amount for Fitness Benefit	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Fitness Benefit Notes (14c4):*	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.
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	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 (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs.

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs.

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	3000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$3,000 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c4)	$3,000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Implant Services	Mandatory
Is this benefit unlimited for Implant Services?	No
Number of visits for Implant Services	2
Implant Services periodicity	Other, Describe
Implant Services periodicity description	implant supported prosthetics 1/tooth/5 yrs, implant svcs 1/tooth/lifetime
Is there a coinsurance?	Yes
Coinsurance percentage for Implant Services	0%
Minimum Coinsurance percentage for Implant Services	0%
Maximum Coinsurance percentage for Implant Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c6)	$2,000 maximum benefit per year that only applies to implant services and implant supported prosthetics
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c7)	$3,000 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Enhanced benefits (17b)	Contact lenses; Eyeglasses (lenses and frames)
Type of benefit for Contact lenses	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Type of benefit for Eyeglasses (lenses and frames)	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	400.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1
Routine Hearing Exams periodicity	Every year
Type of benefit for Fitting/Evaluation for Hearing Aid	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Number for Fitting/Evaluation for Hearing Aid	1
Fitting/Evaluation for Hearing Aid periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Minimum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Maximum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	Yes
Enhanced benefits (18b)	Hearing Aids (all types)
Type of benefit for Prescription Hearing Aids (all types)	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Quantity for Hearing Aids (all types)	2
Hearing Aids (all types) periodicity	Every year
Service maximum plan benefit coverage	Yes
Select Coverage	Per ear
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	250.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a copayment ?	Yes
Minimum Copayment amount per Hearing Aid (all types)	$0.00
Maximum Copayment amount per Hearing Aid (all types)	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

18c OTC Hearing Aids Service Category Description Benefit Description	
Question	**Response**

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

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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 1 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
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**
MA Rebates Used to Reduce Part B Premium:	No

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,10b1 Transportation Services - Plan Approved Health-related Location,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c6 Implant Services,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

Tiered Cost sharing for Part B Services	
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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No

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2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	No

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

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5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Enhanced benefit (10b)	Plan Approved Health-related Location
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
Number of trips for Plan Approved Health-related Location	12
Plan Approved Health-related Location Trips periodicity	Every year
Type of Transportation for Plan Approved Health-related Location	One-way
Mode of Transportation for Plan Approved Health-related Location	Rideshare Services; Van; Other, Describe
Mode of Transportation for Plan Approved Health-related Location description	Car, wheelchair access vehicle
Is there a service specific maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (10b)	This benefit offers unlimited miles per trip.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Minimum coinsurance	10%
Maximum coinsurance	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes
Notes (11a MC)	10% Continuous Glucose Monitor - DME Prov $0 Continuous Glucose Monitor - Pharmacy 10% DME - DME Prov 10% DME - Pharmacy _

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Which Prosthetics/Medical Supplies have a Coinsurance	Medicare-covered Prosthetic Devices
Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	Yes
Maximum plan benefit coverage amount	2280.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	The plan will provide 1 blood pressure monitoring unit every 5 years for members who meet the medical criteria.

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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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes (14b)	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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
Type of benefit for Fitness Benefit	Mandatory
Type of Fitness Benefit offered	Physical Fitness
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Fitness Benefit	$0.00
Maximum Copayment amount for Fitness Benefit	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Fitness Benefit Notes (14c4):*	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.
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Referral required for this benefit?	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 (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs. _
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	2500.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$2,500 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c4)	$2,500 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Implant Services	Mandatory
Is this benefit unlimited for Implant Services?	No
Number of visits for Implant Services	2
Implant Services periodicity	Other, Describe
Implant Services periodicity description	implant supported prosthetics 1/tooth/5 yrs, implant svcs 1/tooth/lifetime
Is there a coinsurance?	Yes
Coinsurance percentage for Implant Services	0%
Minimum Coinsurance percentage for Implant Services	0%
Maximum Coinsurance percentage for Implant Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c6)	$2,500 maximum benefit per year that only applies to implant services and implant supported prosthetics
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c7)	$2,500 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	500.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Routine Hearing Exams periodicity	Every year
Type of benefit for Fitting/Evaluation for Hearing Aid	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Number for Fitting/Evaluation for Hearing Aid	1
Fitting/Evaluation for Hearing Aid periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Minimum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Maximum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	Yes
Enhanced benefits (18b)	Hearing Aids (all types)

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Type of benefit for Prescription Hearing Aids (all types)	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Quantity for Hearing Aids (all types)	2
Hearing Aids (all types) periodicity	Every year
Service maximum plan benefit coverage	Yes
Select Coverage	Per ear
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	1000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Minimum Copayment amount per Hearing Aid (all types)	$0.00
Maximum Copayment amount per Hearing Aid (all types)	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

18c OTC Hearing Aids Service Category Description Benefit Description	
Question	**Response**

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

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Does this plan offer Special Supplemental Benefits for Chronically Ill?	No
Does this plan offer VBID hospice benefits?	No
Does this plan offer value-based design flexibilities by condition, socioeconomic state, or area deprivation index under the VBID model?	Yes
Value-Based Insurance Design Attestation	I attest that: * 1) The benefits entered comply with CMS requirements for benefits offered in the VBID model; 2) The benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID model, unless otherwise approved by CMS in writing; 3) The benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary; and 4) Including any proposed benefits offered through the VBID Model in this PBP, this PBP offers a minimum of two supplemental benefits to address priority HRSNs from among the categories of food and nutrition, transportation, and housing and living environment. NOTE: This does not apply to PBPs participating only in the Hospice Benefit Component.
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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)	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	Type of Package	VBID
		Target Methodology (Required)	Socioeconomic Status

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		For VBID Additional Benefits package, when socioeconomic status is selected then provide the LIS reduction level Dual-Eligible Status.	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted	2618
		Expected Number of Enrollees to be engaged and receive Model benefits	2618
		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?	No
		Prerequisite for any additional benefits for this package?	No
		Non-Medicare-covered additional benefits offered in this package: (Maximum of 30 service categories can be added to a package)	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS); 13i6: Social Needs Benefit
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount	2280.00
		Package level maximum coverage periodicity	Every year
		Mode of delivery for maximum coverage amount	Debit Card
		Non-Medicare-covered benefits that apply to the package level maximum coverage	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i6: Social Needs Benefit; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS)
		B19b Notes	$190.00 loaded on a prepaid card every month to spend at participating retailers. Unused funds will roll over to the next month and expire at the end of the plan year.

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
		Type of benefit for OTC Items	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
		Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Type of benefit for Food and Produce	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i1)	Allowance loaded on a prepaid card every month to spend at participating retailers toward plan-approved food and produce.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
		Type of benefit for Pest Control	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i3)	Allowance loaded on a prepaid card every month to spend toward pest control services.
		Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
		Enhanced benefit	Any Location
		Type of benefit for Any Location	Mandatory
		Is this benefit unlimited for number of trips for Any Location?	Yes
		Type of Transportation for Non-Medical Needs for Any Location	One-way
		Mode of Transportation for Non-Medical Needs for Any Location	Taxi; Rideshare Services; Bus/Subway; Van; Medical Transport
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i4)	Allowance loaded on a prepaid card every month to spend on non-medical transportation.
		Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
		Type of benefit for Indoor Air Quality Equipment and Services	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i5)	Allowance loaded on a prepaid card every month to spend toward indoor air quality equipment and services.
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Type of benefit for Social Needs Benefit	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a 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**
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i6)	Allowance loaded on a prepaid card every month to address enrollee social needs pertaining to social isolation and to improve emotional and/or cognitive function.
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Type of benefit for General Supports for Living	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i10)	Allowance loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, disaster relief kits, utilities, and internet service payments.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Other 1
		Service Name	Healthy Living and Aging Support
		Type of benefit for Other 1	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	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 a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i-01)	Allowance loaded on a prepaid card every month to spend on products to support healthy living and aging such as home supplies, personal wellness products, 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
		Enhanced benefits (14c)	14c8: Home and Bathroom Safety Devices and Modifications*; 14c11: Personal Emergency Response System (PERS)
		Type of benefit for Home and Bathroom Safety Devices and Modifications	Mandatory
		Type of benefit for Personal Emergency Response System (PERS)	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 (MOOP) for Other Defined Supplemental Benefits?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Minimum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Maximum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Authorization required for this benefit?	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**
		Referral required for this benefit?	No
		Home and Bathroom Safety Devices and Modifications Notes (14c8):*	Allowance loaded on a prepaid card every month to spend on bathroom safety devices and equipment.
		Personal Emergency Response System (PERS) Notes (14c11)	Allowance loaded on a prepaid card every month to spend on personal emergency response system device and services through the plan's participating vendor.

[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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PBP Benefits Report

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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 1 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
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**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$90.00

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c6 Implant Services,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a copayment?	No

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Enhanced benefits (7b)	Routine Care
Type of benefit for Routine Care	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Number of visits for Routine Care	12
Routine Care periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services; Routine Care
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount per visit for Routine Care	$0.00
Maximum Copayment amount per visit for Routine Care	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

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9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services; Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

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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?	No

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Minimum coinsurance	10%
Maximum coinsurance	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes
Notes (11a MC)	10% Continuous Glucose Monitor - DME Prov $0 Continuous Glucose Monitor - Pharmacy 10% DME - DME Prov 10% DME - Pharmacy _

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Which Prosthetics/Medical Supplies have a Coinsurance	Medicare-covered Prosthetic Devices
Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	Yes
Maximum plan benefit coverage amount	1260.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes (14b)	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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
Type of benefit for Fitness Benefit	Mandatory
Type of Fitness Benefit offered	Physical Fitness
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c4: Fitness Benefit*; 14c8: Home and Bathroom Safety Devices and Modifications*
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Fitness Benefit	$0.00
Maximum Copayment amount for Fitness Benefit	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Fitness Benefit Notes (14c4):*	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.
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Referral required for this benefit?	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 (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs. _
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	2000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$2,000 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c4)	$2,000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Implant Services	Mandatory
Is this benefit unlimited for Implant Services?	No
Number of visits for Implant Services	2
Implant Services periodicity	Other, Describe
Implant Services periodicity description	implant supported prosthetics 1/tooth/5 yrs, implant svcs 1/tooth/lifetime
Is there a coinsurance?	Yes
Coinsurance percentage for Implant Services	0%
Minimum Coinsurance percentage for Implant Services	0%
Maximum Coinsurance percentage for Implant Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c6)	$2,000 maximum benefit per year that only applies to implant services and implant supported prosthetics
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No

16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c7)	$2,000 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	300.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Routine Hearing Exams periodicity	Every year
Type of benefit for Fitting/Evaluation for Hearing Aid	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Number for Fitting/Evaluation for Hearing Aid	1
Fitting/Evaluation for Hearing Aid periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Minimum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Maximum Copayment amount for Fitting/Evaluation for Hearing Aid	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	Yes
Enhanced benefits (18b)	Hearing Aids (all types)

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Type of benefit for Prescription Hearing Aids (all types)	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Quantity for Hearing Aids (all types)	2
Hearing Aids (all types) periodicity	Every year
Service maximum plan benefit coverage	Yes
Select Coverage	Per ear
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	500.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Minimum Copayment amount per Hearing Aid (all types)	$0.00
Maximum Copayment amount per Hearing Aid (all types)	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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18c OTC Hearing Aids 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 this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Does this plan offer Special Supplemental Benefits for Chronically Ill?	No
Does this plan offer VBID hospice benefits?	No
Does this plan offer value-based design flexibilities by condition, socioeconomic state, or area deprivation index under the VBID model?	Yes
Value-Based Insurance Design Attestation	I attest that: * 1) The benefits entered comply with CMS requirements for benefits offered in the VBID model; 2) The benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID model, unless otherwise approved by CMS in writing; 3) The benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary; and 4) Including any proposed benefits offered through the VBID Model in this PBP, this PBP offers a minimum of two supplemental benefits to address priority HRSNs from among the categories of food and nutrition, transportation, and housing and living environment. NOTE: This does not apply to PBPs participating only in the Hospice Benefit Component.
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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)	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	Type of Package	VBID
		Target Methodology (Required)	Socioeconomic Status

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		For VBID Additional Benefits package, when socioeconomic status is selected then provide the LIS reduction level Dual-Eligible Status.	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted	7880
		Expected Number of Enrollees to be engaged and receive Model benefits	7880
		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?	No
		Prerequisite for any additional benefits for this package?	No
		Non-Medicare-covered additional benefits offered in this package: (Maximum of 30 service categories can be added to a package)	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS); 13i6: Social Needs Benefit
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount	1260.00
		Package level maximum coverage periodicity	Every year
		Mode of delivery for maximum coverage amount	Debit Card
		Non-Medicare-covered benefits that apply to the package level maximum coverage	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i6: Social Needs Benefit; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS)
		B19b Notes	$105.00 loaded on a prepaid card every month to spend at participating retailers. Unused funds will roll over to the next month and expire at the end of the plan year.

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
		Type of benefit for OTC Items	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
		Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Type of benefit for Food and Produce	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a 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**
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i1)	Allowance loaded on a prepaid card every month to spend at participating retailers toward plan-approved food and produce.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
		Type of benefit for Pest Control	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i3)	Allowance loaded on a prepaid card every month to spend toward pest control services.
		Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
		Enhanced benefit	Any Location
		Type of benefit for Any Location	Mandatory
		Is this benefit unlimited for number of trips for Any Location?	Yes
		Type of Transportation for Non-Medical Needs for Any Location	One-way
		Mode of Transportation for Non-Medical Needs for Any Location	Taxi; Rideshare Services; Bus/Subway; Van; Medical Transport
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i4)	Allowance loaded on a prepaid card every month to spend on non-medical transportation.
		Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
		Type of benefit for Indoor Air Quality Equipment and Services	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i5)	Allowance loaded on a prepaid card every month to spend toward indoor air quality equipment and services.
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Type of benefit for Social Needs Benefit	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a 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**
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i6)	Allowance loaded on a prepaid card every month to address enrollee social needs pertaining to social isolation and to improve emotional and/or cognitive function.
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Type of benefit for General Supports for Living	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i10)	Allowance loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, disaster relief kits, utilities, and internet service payments.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Other 1
		Service Name	Healthy Living and Aging Support
		Type of benefit for Other 1	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	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 a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i-01)	Allowance loaded on a prepaid card every month to spend on products to support healthy living and aging such as home supplies, personal wellness products, 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
		Enhanced benefits (14c)	14c8: Home and Bathroom Safety Devices and Modifications*; 14c11: Personal Emergency Response System (PERS)
		Type of benefit for Home and Bathroom Safety Devices and Modifications	Mandatory
		Type of benefit for Personal Emergency Response System (PERS)	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 (MOOP) for Other Defined Supplemental Benefits?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Minimum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Maximum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Authorization required for this benefit?	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**
		Referral required for this benefit?	No
		Home and Bathroom Safety Devices and Modifications Notes (14c8):*	Allowance loaded on a prepaid card every month to spend on bathroom safety devices and equipment.
		Personal Emergency Response System (PERS) Notes (14c11)	Allowance loaded on a prepaid card every month to spend on personal emergency response system device and services through the plan's participating vendor.

[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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HUMANA HEALTH PLANS OF PUERTO RICO, INC.
H4007 - 031
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 H4007-031 (HMO D-SNP)
Plan Geographic Name:	Puerto Rico Island Wide
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 1 - Renewal - Successfully exported to desk review (06/04/24)**
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, 00025454
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**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$100.00

Prior Authorization	
Question	**Response**
Is prior authorization required for any In-Network service categories?	Yes
In-Network service categories that require prior authorization:	1a Inpatient Hospital-Acute,1a1 Additional Days for Inpatient Hospital-Acute,1b Inpatient Hospital Psychiatric,2 Skilled Nursing Facility (SNF),3-1 Additional Cardiac Rehabilitation Services,3-2 Additional Intensive Cardiac Rehabilitation Services,3-3 Additional Pulmonary Rehabilitation Services,3-4 Additional SET for PAD Services,5 Partial Hospitalization,6 Home Health Services,7c Occupational Therapy Services,7i Physical Therapy and Speech-Language Pathology Services,8a1 Diagnostic Procedures/Tests,8b1 Diagnostic Radiological Services,8b2 Therapeutic Radiological Services,8b3 Outpatient X-Ray Services,9a1 Outpatient Hospital Services,9a2 Observation Services,9b Ambulatory Surgical Center (ASC) Services,10a1 Ground Ambulance Services,10a2 Air Ambulance Services,11a Durable Medical Equipment (DME),11b1 Prosthetic Devices,11b2 Medical Supplies,13c Meal Benefit,14c8 Home and Bathroom Safety Devices and Modifications,15-1-I Medicare Part B Insulin Drugs,15-2 Medicare Part B Chemotherapy/Radiation Drugs,15-3 Other Medicare Part B Drugs,16a Medicare Dental Services,16c1 Restorative Services,16c2 Endodontics,16c3 Periodontics,16c4 Prosthodontics, removable,16c7 Prosthodontics, fixed,16c8 Oral and Maxillofacial Surgery,17a Eye Exams,17b Eyewear
Is prior authorization required for any Out-of-Network service categories?	No
Out-of-Network service categories that require prior authorization:	N/A

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Referral	
Question	**Response**
Is referral required for any In-Network service categories ?	Yes
In-Network service categories that require referral:	7b Chiropractic Services,7d Physician Specialist Services,8a1 Diagnostic Procedures/Tests,8a2 Lab Services,16a Medicare Dental Services
Is referral required for any Out-of-Network service categories?	No
Out-of-Network service categories that require referral:	N/A

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
Enhanced benefits	Additional Days
Type of benefit for Additional Days	Mandatory
Is this benefit unlimited for Additional Days?	Yes
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for Medicare-covered lifetime reserve days	Zero (No Copayment per Day)
Tier 1: Number of day intervals for Additional Days	Zero (No Copayment per Day)
What is the Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Copayment for Medicare-covered stay	$0.00
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
Tier 1: Day intervals for 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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Number of Hospital Days Required Prior to SNF Admission (0-2)	Zero
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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 a coinsurance?	No
Is there a copayment?	Yes
Do you charge the Medicare-defined cost share for tier 1?	No
Number of day intervals for Medicare-covered stay	Zero (No Copayment per Day)
What is your SNF benefit period?	Original Medicare
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Cardiac and Pulmonary Rehabilitation Services have a Copayment	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
Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services	$0.00
Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**
Is there a coinsurance?	No
Is there a copayment?	No
Does the cost sharing count towards any plan-level deductible?	No

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does the cost sharing count towards any plan-level deductible?	No
Is the copayment for Medicare-covered benefits waived if admitted to hospital?	No

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
Enhanced benefits (4c)	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Type of benefit for Worldwide Emergency Coverage	Mandatory
Type of benefit for Worldwide Urgent Coverage	Mandatory
Type of benefit for Worldwide Emergency Transportation	Mandatory
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there an enrollee Coinsurance?	No

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4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	Yes
Which Worldwide Services have a Copayment	Worldwide Emergency Coverage; Worldwide Urgent Coverage; Worldwide Emergency Transportation
Minimum Copayment amount for Worldwide Emergency Coverage	$0.00
Maximum Copayment amount for Worldwide Emergency Coverage	$0.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Urgent Coverage	$0.00
Maximum Copayment amount for Worldwide Urgent Coverage	$0.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	No
Minimum Copayment amount for Worldwide Emergency Transportation	$0.00
Maximum Copayment amount for Worldwide Emergency Transportation	$0.00
Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital?	No
Is there a deductible?	No

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there copayment?	Yes

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Which Chiropractic Services have a Copayment	Medicare-covered Chiropractic Services
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Is there a deductible?	No
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Mental Health Specialty Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment?	Yes
Which Podiatry Services have a Copayment	Medicare-covered Podiatry Services
Minimum Copayment amount per visit for Medicare-covered Benefits	$0.00
Maximum Copayment amount per visit for Medicare-covered Benefits	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a copayment ?	Yes
Which Psychiatric Services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7i Physical Therapy and Speech-Language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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**
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
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic Procedures/Tests/Lab Services have a Copayment	Medicare-covered Diagnostic Procedures/Tests; Medicare-covered Lab Services
Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests	$0.00
Minimum Copayment amount for Medicare-covered Lab Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Outpatient Diagnostic/Therapeutic Radiological Services have a Copayment	Medicare-covered Diagnostic Radiological Services; Medicare-covered Therapeutic Radiological Services; Medicare-covered X-Ray Services
Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00
Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.)	$0.00

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services	$0.00
Minimum Copayment amount for Medicare-covered X-Ray Services	$0.00
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
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Which Services have a Copayment	Medicare-covered Outpatient Hospital Services; Medicare-covered Observation Services
Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services	$0.00
Minimum Copayment amount for Medicare-covered Observation Services	$0.00
Maximum Copayment amount for Medicare-covered Observation Services	$0.00
Observation Services copayment is charged periodicity	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

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9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Outpatient Substance Abuse services have a Copayment	Medicare-covered Individual Sessions; Medicare-covered Group Sessions
Minimum Copayment amount for Medicare-covered Individual Sessions	$0.00
Maximum Copayment amount for Medicare-covered Individual Sessions	$0.00
Minimum Copayment amount for Medicare-covered Group Sessions	$0.00
Maximum Copayment amount for Medicare-covered Group Sessions	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Enhanced benefit	Three (3) Pint Deductible Waived
Type of benefit for Three (3) Pint Deductible Waived	Mandatory
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	Medicare-covered Ground Ambulance Services, Medicare-covered Air Ambulance Services
Minimum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Ground Ambulance Services	$0.00
Minimum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Maximum Copayment amount for Medicare-covered Air Ambulance Services	$0.00
Is this Copayment waived if admitted to hospital?	No
Authorization required for this benefit?	Yes

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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?	No

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Minimum coinsurance	10%
Maximum coinsurance	10%
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Authorization required for this benefit?	Yes
Notes (11a MC)	10% Continuous Glucose Monitor - DME Prov $0 Continuous Glucose Monitor - Pharmacy 10% DME - DME Prov - DME - Pharmacy

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	Yes
Which Prosthetics/Medical Supplies have a Coinsurance	Medicare-covered Prosthetic Devices
Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%
Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices	10%

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a deductible?	No
Is there a copayment ?	Yes
Which Prosthetics/Medical Supplies have a Copayment	Medicare-covered Medical Supplies
Minimum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Medical Supplies	$0.00
Authorization required for this benefit?	Yes

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Diabetic Supplies and Services have a Copayment	Medicare-covered Diabetes Supplies; Medicare-covered Diabetic Therapeutic Shoes or Inserts
Minimum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Maximum Copayment amount per item for Medicare-covered Diabetes Supplies	$0.00
Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts	$0.00
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
Authorization required for this benefit?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Enhanced benefits (13a)	Number of Treatments
Type of benefit for Number of Treatments	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Limit for Number of Treatments	20
Number of Treatments periodicity	Every year
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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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
Type of benefit for OTC Items	Mandatory
Is there a maximum plan benefit coverage amount?	Yes
Maximum plan benefit coverage amount	1620.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
Notes (13b)	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
Type of benefit for Meals	Mandatory
Type of primarily health related meals benefit offered	Immediately following surgery or inpatient hospitilization
Is there a maximum plan benefit coverage amount?	No

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (13c)	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**

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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.
Authorization required for this benefit?	No
Referral required for this benefit?	No

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
Type of benefit for the Annual Physical Exam	Mandatory
Is there a maximum plan benefit coverage amount?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment?	Yes
Minimum copayment for each Annual Physical Exam	$0.00

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14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Maximum copayment for each Annual Physical Exam	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No
Notes (14b)	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
Enhanced benefits (14c)	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c8: Home and Bathroom Safety Devices and Modifications*
Type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling	Mandatory
Number of visits offered in addition to Medicare	4
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 (MOOP) for Other Defined Supplemental Benefits?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Which Other Defined Supplemental Benefits have a Copayment	14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling; 14c8: Home and Bathroom Safety Devices and Modifications*
Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling	$0.00
Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Home and Bathroom Safety Devices and Modifications Notes (14c8):*	The plan will provide 1 contracted standard bath or shower chair with or without wheels, any size every 5 years.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Minimum copayment	$0.00
Maximum copayment	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost (MOOP) for Other Medicare-covered Preventive Services?	No
Is there a coinsurance?	No
Is there a deductible?	No
Is there a copayment ?	Yes
Which Services have a Copayment	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
Minimum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Maximum Copayment amount for Medicare-covered Glaucoma Screening	$0.00
Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training	$0.00
Minimum Copayment amount for Medicare-covered Barium Enemas	$0.00
Maximum Copayment amount for Medicare-covered Barium Enemas	$0.00
Minimum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Maximum Copayment amount for Medicare-covered Digital Rectal Exams	$0.00
Minimum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
Maximum Copayment amount for Medicare-covered EKG following Welcome Visit	$0.00
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.
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Medicare Part B Rx Drugs have a Copayment	Medicare Part B Chemotherapy/Radiation Drugs; Other Medicare Part B Drugs
Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs	$0.00
Minimum Copayment Amount for other Medicare Part B Drugs	$0.00
Maximum Copayment Amount for other Medicare Part B Drugs	$0.00
Is there a coinsurance for Insulin?	No
Is there an copayment for Insulin?	Yes
Minimum Copayment Amount for Insulin	$0.00
Maximum Copayment Amount for Insulin	$0.00
Does the Part B drugs - Insulin cost sharing count towards any plan-level deductible?	No
Is there a deductible?	No
Authorization required for this benefit?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from?	Part B to Part B
Notes (15-1)	$0 Medicare Part B Insulin Drugs - OPH $0 Medicare Part B Insulin Drugs - Pharmacy $0 Medicare Part B Insulin Drugs - PCP $0 Medicare Part B Insulin Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _
Notes (15-2)	$0 Chemo Drugs & Administration - OPH $0 Chemo Drugs & Administration - SPC NOTE: Cost-share may be lower for rebatable drugs. _

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Notes (15-3)	$0 Other Medicare Part B Drugs - OPH $0 Other Medicare Part B Drugs - Pharmacy $0 Other Medicare Part B Drugs - PCP $0 Other Medicare Part B Drugs - SPC NOTE: Cost-share may be lower for rebatable drugs. _

16a Medicare Dental Services Service Category Description Benefit Description	
Question	**Response**
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment?	Yes
Copayment amount for Medicare	$0.00
Minimum Copayment amount for Medicare	$0.00
Maximum Copayment amount for Medicare	$0.00
Is there a deductible?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	Yes

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16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a Coinsurance for combination of services included in a single cost per office visit?	No
Is there a Copayment for combination of services included in a single cost per office visit?	No
Is there a deductible?	No
Type of benefit for Oral Exams	Mandatory

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Oral Exams?	No
Number of visits for Oral Exams	2
Oral Exams periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Oral Exams	0%
Minimum Coinsurance percentage for Oral Exams	0%
Maximum Coinsurance percentage for Oral Exams	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Dental X-Rays	Mandatory
Is this benefit unlimited for Dental X-Rays?	No
Number of X-Rays	8
Dental X-Rays periodicity	Other, Describe
Dental X-Rays periodicity description	bitewing x-rays 1 set(s)/yr, intraoral x-rays 6/yr, pano film 1/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Dental X-Rays	0%
Minimum Coinsurance percentage for Dental X-Rays	0%
Maximum Coinsurance percentage for Dental X-Rays	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Diagnostic Dental Services	Mandatory
Is this benefit unlimited for Other Diagnostic Dental Services?	No
Number of visits for Other Diagnostic Dental Services	4
Other Diagnostic Dental Services periodicity	Other, Describe
Other Diagnostic Dental Services periodicity description	comp oral exam, cone beam CT imaging 1/3 yrs, pulp vitality test 2 per quadrant/yr
Is there a coinsurance?	Yes

16b Diagnostic and Preventive Dental Services Service Category Description Benefit Description	
Question	**Response**
Coinsurance percentage for Other Diagnostic Dental Services	0%
Minimum Coinsurance percentage for Other Diagnostic Dental Services	0%
Maximum Coinsurance percentage for Other Diagnostic Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Prophylaxis (cleaning)	Mandatory
Is this benefit unlimited for Prophylaxis (cleaning)?	No
Number of visits for Prophylaxis (cleaning)	2
Prophylaxis (cleaning) periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Prophylaxis (cleaning)	0%
Minimum Coinsurance percentage for Prophylaxis (cleaning)	0%
Maximum Coinsurance percentage for Prophylaxis (cleaning)	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No
Type of benefit for Other Preventive Dental Services	Mandatory
Is this benefit unlimited for Other Preventive Dental Services?	No
Number of visits for Other Preventive Dental Services	2
Other Preventive Dental Services periodicity	Every year
Is there a coinsurance?	Yes
Coinsurance percentage for Other Preventive Dental Services	0%
Minimum Coinsurance percentage for Other Preventive Dental Services	0%
Maximum Coinsurance percentage for Other Preventive Dental Services	0%
Is there a copayment?	No
Authorization required for this benefit?	No
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Maximum plan benefit coverage amount	1000.00
Maximum plan benefit coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a deductible?	No
Type of benefit for Restorative Services	Mandatory
Is this benefit unlimited for Restorative Services?	No
Number of visits for Restorative Services	3
Restorative Services periodicity	Other, Describe
Restorative Services periodicity description	core buildup/prefab post/core 1/tooth/lifetime, crown 1/tooth/5 yrs, filling 1/tooth/3 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Restorative Services	0%
Minimum Coinsurance percentage for Restorative Services	0%
Maximum Coinsurance percentage for Restorative Services	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c1)	$1,000 maximum benefit per year that only applies to crowns and other restorative services - core buildup and prefabricated post and core
Type of benefit for Endodontics	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Endodontics	0%
Minimum Coinsurance percentage for Endodontics	0%
Maximum Coinsurance percentage for Endodontics	0%
Is there a copayment?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Periodontics	Mandatory
Is this benefit unlimited for Periodontics?	No
Number of visits for Periodontics	2
Periodontics periodicity	Other, Describe
Periodontics periodicity description	period surg 1 per quadrant/3 yrs, scaling/root planing 1 per quadrant/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Periodontics	0%
Minimum Coinsurance percentage for Periodontics	0%
Maximum Coinsurance percentage for Periodontics	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Type of benefit for Prosthodontics, removable	Mandatory
Is this benefit unlimited for Prosthodontics, removable?	No
Number of visits for Prosthodontics, removable	6
Prosthodontics, removable periodicity	Other, Describe
Prosthodontics, removable periodicity description	comp dentures, comp/part denture reline, part dentures 1/5 yrs, comp/part denture repair 3/yr, denture adj unl/yr
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, removable	0%
Minimum Coinsurance percentage for Prosthodontics, removable	0%
Maximum Coinsurance percentage for Prosthodontics, removable	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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16c Comprehensive Dental Services Service Category Description Benefit Description	
Question	**Response**
Notes (16c4)	$1,000 maximum benefit per year that only applies to adjustments to dentures, complete dentures, complete or partial denture reline, complete or partial denture repair and partial dentures
Type of benefit for Prosthodontics, fixed	Mandatory
Is this benefit unlimited for Prosthodontics, fixed?	No
Number of visits for Prosthodontics, fixed	1
Prosthodontics, fixed periodicity	Other, Describe
Prosthodontics, fixed periodicity description	bridges 1/5 yrs
Is there a coinsurance?	Yes
Coinsurance percentage for Prosthodontics, fixed	0%
Minimum Coinsurance percentage for Prosthodontics, fixed	0%
Maximum Coinsurance percentage for Prosthodontics, fixed	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No
Notes (16c7)	$1,000 maximum benefit per year that only applies to bridges
Type of benefit for Oral and Maxillofacial Surgery	Mandatory
Is this benefit unlimited for Oral and Maxillofacial Surgery?	Yes
Is there a coinsurance?	Yes
Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Minimum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Maximum Coinsurance percentage for Oral and Maxillofacial Surgery	0%
Is there a copayment?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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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
Enhanced benefits (17a)	Routine Eye Exams
Type of benefit for Routine Eye Exams	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Number of exams for Routine Eye Exams	1
Routine Eye Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Eye Exams have a Copayment	Medicare-covered Benefits; Routine Eye Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Eye Exams	$0.00
Maximum Copayment amount for Routine Eye Exams	$0.00
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Type of benefit for Eyeglasses (lenses and frames)	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Is there a maximum plan benefit coverage?	Yes
Maximum plan benefit coverage type	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Combined maximum amount	200.00
Combined Maximum Plan Benefit Coverage periodicity	Every year
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Is there a copayment ?	Yes
Which Eyewear Benefits have a Copayment	Medicare-covered Benefits; Contact lenses; Eyeglasses (lenses and frames)
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Contact lenses	$0.00
Maximum Copayment amount for Contact lenses	$0.00
Minimum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Maximum Copayment amount for Eyeglasses (lenses and frames)	$0.00
Authorization required for this benefit?	Yes
Referral required for this benefit?	No

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Enhanced benefits (18a)	Routine Hearing Exams

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Type of benefit for Routine Hearing Exams	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Number for Routine Hearing Exams	1
Routine Hearing Exams periodicity	Every year
Is there a maximum plan benefit coverage?	No
Is there a deductible (MC)?	No
Is there a deductible (NMC)?	No
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
Is there a coinsurance?	No
Is there a copayment ?	Yes
Which Hearing Exam Benefits have a Copayment	Medicare-covered Benefits; Routine Hearing Exams
Minimum Copayment amount for Medicare-covered Benefits	$0.00
Maximum Copayment amount for Medicare-covered Benefits	$0.00
Minimum Copayment amount for Routine Hearing Exams	$0.00
Maximum Copayment amount for Routine Hearing Exams	$0.00
Authorization required for this benefit?	No
Referral required for this benefit?	No

18b Prescription Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Prescription Hearing Aids as a supplemental benefit under Part C?	No

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18c OTC Hearing Aids 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 this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Does this plan offer Special Supplemental Benefits for Chronically Ill?	No
Does this plan offer VBID hospice benefits?	No
Does this plan offer value-based design flexibilities by condition, socioeconomic state, or area deprivation index under the VBID model?	Yes
Value-Based Insurance Design Attestation	I attest that: * 1) The benefits entered comply with CMS requirements for benefits offered in the VBID model; 2) The benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID model, unless otherwise approved by CMS in writing; 3) The benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary; and 4) Including any proposed benefits offered through the VBID Model in this PBP, this PBP offers a minimum of two supplemental benefits to address priority HRSNs from among the categories of food and nutrition, transportation, and housing and living environment. NOTE: This does not apply to PBPs participating only in the Hospice Benefit Component.
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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)	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	Type of Package	VBID
		Target Methodology (Required)	Socioeconomic Status
		For VBID Additional Benefits package, when socioeconomic status is selected then provide the LIS reduction level Dual-Eligible Status.	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted	1324
		Expected Number of Enrollees to be engaged and receive Model benefits	1324
		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?	No
		Prerequisite for any additional benefits for this package?	No
		Non-Medicare-covered additional benefits offered in this package: (Maximum of 30 service categories can be added to a package)	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS); 13i6: Social Needs Benefit
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount	1620.00
		Package level maximum coverage periodicity	Every year
		Mode of delivery for maximum coverage amount	Debit Card

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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**
		Non-Medicare-covered benefits that apply to the package level maximum coverage	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i6: Social Needs Benefit; 13i10: General Supports for Living; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 14c8: Home and Bathroom Safety Devices and Modifications; 14c11: Personal Emergency Response System (PERS)
		B19b Notes	$135.00 loaded on a prepaid card every month to spend at participating retailers. 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
		Type of benefit for OTC Items	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	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.
		Are you offering Naloxone coverage as a Part C OTC benefit?	Yes
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual	No
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; General Supports for Living

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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 the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Type of benefit for Food and Produce	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment ?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i1)	Allowance loaded on a prepaid card every month to spend at participating retailers toward plan-approved food and produce.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
		Type of benefit for Pest Control	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i3)	Allowance loaded on a prepaid card every month to spend toward pest control services.
		Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Yes
		Enhanced benefit	Any Location

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Type of benefit for Any Location	Mandatory
		Is this benefit unlimited for number of trips for Any Location?	Yes
		Type of Transportation for Non-Medical Needs for Any Location	One-way
		Mode of Transportation for Non-Medical Needs for Any Location	Taxi; Rideshare Services; Bus/Subway; Van; Medical Transport
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i4)	Allowance loaded on a prepaid card every month to spend on non-medical transportation.
		Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Yes
		Type of benefit for Indoor Air Quality Equipment and Services	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	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**
		Notes (13i5)	Allowance loaded on a prepaid card every month to spend toward indoor air quality equipment and services.
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Type of benefit for Social Needs Benefit	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i6)	Allowance loaded on a prepaid card every month to address enrollee social needs pertaining to social isolation and to improve emotional and/or cognitive function.
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Type of benefit for General Supports for Living	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i10)	Allowance loaded on a prepaid card every month to spend on general supports for living including rent and mortgage assistance, disaster relief kits, utilities, and internet service payments.

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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 - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	What Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes	Other 1
		Service Name	Healthy Living and Aging Support
		Type of benefit for Other 1	Mandatory
		Is there a maximum plan benefit coverage amount?	No
		Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	No
		Is there a coinsurance?	No
		Is there a deductible?	No
		Is there a copayment?	No
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Notes (13i-01)	Allowance loaded on a prepaid card every month to spend on products to support healthy living and aging such as home supplies, personal wellness products, 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
		Enhanced benefits (14c)	14c8: Home and Bathroom Safety Devices and Modifications*; 14c11: Personal Emergency Response System (PERS)
		Type of benefit for Home and Bathroom Safety Devices and Modifications	Mandatory
		Type of benefit for Personal Emergency Response System (PERS)	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 (MOOP) for Other Defined Supplemental Benefits?	No
		Is there a coinsurance?	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 a deductible?	No
		Is there a copayment ?	No
		Minimum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Maximum Copayment amount for Home and Bathroom Safety Devices and Modifications	$0.00
		Minimum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Maximum Copayment amount for Personal Emergency Response System (PERS)	$0.00
		Authorization required for this benefit?	No
		Referral required for this benefit?	No
		Home and Bathroom Safety Devices and Modifications Notes (14c8):*	Allowance loaded on a prepaid card every month to spend on bathroom safety devices and equipment.
		Personal Emergency Response System (PERS) Notes (14c11)	Allowance loaded on a prepaid card every month to spend on personal emergency response system device and services through the plan's participating vendor.

[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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