Summary of Benefits

2021

Allwell Dual Medicare (HMO D-SNP) H3499: 005
Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, De Kalb, Dearborn, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, LaGrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, and Whitley counties, IN

H3499_005_21_18999SB_M Accepted 09012020

This booklet provides you with a summary of what we cover and the cost-sharing responsibilities. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at allwell.mhsindiana.com.

You are eligible to enroll in Allwell Dual Medicare (HMO D-SNP) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within the Allwell Dual Medicare (HMO D-SNP) service area counties). Our service area includes the following counties in Indiana: Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, De Kalb, Dearborn, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, LaGrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, and Whitley.
- For Allwell Dual Medicare (HMO D-SNP), you must also be enrolled in the Indiana Medicaid plan. Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive. Your Part B premium is paid by the State of Indiana for full-dual enrollees. Please contact the plan for further details.

The Allwell Dual Medicare (HMO D-SNP) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit allwell.mhsindiana.com. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Allwell Dual Medicare (HMO D-SNP) will be responsible for the costs.)

This Allwell Dual Medicare (HMO D-SNP) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source.

Summary of Benefits

JANUARY 1, 2021 – DECEMBER 31, 2021

Benefits	Allwell Dual Medicare (HMO D-SNP) H3499: 005 Premiums / Copays / Coinsurance
Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive	
Monthly Plan Premium	$0 (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.)
Deductibles	• $0 deductible for covered medical services • $445 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5)
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,450 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
Inpatient Hospital Coverage*	$0 copay per stay
Outpatient Hospital Coverage*	• Outpatient Hospital: $0 copay per visit • Observation Services: $0 copay per visit
Doctor Visits (Primary Care Providers and Specialists)	• Primary Care: $0 copay per visit • Specialist: $0 copay per visit
Preventive Care (e.g. flu vaccine, diabetic screening)	$0 copay for most Medicare-covered preventive services Other preventive services are available.
Emergency Care	$0 copay per visit
Urgently Needed Services	$0 copay per visit

Services with an * (asterisk) may require prior authorization from your doctor.

Benefits	Allwell Dual Medicare (HMO D-SNP) H3499: 005 Premiums / Copays / Coinsurance
Diagnostic Services/ Labs/Imaging* (includes diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	COVID-19 testing and specified testing-related services at any location are $0. • Lab services: $0 copay • Diagnostic tests and procedures: $0 copay • Outpatient X-ray services: $0 copay • Diagnostic Radiology services (such as, MRI, MRA, CT, PET): $0 copay
Hearing Services	• Hearing exam (Medicare-covered): $0 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 copay (2 hearing aids total, 1 per ear, per calendar year)
Dental Services	• Dental services (Medicare-covered): $0 copay per visit • Preventive Dental Services: $0 copay (including oral exams, cleanings, fluoride treatment, and X-rays). • Comprehensive dental services: Additional comprehensive dental benefits are available. • There is a maximum allowance of $3,000 every calendar year; it applies to all comprehensive dental benefits.
Vision Services	• Vision exam (Medicare-covered): $0 copay per visit • Routine eye exam: $0 copay per visit (up to 1 every calendar year) • Routine eyewear: up to $300 allowance every calendar year
Mental Health Services	Individual and group therapy: $0 copay per visit
Skilled Nursing Facility*	Days 1-100: $0 copay per stay, per benefit period.
Physical Therapy*	$0 copay per visit

Services with an * (asterisk) may require prior authorization from your doctor.

Benefits	Allwell Dual Medicare (HMO D-SNP) H3499: 005 Premiums / Copays / Coinsurance
Ambulance	$0 copay (per one-way trip) for ground or air ambulance services
Ambulatory Surgery Center*	Ambulatory Surgery Center: $0 copay per visit
Transportation	• $0 copay for each one-way trip • Up to 50 one-way trips to plan-approved health-related locations every calendar year. Mileage limits may apply.
Medicare Part B Drugs*	• Chemotherapy drugs: $0 copay • Other Part B drugs: $0 copay

Services with an * (asterisk) may require prior authorization from your doctor.

Part D Prescription Drugs		
Deductible Stage	$445 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5). The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your Part D drugs until you reach the plan's deductible amount. Once you have paid the plan's deductible amount for your Part D drugs, you leave the Deductible Stage and move on to the next payment stage (Initial Coverage Stage). If you receive "Extra Help" to pay for your prescription drugs, your deductible amount will be either $0 or $92 depending on the level of "Extra Help" you receive.	
Initial Coverage Stage (after you pay your Part D deductible, if applicable)	After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. "Total drug costs" is the total of all payments made for your covered Part D drugs. It includes what the plan pays and what you pay. Once your "total drug costs" reach $4,130 you move to the next payment stage (Coverage Gap Stage).	
	Standard Retail Rx 30-day supply	**Mail Order Rx 90-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay
Tier 2: Generic Drugs	$20 copay	$60 copay
Tier 3: Preferred Brand Drugs	$47 copay	$141 copay
Tier 4: Non-Preferred Drugs	49% coinsurance	49% coinsurance
Tier 5: Specialty	25% coinsurance	Not available
Coverage Gap Stage	During this payment stage, you receive a 70% manufacturer's discount on covered brand name drugs and the plan will cover another 5%, so you will pay 25% of the negotiated price and a portion of the dispensing fee on brand-name drugs. In addition the plan will pay 75% and you pay 25% for generic drugs. (The amount paid by the plan does not count towards your out-of-pocket costs). You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches $6,550. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs).	

Part D Prescription Drugs	
	Once your “out-of-pocket costs” reach $6,550, you move to the next payment stage (Catastrophic Coverage Stage). If you qualify for “Extra Help” this stage doesn’t apply-If you are not eligible for “Extra Help”, call the plan or refer to the Evidence of Coverage (EOC), Chapter 6, for outpatient prescription drug cost-sharing information.
Catastrophic Coverage Stage	During this payment stage, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment ($3.70 for a generic drug or a drug that is treated like a generic, $9.20 for all other drugs).
Important Info:	Cost-sharing may change depending on the level of help you receive, the pharmacy you choose (such as Standard Retail, Mail Order, Long-Term Care, or Home Infusion) and when you enter any of the four stages of the Part D benefit. For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our EOC online. Low income subsidy (LIS) is extra help you receive from Medicare. To find out if you qualify, visit Medicare.gov or call Member Services at 1-833-202-4704 (TTY: 711).

Additional Covered Benefits	
Benefits	**Allwell Dual Medicare (HMO D-SNP) H3499: 005** **Premiums / Copays / Coinsurance**
Additional Telehealth Services	The cost share of Medicare-covered additional telehealth services with primary care physicians, specialists, individual/group sessions with mental health and psychiatric providers and other health care practitioners within these practices will be equal to the cost share of these individual services' office visits.
Opioid Treatment Program Services	• Individual setting: $0 copay per visit • Group setting: $0 copay per visit
Over-the-Counter (OTC) Items	$0 copay ($325 allowance per quarter) for items available via mail There is a limit of 9 per item, per order, with the exception of certain products which have additional limits. You are allowed to order once per quarter and any unused money does not carry over to the next quarter. Please visit the plan's website to see the list of covered over-the-counter items.
Meals	$0 copay Plan covers home-delivered meals (up to 2 meals per day for 14 days) following discharge from an inpatient facility or skilled nursing facility. Services are contingent on medical necessity and Case Management review and prior authorization to the vendor.
Chiropractic Care	Chiropractic services (Medicare-covered): $0 copay per visit
Acupuncture	• Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Specialist's office
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): $0 copay • Prosthetics (e.g., braces, artificial limbs): $0 copay • Diabetic supplies: $0 copay
Foot Care (Podiatry Services)	Foot exams and treatment (Medicare-covered): $0 copay per visit

Services with an * (asterisk) may require prior authorization from your doctor

Additional Covered Benefits	
Benefits	**Allwell Dual Medicare (HMO D-SNP) H3499: 005** **Premiums / Copays / Coinsurance**
Virtual Visit	Teladoc™ plan offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions.
Wellness Programs	• Fitness program: $0 copay • 24-hour Nurse Connect: $0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): $0 copay For a detailed list of wellness program benefits offered, please refer to the EOC.
Routine Annual Exam	$0 Copay
Special Supplemental Benefits for the Chronically Ill	The following services are available for members with chronic conditions • Coverage for one Personal Emergency Medical Response Device per lifetime. $0 copay • Companion Care (monthly calls with an Outreach representative): $0 copay • Additional 10 one-way trips are covered to approved non-medical locations for members with chronic conditions per calendar year. Such locations would include banking, grocery shopping, fitness, community centers and other social events. Mileage limits may apply. For a detailed list of benefits offered, please refer to the EOC.
Additional Services that are covered for the Chronically Ill	The following service is available for members with chronic conditions • Medication Management System (a medication dispenser and monthly monitoring of the dispenser): $0 copay For a detailed list of benefits offered, please refer to the EOC.

Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Medicare Advantage plan. For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. Coverage of the benefits described in this Summary of Benefits depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is,
Allwell Dual Medicare (HMO D-SNP) will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Medicaid toll-free at 1-800-403-0864, (TTY: 711).

Our source of information for Medicaid benefits is http://member.indianamedicaid.com/. All Medicaid covered services are subject to change at any time. For the most current Indiana Medicaid coverage information, please visit http://member.indianamedicaid.com/ or call Member Services for assistance. A detailed explanation of Indiana Medicaid benefits can be found in the Indiana Summary of Services online at http://member.indianamedicaid.com/

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Institutional and Clinic Services					
Clinic Services by an organized facility or clinics not part of a hospital; Freestanding Ambulatory Surgery Center					
Yes				Fee for service, with surgical procedures grouped using Medicare methodology	CN
Clinic Services by an organized facility or clinics not part of a hospital; Public Health and Mental Health Clinics					
Yes				Fee for service or reasonable charge	CN
Federally Qualified Health Center Services					
Yes				Prospective cost based rate/encounter	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Inpatient Hospital Services, other than in an Institution for Mental Diseases					
Yes		Specified admissions, including to rehab and burn centers	Second opinions required for specified procedures, LOS less than 24 hours considered outpatient except for newborns, substance abuse treatment limited to detoxification	Prospective payment/ discharge using DRG, prospective per diem for rehab and burn centers	CN
Outpatient Hospital Services					
Yes	$3/non-emergency visit in ER			Fee for service, with surgical procedures grouped using Medicare Methodology	CN
Rehabilitation Services: Mental Health and Substance Abuse					
Yes		Yes	14 Therapeutic leave days/year in psychiatric residential treatment facilities	Fee for service with services of specified med-level practitioners paid 75% of physician fee, prospective cost based per diem for psych residential treatment facilities	CN
Rural Health Clinic Services					
Yes				Prospective cost based rate/encounter	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Practitioner services					
Certified Registered Nurse Anesthetist Services					
Yes				Fee for services at 60% physician fee	CN
Chiropractor Services					
Yes			50 therapeutic physical medicine treatment/year including up to 5 office visits	Fee for service	CN
Dental Services					
Yes		Specified services including non-emergency inpatient procedures and oral surgery	$1000 maximum benefit/year included with denture services, exam and cleaning 1/year (2/year for nursing facility residents), frequency of x-rays limited by type, periodontia limited, second opinions required for specified procedures	Fee for service	CN
Medical and Remedial Care – Other Practitioner					

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Medical/Surgical Services of a Dentist					
Yes		Specified services including non-emergency services provided on an inpatient hospital bases and oral surgery	Second opinions required for specified procedures, ambulatory services limited	Fee for service	CN
Nurse Midwife Services					
Yes				Fee for service	CN
Nurse Practitioner Services					
Yes				Fee for service at 75% of physician fee	CN
Optometrist Services					
Yes			1 refractive exam/2 years	Fee for service	CN
Physician Services					
Yes		Specified surgical procedures, procedures exceeding specified cost limits	30 visits/year	Fee for services, services performed with assistance of second surgeon or in outpatient setting rather than office paid reduced fee	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Podiatrist Services					
Yes		Inpatient hospital services and specified services associated with orthopedic shoes and appliances	Routine foot care covered only for specified systemic conditions at 6 visits/year, second opinion required for specified services	Fee for service	CN
Psychologist Services					
Yes		Specified services including psycho-logical testing	20 service/time units/year	Fee for service	CN
Prescription Drugs					
Prescription Drugs					
Yes	$3/RX	Specified drugs		AWP – 16% for brand Rx, AWP- 20% for generic Rx, plus $4.90 dispensing fee	CN
Physical Therapy and Other Services					
Occupational Therapy					
Yes		Therapy not following hospital discharge or after 30 days of discharge	30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Physical Therapy Services					
Yes		Therapy not following hospital discharge or after 30 days of discharge	12/hours/30 days or 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN
Services for Speech, Hearing and Language Disorders					
Yes		Specified services including therapy not following hospital discharge or after 30 days of discharge	1 audiological testing and evaluation/3 years, 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN
Products and Devices					
Dentures					
Yes		Yes	$600 maximum benefit/year included with dental services	Fee for service	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Eyeglasses					
Yes			1 Pair eyeglasses/5 years, age-specific minimum diopter correction required for initial and replacement eyeglasses	Fee for service	CN
Hearing Aids					
Yes		Yes	1 hearing aid/5 years	Fee for service	CN
Medical Equipment and Supplies					
Yes		Specified med equipment and med supply items	$1950 maximum benefit/year for incontinence products and products must be obtained from a contracted vendor	Fee for service using historical Medicare payment rates	CN
Prosthetic and Orthotic Devices					
Yes		Yes		Fee for service	CN
Transportation Services					
Ambulance Services					
Yes	$.50 - $2/non-emergency transport, depending on payment	Non-emergency transports or transports greater than 50 miles		Fee for service	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Non-Emergency Medical Transportation Services					
Yes	$.50 - $2/trip depending on payment		20 one-way trips less than 50 miles/year	See service-specific FN	CN
Other Services					
Diagnostic, Screening and Preventive Services					
Yes				Dependent upon services and billing provider	CN
Early and Periodic Screening, Diagnosis and treatment					
See service-specific FN.					
Extended Services for Pregnant Women					
Family Planning Services					
See service-specific FN.					
Laboratory and X-Ray Services, outside Hospital or Clinic					
Yes				Fee for service	CN
Targeted Case Management					
Yes			Quantity and frequency limits vary by group served	Fee for service	CN
Long-Term Care Services					
Community Based Care					
Home and Community Based Services Waiver					
Yes		Yes	Services for the	Dependent upon the services provided	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Home Health Services, includes nursing services, home health aides, and medical supplies/equipment					
Yes			120 hours of care within 30 days of hospital discharge if ordered by physician, 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Prospective cost based rates	CN
Hospice					
Yes		Yes		Prospective rates based on Medicare methodology	CN
Personal Care Services					
No					
Private Duty Nursing Services					
No					
Program of All-Inclusive Care for the Elderly					
No					
Institutional Care					
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, and 65 and older					
Yes		Yes for elective admissions	Services limited to hospital settings, 60 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Inpatient Psychiatric Services, under age 21					
Yes		Yes	14 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN
Intermediate Care Facility Services for the Mentally Retarded					
Yes		For LOC de-termination upon admission	15 hosp leave days/ hospitalization, 60 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN
Nursing Facility Services, other that in an Institution for Mental Diseases					
Yes		For LOC de-termination upon admission	15 hosp leave days/ hospitalization, 30 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate if 90% occupancy requirement met	CN
Religious Non-Medical Health Care Institution and Practitioner Services					
Yes			Practitioner services not covered	Prospective cost based per diem	CN

For more information, please contact:

Allwell Dual Medicare (HMO D-SNP)
550 N. Meridian Street
Suite 101
Indianapolis, IN 46204

allwell.mhsindiana.com

Current members should call: 1-833-202-4704 (TTY: 711)

Prospective members should call: 1-877-891-6093 (TTY: 711)

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is not a complete description of benefits. Call 1-833-202-4704 (TTY: 711) for more information.

“Coinsurance” is the percentage you pay of the total cost of certain medical and/or prescription drug services.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This document is available in other formats such as Braille, large print or audio.

Allwell is contracted with Medicare for an HMO D-SNP plan and with the state Medicaid program. Enrollment in Allwell depends on contract renewal.

SBS041361EK00 (6/20)