PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 017, SEGMENT 0

Module: PBP

Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/30/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 05/30/2019 11:38:56 AM SA Western Standard

Time

MA BPT Timestamp: 05/28/2019 06:45:48 PM SA Western Standard

Time

PD BPT Timestamp: 05/28/2019 06:45:48 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

Upload Status: 06/02/2019 #01893

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed

Section B3 Status

Completed

Completed

Section B4 Status

Completed

Section B5 Status

Completed

Completed

Section B6 Status

Completed

Section B7 Status Completed
Section B8 Status Completed
Section B9 Status Completed

Section B9 Status Completed
Section B10 Status Completed
Section B11 Status Completed

Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed

Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed

Section B18 Status Completed
Section B19 Status Completed

Section C Status Completed
Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1

A

W



Organization Legal Name: **Organization Marketing Name:** Organization Web Site: Plan Name: Organization Type: Plan Type: Enrollee Type: Service Area(s): Service Area(s):

MMM HEALTHCARE, LLC Medicare y Mucho Más www.mmmpr.com MMM Diamante Platino (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

40290 - Guayanilla, PR 40300 - Guaynabo, PR





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

40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

> 40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR

40330 - Hormigueros, PR





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Service Area(s):

PBP Data Report

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	017
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member months for this plan:	882694
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmm-pr.com
Formulary Website Address:	www.mmm-pr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for	(866)333-5470

(833)647-9555

(787)620-2397

(833)647-9555

(787)620-2396

(866)333-5470

(787)620-2397

(787)620-2396



Current Medicare Beneficiaries:

for Current Medicare Beneficiaries:

Prospective Medicare Beneficiaries:

for Prospective Medicare Beneficiaries:

Current Part D Medicare Beneficiaries:

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

Prospective Part D Medicare Beneficiaries:

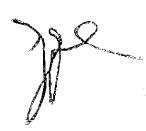
SECTION A: SECTION A-4

Customer Service Contact Local Phone Number

Customer Service Contact Phone Number for

Customer Service Contact Phone Number for

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No d
SECTION B: #1A INPATIENT HOSPITAL	-ACUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL	-ACUTE - BASE 2
Is there a service-specific Maximum Enrollee	No





Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

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





period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

Notes:

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee No

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?
Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part No

70

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days Required

Zero

Prior to SNF Admission (0-2): Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

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Is there an enrollee Copayment?

No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?
Is a referral required for SNF Services?

Yes No

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

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

benefit under Part C?

benefit under Fart C:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

select type of beliefit for worldwide Emergenc

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

JA

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

No

Coverage?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

Yes

Select which Worldwide Services have a

: Worldwide Emergency Coverage

Copayment (Select all that apply):

: Worldwide Urgent Coverage

Indicate Minimum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services?

No

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

Is there a service-specific Maximum Enrollee





Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care? No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined No

with either the Acupuncture or Alternative

Is there a service-specific Maximum Plan

Therapies benefit, or both?

Yes

No

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

750.00

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Services?

Yes

Notes:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?





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

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

Is authorization required?

No

Is a referral required for Physician Specialist Services?

Yes

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

Notes:

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

Indicate number of Routine Foot Care visits:

1

Select the Routine Foot Care periodicity:

Every year

Is there a service-specific Maximum Plan

No

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

Yes Is authorization required? Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required?

Yes

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Psychiatric Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit No

for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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







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Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Nο

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

No

Is a referral required for Medicare-covered Observation Services?

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

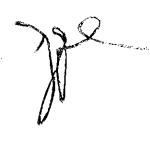
No

SECTION B: #9B ASC SERVICES - BASE 2

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

Is authorization required?

Yes







about:blank 6/3/2019 Is a referral required for Ambulatory Surgical

Center Services?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Substance

Yes

Abuse?

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

Does the plan provide Outpatient Blood

No

Services as a supplemental benefit under Part

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

Yes

Select enhanced benefit:

Plan Approved Health-related Location

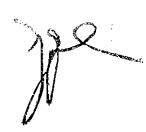
Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?





Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan

One-way

Every year

20

Approved Health-related Location:

Select Mode of Transportation for Plan

Approved Health-related Location: : Bus/Subway

: Van

: Taxi

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No
As authorization required? Yes

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

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Is authorization required? Yes

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

We -





Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AN	D SERVICES - BASE 2
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes
Notes:	
SECTION B: #12 DIALYSIS SERVICES - BAS	SE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BAS	SE 2
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	•
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	· CÁ
Is there an enrollee Coinsurance?	No Mo
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No





Yes

Is authorization required?

Is a referral required for Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

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

nems as a supplemental benefit under Pal

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

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Yes

Mandatory

Yes

75.00

Every three months

No

No

Yes

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

No

No

No

No

THE FOLLOWING CATEGORIES AN COVERED:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5)IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE



Page 17 of 29



PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT REQUIRES MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

6) INCONTINENCE SUPPLIES (ADULT **DIAPERS & UNDER PADS)**

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Yes

Select type of benefit for Meals:

How many days does your Meal Benefit last? What is the maximum number of meals the

benefit provides?

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

5 10

No

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance? No No Is there an enrollee Deductible? Is there an enrollee Copayment? No Is authorization required? Is a referral required for the Meal Benefit? Yes

Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 1 TIME PER YEAR FOR 10 MEALS MAX PER

YEAR

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

Medicare-covered Zero Dollar Preventive Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at

zero dollar cost sharing.

Yes Is authorization required? Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?



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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Mandatory

Indicate number of visits offered in addition to

Medicare:

9

Select type of benefit for Remote Access Technologies (including Web/Phone-based Mandatory

technologies and Nursing Hotline):

: Nursing Hotline

Select the type of Remote Access Technologies

Afferred (Select all that apply):

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEP IS RESPONSIBLE OF

DEVELOPING AND IMPLEMENTING
EDUCATIONAL INTERVENTIONS SUCH
AS DIABETES AND HYPERTENSION
MANAGEMENT AND NUTRITIONAL
EDUCATION, TO HELP WHO RECEIVE
MEDICAL SERVICES PROVIDING AN

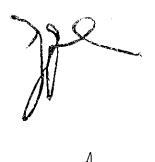
OPPORTUNITY TO ENGAGE IN

BEHAVIOR

Acc



Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



THAT WILL IMPROVE AND SUSTAIN HEALTHIER LIFESTYLE.

SCOPE:

IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE

PREVENTION OF COMPLICATIONS, IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE, WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND INDIVIDUAL MANAGEMENT OF HIGH RISK CASES

REFERRED BY CAR.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR, OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS, THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS. AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS, TO PREVENT A



RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes:



THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS, HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911

EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE **EDUCATION REGARDING THE** SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease



Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Glaucoma Screening?

Yes

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

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

Yes

Yes

Is authorization required for Medicare-covered

Digital Rectal Exams?

Yes

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is authorization required for Other Medicare-

Yes

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is Authorization Required? Yes Does the plan offer step therapy? No

SECTION B: #15 MEDICARE PART B RX DRUGS - NOTES

Notes:

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

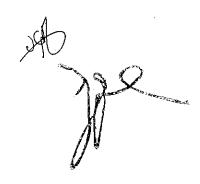
No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental





Items as a supplemental benefit under Part C?

Select enhanced benefits:

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Yes

Other Oral/Maxillofacial Surgery, Other

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

amount:

3000.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Yes

Select which Comprehensive Dental Services

have a Coinsurance (Select all that apply):

: Medicare-covered Benefits

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate the Minimum Coinsurance percentage

for Medicare-covered Benefits:

0%

Indicate the Maximum Coinsurance percentage

for Medicare-covered Benefits:

0%

Indicate Minimum Coinsurance percentage for

0%

Restorative Services:

0%

Indicate Maximum Coinsurance percentage for

Restorative Services:

0%

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

0%

Surgery, Other Services:

Is there an enrollee Deductible?



SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental Services?

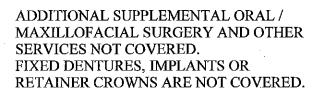
No

Notes:



RESTORATIVE SERVICES- POST AND CORE ARE COVERED UP TO TWO (2) PER MEMBER PER YEAR AND /OR UP TO TWO (2) SINGLE CROWNS PER MEMBER PER YEAR, AND REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. COINSURANCE AMOUNT WILL ONLY APPLY FOR POST AND CORE AND SINGLE CROWNS.

PROSTHODONTIC SERVICESREMOVABLE COMPLETE OR PARTIAL
DENTURES IN RESIN AND METAL BASE,
COVERED EVERY 5 YEARS. DENTURE
REPAIR SERVICES, INCLUDING
SERVICES RELATED TO THE REPAIR OF
EXISTING COMPLETE OR PARTIAL
DENTURES ARE COVERED.
REMOVABLE PARTIAL FLEXIBLE BASE
DENTURES COVERED EVERY 8 YEARS.
ADJUSTMENT OR REPAIRS ARE NOT
COVERED IN FLEXIBLE BASE DENTURES
AND/OR FLEXIBLE BASE ARE NOT
COVERED IN COMPLETE OR FULL
DENTURES.



THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR PROSTHODONTIC SERVICES.

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

Is there a service-specific Maximum Enrollee

SECTION B: #17A EYE EXAMS - BASE 1

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

No



Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No STACION
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes (S)
Is a referral required for Eye Exams?	No No
SECTION B: #17B EYEWEAR - BASE 1	1
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses
	: Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	825.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	•
Is there a service-specific Maximum Enrollee	No
Out-of-Pocket Cost?	~ O
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	V/
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No // "
SECTION B: #17B EYEWEAR - BASE 6	

SECTION B: #18A HEARING EXAMS - BASE 1

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

Yes

No

No

Is a referral required for Eyewear?

Is authorization required?



Notes:

Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid
Select type of benefit for Fitting/Evaluation for	Mandatory
Hearing Aid:	
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASI	E 2
Is there a service-specific Maximum Plan Benefit Coverage amount?	No Signatura Control of the Control
Is there an enrollee Deductible?	No Contrato Mamero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No (20-002)
Is there an enrollee Coinsurance?	No No
SECTION B: #18A HEARING EXAMS - BASI	E 3
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	M
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #18B HEARING AIDS - BASE 3	Λ
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No ,S
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

Yes

Is a referral required for Hearing Aids?

No

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

Does your plan include MA Uniformity

Yes

Flexibility with reductions in cost or additional

benefits?

No

Do you offer Special Supplemental Benefits for the Chronically III?

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

1

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Diseas

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Other I Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

No

Yes

No

notes.

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

INFO): PACKAGE #1

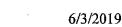
Is there a prerequisite for any additional benefits

for this package?

Which prerequisites are required for this

: Participation in a Wellness or Care

,





package?

Management Program

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN THE MULTIDISCIPLINARY CLINIC

PROGRAM

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies

offered (Select all that apply):

: Web/Phone-based technologies

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Is there an enrollee Deductible?

Nο

Jest J

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 13: PACKAGE #1**

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND VIDEO TECHNOLOGIES CONSULTATION

SERVICE PROVIDED BY STATE LICENSED PROVIDER SUCH AS:

ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST,

PSYCHIATRIST, AMONG OTHERS.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

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

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3250.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Medicare-covered plan services?

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

: In-Network Medicare-covered benefits

: In-Network Non-Medicare-covered benefits

Yes

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?

No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your network

(select all that apply):

Defined Standard Benefit

: Standard Retail Cost-Sharing

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy



about:blank

Sponsor attests that it will comply with 42 CFR 423,154,

: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

Yes

No

No

Yes

No

Yes

No



SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:

: In-Network Retail Pharmacy - one month supply

: In-Network Retail Pharmacy - three month

supply

Enter number of days for Standard Retail Costsharing one month supply:

Enter number of days for Standard Retail Costsharing three month supply:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy one month supply:

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

Enter number of days for Standard Mail Order Cost-Sharing three month supply:

Select the Long Term Care Pharmacy one

month Location/supply amount(s) that apply:

Enter number of days for Long Term Care Pharmacy one month supply:

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

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

30

90

: Out-of-Network Pharmacy - one month supply

30

: Standard Mail Order - three month supply

90

: Long Term Care Pharmacy - one month supply

31

No





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 041, SEGMENT 0

Module: PBP

Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/30/2019
PBP Software Version: 2020.01

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MA BPT Timestamp: 05/28/2019 06:46:00 PM SA Western Standard

Time

PD BPT Timestamp: 05/28/2019 06:46:00 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

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PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed
Section B2 Status Completed
Section B3 Status Completed
Section B4 Status Completed

Section B4 Status Completed
Section B5 Status Completed
Section B6 Status Completed
Section B7 Status Completed

Section B8 StatusCompletedSection B9 StatusCompletedSection B10 StatusCompletedSection B11 StatusCompleted

Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed
Section B15 Status Completed

Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed

Section B18 Status Completed
Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1







Organization Legal Name:

Organization Marketing Name:

Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

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

Service Area(s):

Service Area(s):

Service Area(s):

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Service Area(s):

MMM HEALTHCARE, LLC

Medicare y Mucho Más

www.mmmpr.com

MMM Completo Platino (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40320 - Hatillo, PR









-

40740 - Vieques, PR









Service Area(s):

	40750 WH-II- DD
G : A(-)	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	041
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan? SECTION A: SECTION A-2	No
	122602
Indicate CY2020 total projected member months for this plan:	122682
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmm-pr.com
Formulary Website Address:	www.mmm-pr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)647-9555
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-4	(833)647-9555
Customer Service Contact Local Phone Number	(787)620-2396





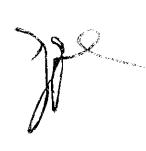


PBP Data Report

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-AG	CUTE - BASE 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-AG	CUTE - BASE 7
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-AC	CUTE - BASE 12
What is your Inpatient Hospital-Acute benefit	Per Admission or Per Stay









period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

Is authorization required?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part

No

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Yes

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Zero

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No





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SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

1 03

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

No

H

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amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

No

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

Select which Worldwide Services have a : Worldwide Emergency Coverage Copayment (Select all that apply): : Worldwide Urgent Coverage

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes
Is a referral required for Partial Hospitalization? Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?







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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Select Routine Care periodicity:

Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

No

Yes

Therapies benefit, or both?

Select enhanced benefit:

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment? No

Is there an enrollee Deductible?

Is authorization required? Yes
Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Copayment?

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Yes

Services?

Notes:

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

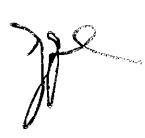
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No







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

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No 1

Indicate number of Routine Foot Care visits:

Every year

Select the Routine Foot Care periodicity: Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Podiatrist Services?

Yes

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

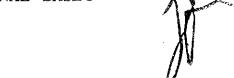
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Copayment?

No







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

Is authorization required?

Yes

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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



Is authorization required? Yes Is a referral required for Psychiatric Services? Yes

Notes:

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

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

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

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit No

for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

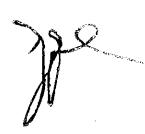
No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?







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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered Observation Services?

103

Obscivation Scivices:

No

Is a referral required for Medicare-covered Outpatient Hospital Services?

. . .

Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Is a referral required for Ambulatory Surgical

Yes No





Center Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes
Is a referral required for Outpatient Substance Yes

Abuse?

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

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Yes

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for

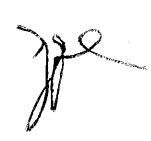
No

Plan Approved Health-related Location?

NO









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Indicate number of trips for Plan Approved

10

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

Select Mode of Transportation for Plan

One-way

Approved Health-related Location:

: Taxi

Approved Health-related Location:

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

No

Is authorization required?

Yes

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

20





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

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

Is there an enrollee Copayment?

No
Do you limit Diabetic Supplies and Services to
No
those from enactified manufacturers?

those from specified manufacturers?

Is authorization required? Yes

Notes:

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? Yes

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

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

Select enhanced benefit: : Number of Treatments

No

Select type of benefit for Number of Mandatory

Is this benefit unlimited for Number of

Treatments?
Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Treatments:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with No either the Chiropractor Services benefit or

Alternative Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

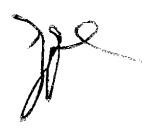
Yes
Indicate Minimum Copayment amount per

\$15.00

treatment:









Indicate Maximum Copayment amount per treatment:

\$15.00

Is authorization required?

Yes

Is a referral required for Acupuncture?

Yes

Yes

SECTION B: #13B OTC ITEMS - BASE 1

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory Yes

Indicate Maximum Plan Benefit Coverage

amount:

45.00

Select Maximum Plan Benefit Coverage

periodicity:

Every three months

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

unused?

No

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

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

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

OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Care Manual?

No

No

No

No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5)IN HOME TESTING AND MONITORING







SPECIFICALLY MONITOR BLOOD
PRESSURE (FOR MEMBERS WHO MEET
MEDICAL CRITERIA FOR ON-GOING
MONITORING OF BLOOD PRESSURE, THE
PLAN WILL PROVIDE ONE (1) BLOOD
PRESSURE MONITOR UNIT EVERY 5
YEARS. THIS BENEFIT REQUIRES
MEDICAL EVALUATION AND/OR
PREAUTHORIZATION.

6) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Select type of benefit for Meals:

How many days does your Meal Benefit last?
What is the maximum number of meals the

benefit provides?

Is there a service-specific Maximum Plan

Benefit Coverage amount?

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

Mandatory

5 10

No

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

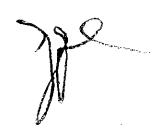
Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for the Meal Benefit?

Yes



SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 1 TIME PER YEAR FOR 10 MEALS MAX PER YEAR

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

Medicare-covered Zero Dollar Preventive Services Attestation

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Is authorization required?

M

Yes

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Is a referral required?

No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

: In-Home Support Services*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Mandatory

Indicate number of visits offered in addition to

9

Medicare:

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies

: Nursing Hotline

offered (Select all that apply):

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

Select type of benefit for In-Home Support

Mandatory

Services:

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

Ac

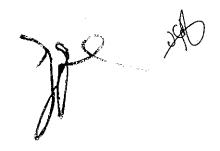
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Health Education Notes:



Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



THE HEP IS RESPONSIBLE OF **DEVELOPING AND IMPLEMENTING** EDUCATIONAL INTERVENTIONS SUCH AS DIABETES AND HYPERTENSION MANAGEMENT AND NUTRITIONAL EDUCATION, TO HELP WHO RECEIVE MEDICAL SERVICES PROVIDING AN OPPORTUNITY TO ENGAGE IN **BEHAVIOR** THAT WILL IMPROVE AND SUSTAIN HEALTHIER LIFESTYLE. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS, IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE, WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND INDIVIDUAL MANAGEMENT OF HIGH RISK CASES

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF

REFERRED BY CAR.

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CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes:



THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 **EMERGENCY LINES, CRISIS** MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE



ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

In-Home Support Services Notes:*

UP TO FOUR 4-HOUR IN-HOME CARE

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VISITS (12 HOURS TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY LIVING FOR MEMBERS WHO MEET **CERTAIN CRITERIA, SUCH AS:** BEDRIDDEN, STROKE, CHF (STAGE 3&4) Y COPD (STAGE 3&4)

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Glaucoma Screening?

Yes

Yes

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Is authorization required for Medicare-covered

Digital Rectal Exams?

Yes

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

Is authorization required for Other Medicare-

Yes

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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



Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is Authorization Required? Yes Does the plan offer step therapy? No

SECTION B: #15 MEDICARE PART B RX DRUGS - NOTES

Notes:

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

2500.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Yes

Select which Comprehensive Dental Services

have a Coinsurance (Select all that apply):

: Medicare-covered Benefits

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services





Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Minimum Coinsurance percentage for Restorative Services:	33%
Indicate Maximum Coinsurance percentage for Restorative Services:	33%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	33%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	33%
Is there an enrollee Deductible? SECTION B: #16B COMPREHENSIVE DENT	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6





Services? Notes:

Is there an enrollee Copayment?

Is a referral required for Comprehensive Dental

Is authorization required?

RESTORATIVE SERVICES- POST AND CORE ARE COVERED UP TO TWO (2) PER MEMBER PER YEAR AND /OR UP TO TWO (2) SINGLE CROWNS PER MEMBER PER YEAR, AND REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. COINSURANCE AMOUNT WILL ONLY APPLY FOR POST AND CORE AND SINGLE CROWNS.

No

Yes

No



PROSTHODONTIC SERVICESREMOVABLE COMPLETE OR PARTIAL
DENTURES IN RESIN AND METAL BASE,
COVERED EVERY 5 YEARS. DENTURE
REPAIR SERVICES, INCLUDING
SERVICES RELATED TO THE REPAIR OF
EXISTING COMPLETE OR PARTIAL
DENTURES ARE COVERED.
REMOVABLE PARTIAL FLEXIBLE BASE
DENTURES COVERED EVERY 8 YEARS.
ADJUSTMENT OR REPAIRS ARE NOT
COVERED IN FLEXIBLE BASE DENTURES
AND/OR FLEXIBLE BASE ARE NOT
COVERED IN COMPLETE OR FULL
DENTURES.

ADDITIONAL SUPPLEMENTAL ORAL /

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MAXILLOFACIAL SURGERY AND OTHER SERVICES NOT COVERED. FIXED DENTURES, IMPLANTS OR RETAINER CROWNS ARE NOT COVERED.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR PROSTHODONTIC SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

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

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

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and frames):

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

SECTION B: #17B EYEWEAR - BASE 3

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

Select the Maximum Plan Benefit Coverage type:

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

Indicate Combined Maximum Plan Benefit Coverage amount:

Select the Combined Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

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

No

No

No

No

No

Yes

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Yes

Mandatory

Yes

Yes

Plan-specified amount per period

Yes

350.00

Every year

No





Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	



SECTION B: #18A HEARING EXAMS - BASE 1

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

Select enhanced benefits: : Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

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

for Hearing Aid?

Indicate number for Fitting/Evaluation for 1

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No
Is authorization required? Yes

Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all Mandatory

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Je.



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Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

amount:

Indicate Maximum Plan Benefit Coverage

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? No No

Is there an enrollee Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? Yes

Is a referral required for Hearing Aids?

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

No

No

No

Both ears combined

400.00

No

Every year

Plan-specified amount per period

Does your plan include MA Uniformity Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

1

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

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility

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

Which disease states does this benefit apply?

(Select all that apply):

: Diabetes

: Chronic Obstructive Pulmonary Disease

: Congestive Heart Failure (CHF)

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: Coronary Artery Disease

: Other 1

Other 1 Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

No

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in

notes.

No



Is there a prerequisite for any additional benefits

for this package?

Yes

Which prerequisites are required for this

package?

: Participation in a Wellness or Care

Management Program

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN THE MULTIDISCIPLINARY CLINIC

PROGRAM

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

Yes

 \mathbf{C} ?

Select enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nurs

Hotline)*

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies

: Web/Phone-based technologies

offered (Select all that apply):

BASE 3: PACKAGE #1 Is there a service-specific Maximum Plan

No

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



Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND VIDEO TECHNOLOGIES CONSULTATION

SERVICE PROVIDED BY STATE LICENSED PROVIDER SUCH AS:

ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST,

PSYCHIATRIST, AMONG OTHERS:

AK

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

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

Is there an In-Network Maximum Enrollee Out-

Yes

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Voluntary

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

3250.00

The table of table

Pocket Cost Amount:

: In-Network Medicare-covered benefits

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

: In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

JA)

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Select the type of drug benefit: Describe the components of your network

(select all that apply):

Sponsor attests that it will comply with 42 CFR

423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? No Does plan utilize ceiling pricing? No Are there quantity limits on certain prescription Yes

drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

Yes

No

Yes



: Standard Retail Cost-Sharing : Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

: Sponsor attests that it will comply with 42

CFR 423.154.

Yes

No

Yes

No



SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:

: In-Network Retail Pharmacy - three month

supply

Enter number of days for Standard Retail Cost-

sharing one month supply:

Enter number of days for Standard Retail Cost-

sharing three month supply:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy one month supply:

Select all Standard Mail Order Cost-Sharing

: In-Network Retail Pharmacy - one month

30

90

30

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order - three month supply

Location/supply amount(s) that apply:

Enter number of days for Standard Mail Order Cost-Sharing three month supply:

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

Enter number of days for Long Term Care Pharmacy one month supply:

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

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

90

: Long Term Care Pharmacy - one month supply

31

No

No



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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 047, SEGMENT 0

Module: **PBP**

Requested By: mint

PLAN SYSTEM INFORMATION

Last entry Date: 05/29/2019 PBP Software Version: 2020.01

05/29/2019 03:56:30 PM SA Western Standard Plan Ready for Upload Timestamp:

Time

MA BPT Timestamp: 06/02/2019 04:56:37 PM SA Western Standard

Time

PD BPT Timestamp: 06/01/2019 12:05:23 AM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

Upload Status: 06/02/2019 #01893

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed

Section B5 Status Completed Section B6 Status Completed

Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed

Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed

Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed

Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed

Section B19 Status Completed Section C Status Completed

Section D Status Completed

Section Mrx Status Completed **SECTION A: SECTION A-1**





Organization Legal Name: Organization Marketing Name: Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

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

Service Area(s):

Service Area(s):

Service Area(s):

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MMM HEALTHCARE, LLC

Medicare y Mucho Más

www.mmmpr.com

MMM Valor Platino (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranguitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR 40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR 40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR







Service Area(s):
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40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR 40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR

40330 - Hormigueros, PR





Service Area(s):

Service Area(s):

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	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	047
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member months for this plan:	33499
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No .
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmm-pr.com
Formulary Website Address:	www.mmm-pr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)647-9555
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)647-9555
SECTION A: SECTION A-4	
	(TOT) (OO O OO O

Customer Service Contact Local Phone Number







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(787)620-2396

for Prospective Part D Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655	
SECTION A: SECTION A-5		
Is your organization filing a standard bid for Section B of the PBP?	No	
Is your organization filing a standard bid for Section C of the PBP?	No	
SECTION A: SECTION A-6		
Is your organization filing a standard bid for Section D of the PBP?	No	
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No	
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No	
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No	
Is there an enrollee Coinsurance?	No	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7		
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12		

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









period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee No

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

Is authorization required?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2): Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

No

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee Coinsurance?

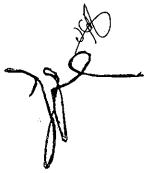
No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No





SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

discharge?

Is authorization required?

Yes

No

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Νo

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

No



amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

Yes : Worldwide Emergency Coverage

Select which Worldwide Services have a

: Worldwide Urgent Coverage

Copayment (Select all that apply):

\$75.00

\$75.00

Indicate Minimum Copayment amount for Worldwide Emergency Coverage:

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Indicate Maximum Copayment amount for

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Νo

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?





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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Yes

Select Routine Care periodicity:

Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Select enhanced benefit:

Is there a service-specific Maximum Plan

Yes

No

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

Is authorization required? Yes
Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Yes

Services?

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No







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

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes Is a referral required for Mental Health Yes

Specialty Services - Non-Physician?

Notes:

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 1

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Select enhanced benefits:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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





Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Psychiatric Services?

Yes

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No No

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

Is authorization required?

Yes

Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

No

for Part B services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Opioid Treatment

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered

Observation Services?

No

Is a referral required for Medicare-covered

Outpatient Hospital Services? Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

SECTION B: #9B ASC SERVICES - BASE 2

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

Is authorization required?

Is there an enrollee Coinsurance?

No Yes





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Is a referral required for Ambulatory Surgical No

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes
Is a referral required for Outpatient Substance
Abuse?

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

No

No

Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Out-of-1 ocact Cost:

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services No as a supplemental benefit under Part C?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

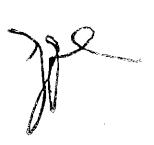
Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization required?

Yes

Notes:

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

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

Yes

Is there an enrollee Coinsurance?

: Medicare-covered Prosthetic Devices

Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for

20%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

20%

y to a Service of the Control of the

Indicate Minimum Coinsurance percentage for

20%

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

20%

Medicare-covered Medical Supplies:

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

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

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

Is authorization required? Ye

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

Is there an enrollee Copayment? No
Do you limit Diabetic Supplies and Services to No

Do you limit Diabetic Supplies and Services to those from specified manufacturers?

Is authorization required?

Yes

Notes:

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?









	GTRACIO
Is there an enrollee Coinsurance?	No No
Is there an enrollee Deductible?	No No
Is there an enrollee Copayment?	No Contrato Número
SECTION B: #12 DIALYSIS SERVICES - BA	SE 2 2 2 0 0 2
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No No DE SE
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage	50.00
amount:	
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
SECTION B: #13B OTC ITEMS - BASE 3	
Notes:	THE FOLLOWING CATEGORIES ARE COVERED:
۸ _	1) MINERALS AND VITAMINS
	2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS

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WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT REQUIRES MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

6) INCONTINENCE SUPPLIES (ADULT **DIAPERS & UNDER PADS)**

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Is authorization required? Is a referral required?

Yes No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Additional Sessions of

Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Mandatory

9

No

No

Mandatory

: Nursing Hotline

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No No

Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes:

THE HEP IS RESPONSIBLE OF

DEVELOPING AND IMPLEMENTING EDUCATIONAL INTERVENTIONS SUCH AS DIABETES AND HYPERTENSION MANAGEMENT AND NUTRITIONAL EDUCATION, TO HELP WHO RECEIVE MEDICAL SERVICES PROVIDING AN

OPPORTUNITY TO ENGAGE IN

BEHAVIOR

THAT WILL IMPROVE AND SUSTAIN

HEALTHIER LIFESTYLE.

SCOPE:

IDENTIFY THE POPULATION WITH

EDUCATIONAL NEEDS, PLAN

EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND

PREVENTION OF COMPLICATIONS,

IMPLEMENT AND CARRY OUT

EDUCATIONAL STRATEGIES.EVALUATE THE RESULTS AND CREATE FUTURE









Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:





GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE, WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND INDIVIDUAL MANAGEMENT OF HIGH RISK CASES REFERRED BY CAR.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR, OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A **QUIT DATE, REDUCE QUANTITY OF** CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO **IMPROVE THE PARTICIPANT'S** COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes:



THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE



AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 **EMERGENCY LINES, CRISIS** MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVID EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY

TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC

CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

H

Glaucoma Screening?

Is authorization required for Medicare-covered Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Yes

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

Is authorization required for Other Medicare-Yes

covered Preventive Services?

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

Is a referral required for any Services?

No

No

Yes

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

No Is there an enrollee Coinsurance?

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

No Is there an enrollee Copayment?

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

Does the plan offer step therapy? No

SECTION B: #15 MEDICARE PART B RX DRUGS - NOTES

Notes:

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion No

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental No

Items as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance? Yes

Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):

: Medicare-covered Benefits

Indicate the Minimum Coinsurance percentage

50%

for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage

50%





for Medicare-covered Benefits:	
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DEN	TAL - BASE 5
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DEN	TAL - BASE 6
Is authorization required?	No
Is a referral required for Comprehensive Dental Services?	No
Notes:	
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	No
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	
SECTION B: #18A HEARING EXAMS - BAS	E 1
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	No ·
SECTION B: #18A HEARING EXAMS - BAS	E 2
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No









SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Hearing Exams?

No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

No

supplemental benefit under Part C?

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

Does your plan include MA Uniformity

Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

No

the Chronically III?

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

1

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

No

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

No

notes.

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

Is there a prerequisite for any additional benefits

Yes

for this package?



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Rost

Which prerequisites are required for this

package?

: Participation in a Wellness or Care

Management Program

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN THE MULTIDISCIPLINARY CLINIC

PROGRAM

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

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nursi

Hotline)*
Mandatory

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Web/Phone-based technologies

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Ale

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 13: PACKAGE #1**

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND VIDEO TECHNOLOGIES CONSULTATION SERVICE PROVIDED BY STATE

LICENSED PROVIDER SUCH AS: ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST,

PSYCHIATRIS, AMONG OTHERS.

SECTION C: /T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

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

Is there an In-Network Maximum Enrollee Outof-Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Voluntary

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3250.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Yes

Medicare-covered plan services? Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Yes

Select the type of drug benefit:

Defined Standard Benefit

Describe the components of your network

: Standard Retail Cost-Sharing

(select all that apply):

: Out-of-Network Pharmacy



Contrato Número

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42 CFR 423.154.

: Sponsor attests that it will comply with 4

CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? Does plan utilize ceiling pricing?

No Yes

No

Are there quantity limits on certain prescription drugs?

Yes

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

No

Do any drugs in your formulary require a step therapy plan?

Yes

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management

No

Program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:

: In-Network Retail Pharmacy - one month

: In-Network Retail Pharmacy - three month

: Standard Mail Order - three month supply

: Long Term Care Pharmacy - one month supply

supply

Enter number of days for Standard Retail Cost-

30

sharing one month supply:

90

Enter number of days for Standard Retail Costsharing three month supply:

Select all Out-of-Network Pharmacy

: Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply:

30

Enter number of days for Out-of-Network

Pharmacy one month supply:

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

Enter number of days for Standard Mail Order

90

Cost-Sharing three month supply:

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

31

Enter number of days for Long Term Care Pharmacy one month supply:

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

No

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

No



first fill?

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,						

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, SEGMENT 0

Module: PBP Requested By: mint

PLAN SYSTEM INFORMATION

Last entry Date: 05/30/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 05/30/2019 12:54:39 PM SA Western Standard

Time

MA BPT Timestamp: 05/28/2019 06:46:18 PM SA Western Standard

Time

PD BPT Timestamp: 05/28/2019 06:46:19 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

Completed

Upload Status: 06/02/2019 #01893

PLAN STATUS

Section B12 Status

Section A Status Plan Ready for Upload

Section B1 Status

Completed
Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Section B7 Status

Section B7 Status

Section B8 Status

Completed
Section B9 Status

Completed
Section B10 Status

Completed
Section B11 Status

Completed

Section B13 Status Completed
Section B14 Status Completed
Section B15 Status Completed
Section B16 Status Completed

Section B17 Status

Section B18 Status

Completed
Section B19 Status

Completed
Section C Status

Completed
Section D Status

Completed
Section Mrx Status

Completed
Completed
Completed

SECTION A: SECTION A-1







Organization Legal Name:
Organization Marketing Name:
Organization Web Site:
Plan Name:
Organization Type:

Plan Type:

Enrollee Type: Service Area(s):

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

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Service Area(s).

Service Area(s):

MMM HEALTHCARE, LLC

PMC Medicare Choice

www.mmmpr.com

PMC Premier Platino (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR 40270 - Guanica, PR

/0000 'C PF

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR





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

40330 - Hormigueros, PR
40340 - Humacao, PR
40350 - Isabela, PR
40360 - Jayuya, PR
40370 - Juana Diaz, PR
40380 - Juncos, PR
40390 - Lajas, PR
40400 - Lares, PR
40410 - Las Marias, PR
40420 - Las Piedras, PR
40430 - Loiza, PR
40440 - Luquillo, PR
40450 - Manati, PR
40460 - Maricao, PR
40470 - Maunabo, PR
40480 - Mayaguez, PR
40490 - Moca, PR
40500 - Morovis, PR
40510 - Naguabo, PR
40520 - Naranjito, PR
40530 - Orocovis, PR
40540 - Patillas, PR
40550 - Penuelas, PR
40560 - Ponce, PR
40570 - Quebradillas, PR
40580 - Rincon, PR
40590 - Rio Grande, PR
40610 - Sabana Grande, PR
40620 - Salinas, PR
40630 - San German, PR
40640 - San Juan, PR
40650 - San Lorenzo, PR
40660 - San Sebastian, PR
40670 - Santa Isabel, PR
40680 - Toa Alta, PR
40690 - Toa Baja, PR
40700 - Trujillo Alto, PR
40710 - Utuado, PR
40720 - Vega Alta, PR
40730 - Vega Baja, PR

40740 - Vieques, PR







Service Area(s):

	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4004	
Plan ID:	048	
Segment ID:	0	
Contract Period:	2020	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Indicate CY2020 total projected member months for this plan:	161931	
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No	
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		1
Participating Pharmacy Website Address:	www.mmmpr.com	1
Formulary Website Address:	www.mmmpr.com	,
Physician Website Address:	www.mmmpr.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5470	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2397	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)647-9555	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5470	
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2397	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)647-9555	
SECTION A: SECTION A-4		
Customer Service Contact Local Phone Number	(787)620-2396	



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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 7
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-AG	CUTE - BASE 12









Per Admission or Per Stay

What is your Inpatient Hospital-Acute benefit

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

Nο

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

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

Is there an enrollee Coinsurance? No

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

No

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

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

No

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Yes

Indicate the Number of Hospital Days Required

Zero

Prior to SNF Admission (0-2):

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

which an enrollee obtains care?

Is there an enrollee Coinsurance?

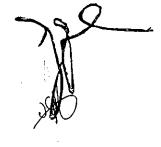
No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No





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SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Per Admission or Per Stay

Do you charge cost sharing on the day of

discharge?

Is authorization required? Yes Is a referral required for SNF Services? No

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

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

No

No

No

Yes

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment? No

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Coverage:

Is there a Maximum Plan Benefit Coverage

Mandatory

No

Mandatory





amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Copayment?

Yes : Worldwide Emergency Coverage

Select which Worldwide Services have a

: Worldwide Urgent Coverage

Copayment (Select all that apply):

75.00

Indicate Minimum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services?

No

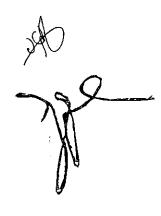
SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?





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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Select Routine Care periodicity:

Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

No

Therapies benefit, or both?

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

Is authorization required? Yes

Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Yes

Services?

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No









Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

Notes:

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No

Indicate number of Routine Foot Care visits:

1

Select the Routine Foot Care periodicity:

Every year

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

No

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

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Podiatrist Services?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No





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Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Other Health Care

Yes

Professional Services?.

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Psychiatric Services?

Yes

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

No

for Part B services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Opioid Treatment

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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









Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

No

Is a referral required for Medicare-covered Observation Services?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No Is authorization required?

Yes

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Is a referral required for Ambulatory Surgical

Center Services?

No

No

No

No

Yes

Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes Is a referral required for Outpatient Substance Yes

Abuse?

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

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee N٥

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Select enhanced benefit:

Plan Approved Health-related Location Mandatory

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for No

Plan Approved Health-related Location?

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Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan

One-way

Every year

24

Approved Health-related Location:

Select Mode of Transportation for Plan

: Taxi

: Bus/Subway Approved Health-related Location:

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No

Is authorization required?

Yes No

No

No

Is a referral required for Transportation

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Yes Is authorization required?

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?







Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No
Do you limit Diabetic Supplies and Services to
No

those from specified manufacturers?

Is authorization required? Yes

Notes:

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? Yes

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Yes

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No.

Treatments?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with No

either the Chiropractor Services benefit or Alternative Therapies benefit, or both?

The file of the fi

SECTION B: #13A ACUPUNCTURE - BASE 2

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

Is there an enrollee Copayment? No
Is authorization required? Yes









Is a referral required for Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

Yes

Mandatory

Yes

120.00

Every month

No

No

Yes

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

No

No

No

No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE





PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT REQUIRES MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

6) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Yes

Select type of benefit for Meals:

How many days does your Meal Benefit last?

What is the maximum number of meals the

benefit provides?

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

10

20

No

. . .

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for the Meal Benefit?

Yes



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SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

POST DISCHARGE

2 MEALS PER DAY FOR 10 DAYS UP TO 1 TIME PER YEAR FOR 20 MEALS MAX PER

YEAR

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

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? Yes
Is a referral required? No

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

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

No

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

: In-Home Support Services*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Additional Sessions of

Smoking and Tobacco Cessation Counseling:

Mandatory

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Remote Access Technologies (including Web/Phone-based Mandatory

technologies and Nursing Hotline):

: Nursing Hotline

Select the type of Remote Access Technologies offered (Select all that apply):

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

Select type of benefit for In-Home Support

Mandatory

Services:

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

Nο

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

Health Education Notes:

THE HEP IS RESPONSIBLE OF

DEVELOPING AND IMPLEMENTING EDUCATIONAL INTERVENTIONS SUCH AS DIABETES AND HYPERTENSION

MANAGEMENT AND NUTRITIONAL

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6/3/2019

EDUCATION, TO HELP WHO RECEIVE MEDICAL SERVICES PROVIDING AN OPPORTUNITY TO ENGAGE IN **BEHAVIOR** THAT WILL IMPROVE AND SUSTAIN HEALTHIER LIFESTYLE. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS, IMPLEMENT AND CARRY OUT **EDUCATIONAL STRATEGIES, EVALUATE** THE RESULTS AND CREATE FUTURE GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL **ACTIVITY AWARENESS AND ONLINE** ACCESS TO EDUCATIONAL LITERATURE. WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND **INDIVIDUAL**

MANAGEMENT OF HIGH RISK CASES REFERRED BY CAR.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR, OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION,

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:





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EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes: THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911

EMERGENCY LINES, CRISIS
MANAGEMENT LINES, EMERGENCY
ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE
EDUCATION REGARDING THE
SYMPTOMS AND MANAGEMENT OF
MEDICAL EMERGENCIES, LABORATORY
TEST, MEDICAL PRESCRIPTIONS,
MEDICATION USE, CHRONIC
CONDITIONS, NUTRITION, PSYCOLOGIC
HELP AND OTHERS CLINICAL AREAS.

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

In-Home Support Services Notes:*

POSD

AK

UP TO FOUR 4-HOUR IN-HOME CARE VISITS (16 HOURS TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY LIVING FOR MEMBERS WHO MEET CERTAIN CRITERIA, SUCH AS: BEDRIDDEN, STROKE, CHF (STAGE 3&4)

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Y COPD (STAGE 3&4)

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Yes

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Yes

Barium Enemas?

Yes

Is authorization required for Medicare-covered

Digital Rectal Exams?

Yes

EKG following Welcome Visit?

Is authorization required for Other Medicare-

Is authorization required for Medicare-covered

Yes

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

Does the plan offer step therapy?

No

No

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

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



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SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Yes

Other Oral/Maxillofacial Surgery, Other

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select enhanced benefits:

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

2000.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Yes

Select which Comprehensive Dental Services

have a Coinsurance (Select all that apply):

: Medicare-covered Benefits

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate the Minimum Coinsurance percentage

for Medicare-covered Benefits:

0%

0%

Indicate the Maximum Coinsurance percentage

for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

0%

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is there an enrollee Deductible?

0%

No





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SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

Notes:

PROSTHODONTIC SERVICES-REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS, DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES COVERED EVERY 8 YEARS. ADJUSTMENT OR REPAIRS ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

ADDITIONAL SUPPLEMENTAL ORAL / MAXILLOFACIAL SURGERY AND OTHER SERVICES NOT COVERED. FIXED DENTURES, IMPLANTS OR RETAINER CROWNS ARE NOT COVERED.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR PROSTHODONTIC SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

No

No

No

No

No

Yes

No

Yes

: Contact lenses



: Eyeglasses (lenses and frames)

Plan-specified amount per period

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Yes

Yes

Mandatory

Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

Coverage amount:

450.00

Yes

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Every year

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear?

No

Notes:

No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Mandatory

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

1

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

No



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Contrato Número



Benefit Coverage amount? No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3** Is there an enrollee Copayment? No Yes Is authorization required? Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? Select enhanced benefits: : Hearing Aids (all types) Select type of benefit for Hearing Aids (all Mandatory types): Is this benefit unlimited for Hearing Aids (all Yes types)? **SECTION B: #18B HEARING AIDS - BASE 2** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined Amount apply per ear or for both ears combined? Select the Maximum Plan Benefit Coverage Plan-specified amount per period type: 2500.00 Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage Every year periodicity: **SECTION B: #18B HEARING AIDS - BASE 3** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18B HEARING AIDS - BASE 4** Is there an enrollee Copayment? No Is there an enrollee Deductible? No SECTION B: #18B HEARING AIDS - BASE 5 Yes Is authorization required? Is a referral required for Hearing Aids? No SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI Does your plan include MA Uniformity Yes









Flexibility with reductions in cost or additional

Do you offer Special Supplemental Benefits for

Yes

the Chronically Ill?

Select what type of benefit your SSBCI

: Additional Benefits

includes:

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Other 1 Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

No

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

notes.

No

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

Is there a prerequisite for any additional benefits

Yes

for this package?

Which prerequisites are required for this

package?

: Participation in a Wellness or Care

Management Program

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No



SERVICE PROVIDED BY STATE LICENSED PROVIDER SUCH AS: ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST, PSYCHIATRIST, AMONG OTHERS.

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

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

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

Are any benefits exempt from the plan-level

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

Nο

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

Notes:

MEAL BENEFIT (BEYOND LIMITED

BASIS):

2 MEALS PER DAY FOR 10 DAYS UP TO 1 TIME PER YEAR FOR 20 MEALS MAX PER

YEAR

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

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill

: Meals (beyond limited basis)

includes:

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?

Select type of benefit for Meals (beyond limited

basis):

How many days do your Meals (beyond limited

basis) last?

What is the maximum number of meals the

benefit provides?

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Mandatory



No



Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN THE MULTIDISCIPLINARY CLINIC

PROGRAM

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies : Web/Phone-based technologies

offered (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

Remote Access Technology (Web/Phone beter CICREAL TIME INTERACTIVE AUDIO AND technologies) Notes:*

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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASI

No

PACKAGE #2

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

Is authorization required? Yes

Is a referral required for the Meals (beyond

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #2

2 MEALS PER DAY FOR 10 DAYS UP TO 1 Notes: TIME PER YEAR FOR 20 MEALS MAX PER

YEAR

Voluntary

3250.00

Yes

Yes

Yes

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

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

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

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your network

(select all that apply):

Yes

No

Defined Standard Benefit

: Standard Retail Cost-Sharing

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: In-Network Medicare-covered benefits

: In-Network Non-Medicare-covered benefits



: Long Term Care Pharmacy Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications OTCs) under the Utilization Management Program?

No No

Yes

Yes

No

Yes

No



Select all Standard Retail Cost-sharing

Location/supply amount(s) that apply:

30

Enter number of days for Standard Retail Costsharing one month supply:

Enter number of days for Standard Retail Costsharing three month supply:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy one month supply:

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

Enter number of days for Standard Mail Order Cost-Sharing three month supply:

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

Enter number of days for Long Term Care Pharmacy one month supply:

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

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

: In-Network Retail Pharmacy - one month

: In-Network Retail Pharmacy - three month

supply

90

: Out-of-Network Pharmacy - one month supply

30

: Standard Mail Order - three month supply

90

: Long Term Care Pharmacy - one month supply

31

No





Module:

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POSDE

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 049, SEGMENT 0

Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/30/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 05/30/2019 11:47:08 AM SA Western Standard

Time

PBP

MA BPT Timestamp: 06/01/2019 12:05:16 AM SA Western Standard

Time

PD BPT Timestamp: 06/01/2019 10:47:37 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

Upload Status: 06/02/2019 #01893

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed
Section B2 Status Completed
Section B3 Status Completed
Section B4 Status Completed

Section B4 Status

Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Section B8 Status

Completed

Section B9 Status Completed
Section B10 Status Completed
Section B11 Status Completed
Section B12 Status Completed

Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed

Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed
Section B18 Status Completed

Section B18 Status Completed
Section B19 Status Completed

Section C Status Completed
Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1





Organization Legal Name:

Organization Marketing Name:

Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

MMM HEALTHCARE, LLC

Medicare y Mucho Más

www.mmmpr.com

MMM Bienestar Platino (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR 40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR









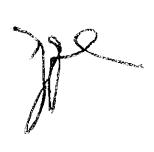
Service Area(s):	
Service Area(s):	
Service Area(s):	4.6
Service Area(s):	

40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR 40720 - Vega Alta, PR

40730 - Vega Baja, PR 40740 - Vieques, PR







Service Area(s):

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	049
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member months for this plan:	63590
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmm-pr.com
Formulary Website Address:	www.mmm-pr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)647-9555
a . a . a	(707) (20, 220)



(833)647-9555

SECTION A: SECTION A-4

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

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number

(787)620-2396



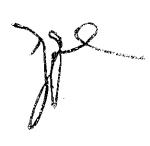
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for Prospective Part D Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655	
SECTION A: SECTION A-5		
Is your organization filing a standard bid for Section B of the PBP?	No	
Is your organization filing a standard bid for Section C of the PBP?	No	
SECTION A: SECTION A-6		
Is your organization filing a standard bid for Section D of the PBP?	No	
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No	
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No	
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No .	
Is there an enrollee Coinsurance?	No	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7		
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12		
What is your Inpatient Hospital-Acute benefit	Per Admission or Per Stay	









period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

Is authorization required?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part No

CO.

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Is there a service-specific Maximum Enrollee

2410

Prior to SNF Admission (0-2):

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No



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SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Nο

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

I GS

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

No

of

about:blank

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amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

No

No

Yes

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment? Yes

Select which Worldwide Services have a : Worldwide Emergency Coverage

Copayment (Select all that apply): : Worldwide Urgent Coverage

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes

Is a referral required for Partial Hospitalization? Yes
SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Home Health Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?







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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefit:

: Routine Care

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Select Routine Care periodicity:

Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

No

Therapies benefit, or both?

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

Yes
Is a referral required for Chiropractic Services?

Yes

Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Occupational Therapy

Yes

No

No

Services?

Notes:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment? No SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No

Indicate number of Routine Foot Care visits:

1

Select the Routine Foot Care periodicity:

Every year No

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

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

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Podiatrist Services?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

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

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Is authorization required?

Is a referral required for Other Health Care

Yes Yes

Professional Services?

Notes:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Psychiatric Services? Yes

Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit No

for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required?

Is a referral required for Opioid Treatment No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Yes









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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered

Observation Services?

Is a referral required for Medicare-covered

Obscivation Scivices:

No

Outpatient Hospital Services?

Is there an enrollee Coinsurance?

No

Is a referral required for Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Ambulatory Surgical No





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Center Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes Yes

Is a referral required for Outpatient Substance

Abuse?

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

Does the plan provide Outpatient Blood

No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Nο

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Yes

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

related Location.

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

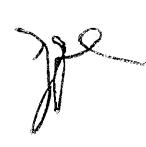
No

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Indicate number of trips for Plan Approved 12

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

Approved Health-related Location:

One-way

Select Mode of Transportation for Plan : Taxi

Approved Health-related Location: : Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Transportation No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

0% Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

No

Is authorization required? Yes

DME Supplies 0%, Wheelchair 5%, DME Hosp Notes:

Bed 5%, DME Power Wheelchair 20%, All

other DME 0%

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

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

No

Is there an enrollee Coinsurance?

Yes

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

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10% Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices: Indicate Maximum Coinsurance percentage for 10% Medicare-covered Prosthetic Devices: Indicate Minimum Coinsurance percentage for 10% Medicare-covered Medical Supplies: Indicate Maximum Coinsurance percentage for 10% Medicare-covered Medical Supplies: SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3 Is authorization required? Yes SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2 Is there an enrollee Copayment? No Do you limit Diabetic Supplies and Services to No those from specified manufacturers? Is authorization required? Yes Notes: **SECTION B: #12 DIALYSIS SERVICES - BASE 1** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #12 DIALYSIS SERVICES - BASE 2** Is authorization required? Yes Is a referral required for Dialysis Services? Nο **SECTION B: #13A ACUPUNCTURE - BASE 1** Does the plan provide Acupuncture as a No supplemental benefit under Part C? SECTION B: #13B OTC ITEMS - BASE 1 Does the plan provide Over-The-Counter (OTC) Yes

Mandatory

Yes

20.00









Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Benefit Coverage amount?

Is there a service-specific Maximum Plan

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

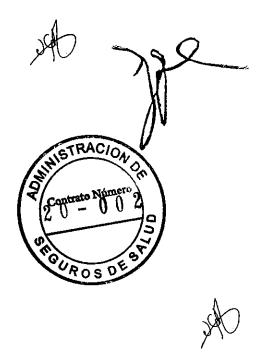
SECTION B: #13B OTC ITEMS - BASE 2

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

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:



Every three months

No

No

Yes

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

No No No No

> THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5)IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS, THIS BENEFIT REQUIRES MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 6) INCONTINENCE SUPPLIES (ADULT **DIAPERS & UNDER PADS)**

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No



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

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance. copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

Is a referral required?

Yes

No

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

Does the plan provide the Annual Physical

Nο

Yes

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Health Education:

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Mandatory

Mandatory

Medicare: Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

Mandatory

: Nursing Hotline

offered (Select all that apply):

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

No

9

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEP IS RESPONSIBLE OF DEVELOPING AND IMPLEMENTING EDUCATIONAL INTERVENTIONS SUCH AS DIABETES AND HYPERTENSION MANAGEMENT AND NUTRITIONAL EDUCATION, TO HELP WHO RECEIVE MEDICAL SERVICES PROVIDING AN OPPORTUNITY TO ENGAGE IN

BEHAVIOR

THAT WILL IMPROVE AND SUSTAIN

HEALTHIER LIFESTYLE.

SCOPE:

IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND

PREVENTION OF COMPLICATIONS,

IMPLEMENT AND CARRY OUT

EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE,

WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND

INDIVIDUAL

MANAGEMENT OF HIGH RISK CASES

REFERRED BY CAR.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:





DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP. MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.



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

Remote Access Technologies (Nursing Hotline) Notes:



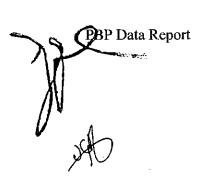


THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERJES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS

MANAGEMENT LINES, EMERGENCY

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ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Nο

Is authorization required?

No Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Yes

Barium Enemas?

Yes

Is authorization required for Medicare-covered

res

Digital Rectal Exams?

Yes

Is authorization required for Medicare-covered

res

EKG following Welcome Visit?

Yes

Is authorization required for Other Medicare-

res

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No



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

Is there an enrollee Copayment?

Nο

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

Does the plan offer step therapy?

No

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Yes

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

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

Select the Maximum Plan Benefit Coverage

amount:

2000.00

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Select which Comprehensive Dental Services

: Medicare-covered Benefits

have a Coinsurance (Select all that apply):

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate the Minimum Coinsurance percentage

for Medicare-covered Benefits:

0%

Indicate the Maximum Coinsurance percentage

for Medicare-covered Benefits:

0%

Indicate Minimum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

33%



Surgery, Other Services:

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is there an enrollee Deductible?

No

33%

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

No

No

Notes:

PROSTHODONTIC SERVICESREMOVABLE COMPLETE OR PARTIAL
DENTURES IN RESIN AND METAL BASE,
COVERED EVERY 5 YEARS. DENTURE
REPAIR SERVICES, INCLUDING
SERVICES RELATED TO THE REPAIR OF
EXISTING COMPLETE OR PARTIAL
DENTURES ARE COVERED.
REMOVABLE PARTIAL FLEXIBLE BASE
DENTURES COVERED EVERY 8 YEARS.
ADJUSTMENT OR REPAIRS ARE NOT
COVERED IN FLEXIBLE BASE DENTURES
AND/OR FLEXIBLE BASE ARE NOT
COVERED IN COMPLETE OR FULL
DENTURES.

ADDITIONAL SUPPLEMENTAL ORAL / MAXILLOFACIAL SURGERY AND OTHER SERVICES NOT COVERED. FIXED DENTURES, IMPLANTS OR RETAINER CROWNS ARE NOT COVERED.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR PROSTHODONTIC SERVICES.



SECTION B: #17A EYE EXAMS - BASE 1

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Ax

and frames)?

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

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

Yes

Yes

Select type of benefit for Contact lenses:

Mandatory

Select type of benefit for Eyeglasses (lenses and Mandatory frames):

Is this benefit unlimited for Eyeglasses (lenses Yes

SECTION B: #17B EYEWEAR - BASE 3

Is this benefit unlimited for Contact lenses?

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

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

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

Indicate Combined Maximum Plan Benefit 300.00 Coverage amount:

Select the Combined Maximum Plan Benefit Every year Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

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

Is there an enrollee Coinsurance? No SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6
Is authorization required? No

Is a referral required for Eyewear? No Notes:

SECTION B: #18A HEARING EXAMS - BASE 1

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

Select enhanced benefits: : Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid:

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

icate number



1 Indicate number for Fitting/Evaluation for Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** Is there a service-specific Maximum Plan No Benefit Coverage amount? No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3** Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? Select enhanced benefits: : Hearing Aids (all types) Select type of benefit for Hearing Aids (all Mandatory types): Is this benefit unlimited for Hearing Aids (all Yes types)? **SECTION B: #18B HEARING AIDS - BASE 2** Is there a service-specific Maximum Plan Yes Contrato Número Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined Amount apply per ear or for both ears combined? Plan-specified amount per period Select the Maximum Plan Benefit Coverage type: Indicate Maximum Plan Benefit Coverage 250.00 amount: Indicate Maximum Plan Benefit Coverage Every three years periodicity: SECTION B: #18B HEARING AIDS - BASE 3 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? **SECTION B: #18B HEARING AIDS - BASE 4** Is there an enrollee Copayment? No Is there an enrollee Deductible? No **SECTION B: #18B HEARING AIDS - BASE 5**

Yes

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Is authorization required?

Contrato Numero

Is a referral required for Hearing Aids?

No

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

Does your plan include MA Uniformity

Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

Yes

the Chronically Ill?

Select what type of benefit your SSBCI

: Additional Benefits

includes:

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

Does your VBID/MA Uniformity

Nο

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Other 1 Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

No

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in

No

notes.

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

INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

for this package?

Yes

Which prerequisites are required for this

package?

: Participation in a Wellness or Care

Management Program

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

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(OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN THE MULTIDISCIPLINARY CLINIC

PROGRAM

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

ct enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

Hotline)*
Mandatory

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

Select the type of Remote Access Technologies

technologies and Nursing Hotline):

: Web/Phone-based technologies

offered (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

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

BASE 13: PACKAGE #1

Is authorization required?

Yes



Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND VIDEO TECHNOLOGIES CONSULTATION

SERVICE PROVIDED BY STATE LICENSED PROVIDER SUCH AS:

ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST, PSYCHIATRIST, AMONG OTHERS.

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

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

MONTHLY ALLOWANCE FOR THE PURCHASE OF SELECTED FOOD AND PRODUCE ITEMS AND HOME DELIVERED MEAL BENEFIT (BEYOND LIMITED

BASIS)

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

Select what type of benefit your Non-Primarily

: Food and Produce

Health Related Benefits for the Chronically Ill

: Meals (beyond limited basis)

includes:

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Mandatory

Yes







Indicate Maximum Plan Benefit Coverage

80.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Other, Describe

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Food and Produce?

Yes

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:

\$80 MONTHLY ALLOWANCE FOR THE PURCHASE OF SELECTED AND VARIED HEALTHY FOOD AND PRODUCE ITEMS TO PROMOTE A WELL-BALANCED DIET.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide Meals (beyond limited Yes basis) as a supplemental benefit under Part C? Select type of benefit for Meals (beyond limited Mandatory basis): How many days do your Meals (beyond limited 10 basis) last? What is the maximum number of meals the 20 benefit provides? Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost?



SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for the Meals (beyond limited basis)?



SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #2

Notes:

2 MEALS PER DAY FOR 10 DAYS UP TO 1 TIME PER YEAR FOR 20 MEALS MAX PER

YEAR

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

No

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

Is there an In-Network Maximum Enrollee Out-

37.00

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3250.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Medicare-covered benefits

: In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Yes

Yes

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

Amount?

No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your network

(select all that apply):

Defined Standard Benefit

: Standard Retail Cost-Sharing

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

No

Does plan utilize ceiling pricing?

No Yes

Are there quantity limits on certain prescription

drugs?

Yes

Is prior authorization required for certain

prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary

design)?

No

Do any drugs in your formulary require a step

therapy plan?

Yes



PBP Data Report Page 30 of 30

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing

Location/supply amount(s) that apply:

: In-Network Retail Pharmacy - one month supply

: In-Network Retail Pharmacy - three month

supply 30

Enter number of days for Standard Retail Cost-

sharing one month supply:

Enter number of days for Standard Retail Cost-

sharing three month supply:

90

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy one month supply:

: Out-of-Network Pharmacy - one month supply

30

90

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

: Standard Mail Order - three month supply

Enter number of days for Standard Mail Order

Cost-Sharing three month supply:

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

Enter number of days for Long Term Care

Pharmacy one month supply:

: Long Term Care Pharmacy - one month supply

Are all of the drugs on your formulary available

with an extended day supply?

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

No

31

No





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 061, SEGMENT 0

Module: PBP

Requested By: mint

PLAN SYSTEM INFORMATION

Last entry Date: 05/30/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 05/30/2019 11:51:55 AM SA Western Standard

Time

MA BPT Timestamp: 06/02/2019 04:56:37 PM SA Western Standard

Time

PD BPT Timestamp: 06/01/2019 10:47:37 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/02/2019 05:53:29 PM SA Western Standard

Time

Upload Status: . 06/02/2019 #01893

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed
Section B2 Status Completed
Section B3 Status Completed

Section B4 Status Completed
Section B5 Status Completed
Section B6 Status Completed

Section B7 Status Completed
Section B8 Status Completed

Section B9 Status Completed
Section B10 Status Completed
Section B11 Status Completed

Section B12 Status Completed
Section B13 Status Completed

Section B14 Status Completed
Section B15 Status Completed

Section B16 Status Completed
Section B17 Status Completed

Section B18 Status Completed
Section B19 Status Completed

Section C Status Completed
Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1



Organization Legal Name: Organization Marketing Name: Organization Web Site: Plan Name: Organization Type: Plan Type: Enrollee Type: Service Area(s): Service Area(s):

MMM HEALTHCARE, LLC

PMC Medicare Choice www.mmmpr.com MMM Relax Platino (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR

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Service Area(s):

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Service Area(s):

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

40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR 40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR









Service Area(s):

	AOGEO XVII II DE
	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	061
Segment ID:	0
Contract Period:	2020 Puerto Rico
Plan Geographic Name:	
Is this an Employer-Only plan? SECTION A: SECTION A-2	No
	215029
Indicate CY2020 total projected member months for this plan:	315938
Does this Plan have a CMS-approved Continuation Area?	No .
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No ROMINISTRACION EN
SECTION A: SECTION A-3	4 / P
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	www.mmmpr.com (866)333-5470
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)647-9555
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5470
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2397
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)647-9555
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number	(787)620-2396

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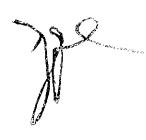
6/3/2019

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for Prospective Part D Medicare Beneficiaries:			
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469		
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)333-5469		
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655		
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655		
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469		
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)333-5469		
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655		
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655		
SECTION A: SECTION A-5			
Is your organization filing a standard bid for Section B of the PBP?	No		
Is your organization filing a standard bid for Section C of the PBP?	No		
SECTION A: SECTION A-6			
Is your organization filing a standard bid for Section D of the PBP?	No		
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No		
SECTION B: #1A INPATIENT HOSPITAL-AG	CUTE - BASE 1		
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No		
SECTION B: #1A INPATIENT HOSPITAL-AG	CUTE - BASE 2		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No		
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No		
Is there an enrollee Coinsurance?	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7			
Is there an enrollee Deductible?	No		
Is there an enrollee Copayment?	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12			
What is your Inpatient Hospital-Acute benefit	Per Admission or Per Stay		









period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part No

<u>_</u>

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

No

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

SECTION B: #2 SNF - BASE 2

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

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6 Is there an enrollee Copayment?





SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

1 03

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

et type of benefit for worldwide Emerg

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

No







amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Copayment?

Yes

Select which Worldwide Services have a

: Worldwide Emergency Coverage

Copayment (Select all that apply):

: Worldwide Urgent Coverage

Indicate Minimum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Urgent Coverage if admitted to hospital?

Yes

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization? Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services? No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?







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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Yes

No

No

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

Is there an enrollee Deductible? No Is authorization required? Yes

Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Yes

Services? Notes:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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Continto Número

Continto Número







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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Is authorization required?

Yes
Is a referral required for Mental Health
Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits:

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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





Is authorization required? Yes
Is a referral required for Other Health Care
Professional Services?

Notes:

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Psychiatric Services? Yes

Notes:

SECTION B: #71 PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Copayment? No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

No









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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Yes

Is authorization required for Medicare-covered

res

Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

Is a referral required for Medicare-covered

Is there an enrollee Coinsurance?

No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

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

No

Out-of-Pocket Cost?

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?

Is a referral required for Ambulatory Surgical

No







Center Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Substance

Yes

Abuse?

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

Does the plan provide Outpatient Blood

No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Νo

as a supplemental benefit under Part C?

SECTION B: #11A DME - BASE 1

Is there an enrollee Coinsurance?

110

Is there a service-specific Maximum Enrollee

e

Out-of-Pocket Cost?

Yes

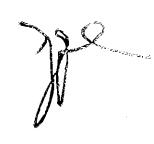
No

Indicate Minimum Coinsurance percentage for

0%









Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits:

No

20%

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

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

No

Is authorization required?

Yes

Notes:

DME Supplies 0%, Wheelchair 5%, DME Hosp Bed 5%, DME Power Wheelchair 20%, All

other DME 0%

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Yes

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

10%

Indicate Maximum Coinsurance percentage for

10%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

10%

Medicare-covered Medical Supplies:

10%

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

Is authorization required?

No

Do you limit Diabetic Supplies and Services to

No

those from specified manufacturers?

Yes

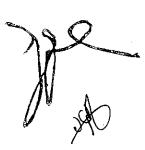
Notes:

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Νo





Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BAS	SE 2
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No No
SECTION B: #13A ACUPUNCTURE - BASE 1	i jan
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No $ \left(\begin{array}{c} C_{\text{contrate}} & R_{\text{dimero}} \\ 0 & 0 & 2 \end{array} \right)_{0} $
SECTION B: #13B OTC ITEMS - BASE 1	3/
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes COROS DE ST
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	40.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No C
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	•
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No SH
SECTION B: #13B OTC ITEMS - BASE 3	
Notes:	THE FOLLOWING CATEGORIES ARE

1) MINERALS AND VITAMINS

COVERED:



3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5)IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT REQUIRES MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

6) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Is authorization required? Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C? No

Yes

Yes

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Additional Sessions of Smoking and Tobacco

Cessation Counseling

: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

about:blank

Select type of benefit for Health Education:

Select type of benefit for Additional Sessions of

Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes:

THE HEP IS RESPONSIBLE OF

DEVELOPING AND IMPLEMENTING EDUCATIONAL INTERVENTIONS SUCH AS DIABETES AND HYPERTENSION MANAGEMENT AND NUTRITIONAL EDUCATION, TO HELP WHO RECEIVE MEDICAL SERVICES PROVIDING AN

OPPORTUNITY TO ENGAGE IN

BEHAVIOR

Mandatory

Mandatory

Mandatory

: Nursing Hotline

9

No

No

No No

No

No

THAT WILL IMPROVE AND SUSTAIN

HEALTHIER LIFESTYLE.

SCOPE:

IDENTIFY THE POPULATION WITH

EDUCATIONAL NEEDS, PLAN

EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND

PREVENTION OF COMPLICATIONS,

IMPLEMENT AND CARRY OUT

EDUCATIONAL STRATEGIES, EVALUATE









Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

THE RESULTS AND CREATE FUTURE GOALS, INTERVENTIONS: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES, NEWSLETTER, PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE. WITH SPECIAL EDUCATIONAL INTERVENTIONS TO DM/SNP AND INDIVIDUAL MANAGEMENT OF HIGH RISK CASES

REFERRED BY CAR.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes:

THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A



SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES, THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS.

3. DIRECT ACCESS TO THE 911 **EMERGENCY LINES, CRISIS** MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

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Is authorization required for Medicare-covered

Glaucoma Screening?

Yes '

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

Is authorization required for Medicare-covered

Barium Enemas?

Yes

Is authorization required for Medicare-covered

Digital Rectal Exams?

Yes

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Yes

Is authorization required for Other Medicare-

covered Preventive Services?

Yes

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

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

Is Authorization Required? Yes Does the plan offer step therapy? No

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

drugs as part of a bundled service as a

No

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Contrato Número

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

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

Services?

Yes



about:blank 6/3/2019 SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Plan-specified amount per period

Every year

2000.00

No

0%

0%

33%

33%

33%

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Select which Comprehensive Dental Services

have a Coinsurance (Select all that apply):

Yes

: Medicare-covered Benefits

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate the Minimum Coinsurance percentage

for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage

for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for

Restorative Services:

Indicate Maximum Coinsurance percentage for

Restorative Services:

Indicate Minimum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

Is there an enrollee Deductible?

33%

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

Notes:

No

RESTORATIVE SERVICES- POST AND CORE ARE COVERED UP TO FOUR (4) PER MEMBER PER YEAR AND /OR UP TO FOUR (4) SINGLE CROWNS PER MEMBER PER YEAR, AND REPLACEMENT

CROWNS COVERED EVERY 5 YEARS PER

TOOTH.

COINSURANCE AMOUNT WILL ONLY



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APPLY FOR POST AND CORE AND SINGLE CROWNS.

PROSTHODONTIC SERVICESREMOVABLE COMPLETE OR PARTIAL
DENTURES IN RESIN AND METAL BASE,
COVERED EVERY 5 YEARS. DENTURE
REPAIR SERVICES, INCLUDING
SERVICES RELATED TO THE REPAIR OF
EXISTING COMPLETE OR PARTIAL
DENTURES ARE COVERED.
REMOVABLE PARTIAL FLEXIBLE BASE
DENTURES COVERED EVERY 8 YEARS.
ADJUSTMENT OR REPAIRS ARE NOT
COVERED IN FLEXIBLE BASE DENTURES
AND/OR FLEXIBLE BASE ARE NOT
COVERED IN COMPLETE OR FULL
DENTURES.

ADDITIONAL SUPPLEMENTAL ORAL / MAXILLOFACIAL SURGERY AND OTHER SERVICES NOT COVERED. FIXED DENTURES, IMPLANTS OR RETAINER CROWNS ARE NOT COVERED.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR PROSTHODONTIC SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

about:blank

Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? No

No

No

No

No

Yes

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Yes

6/3/2019

Select type of benefit for Eyeglasses (lenses and Mandatory frames): Is this benefit unlimited for Eyeglasses (lenses Yes and frames)? **SECTION B: #17B EYEWEAR - BASE 3** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Select the Maximum Plan Benefit Coverage Plan-specified amount per period type: Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 350.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #17B EYEWEAR - BASE 5** Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #17B EYEWEAR - BASE 6 Is authorization required? No Is a referral required for Eyewear? No Notes: **SECTION B: #18A HEARING EXAMS - BASE 1** Yes Does the plan provide Hearing Exams as a supplemental benefit under Part C? Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** Is there a service-specific Maximum Plan No Benefit Coverage amount?

No

No







Is there an enrollee Deductible?

Out-of-Pocket Cost?

Is there a service-specific Maximum Enrollee

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No Yes Is authorization required? Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

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

Select enhanced benefits: : Hearing Aids (all types)

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

Is this benefit unlimited for Hearing Aids (all Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Both ears combined

Amount apply per ear or for both ears combined?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

250.00

Indicate Maximum Plan Benefit Coverage

amount:

Indicate Maximum Plan Benefit Coverage

Every three years periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for No

the Chronically Ill?

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C

Contrato Número



Contrato Número

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

1

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Other 1 Description:

Cardiovascular Disorders

Does the enrollee need to have all diseases

selected to qualify?

No

No

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

notes.

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

INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

for this package?

Yes

Which prerequisites are required for this

package?

: Participation in a Wellness or Care

Management Program

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

SERVICE COVERED ONLY IN CERTAIN PARTICIPATING MULTIDISCIPLINARY CLINICS TO MEMBERS ENROLLED IN

THE MULTIDISCIPLINARY CLINIC





SDE

PROGRAM

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Remote Access Technologies (including

Web/Phone-based technologies and Nu

Hotline)*
Mandatory

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies : Web/Phone-based technologies

offered (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 11: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

BASE 13: PACKAGE #1

Is authorization required?

Yes

Is a referral required for Other Defined

Yes

Supplemental Benefits?

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

BASE 14: PACKAGE #1

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND VIDEO TECHNOLOGIES CONSULTATION

SERVICE PROVIDED BY STATE

LICENSED PROVIDER SUCH AS:
ENDOCRINOLOGIST PULMONOLOGI

ENDOCRINOLOGIST, PULMONOLOGIST, CARDIOLOGIST, RHEUMATOLOGIST, PROCEED AMONG OTHERS

PSYCHIATRIST, AMONG OTHERS.

SECTION C: V/T - GENERAL - US

We-

6/3/2019

about:blank

Do you offer a US Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

No

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

Is there an In-Network Maximum Enrollee Outof-Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3250.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Non-Medicare-covered benefits Yes

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Yes

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your network

(select all that apply):

Defined Standard Benefit

: Standard Retail Cost-Sharing : Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: In-Network Medicare-covered benefits

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR 423 154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Is prior authorization required for certain

prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step

therapy plan?

Νo

No

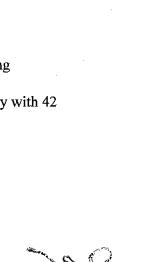
Yes

Yes

No

Yes





Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost-sharing Location/supply amount(s) that apply:

: In-Network Retail Pharmacy - one month

: In-Network Retail Pharmacy - three month

supply

Enter number of days for Standard Retail Cost-

sharing one month supply:

30

Enter number of days for Standard Retail Cost-

sharing three month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy one month supply:

30

Select all Standard Mail Order Cost-Sharing

Location/supply amount(s) that apply:

90

Enter number of days for Standard Mail Order Cost-Sharing three month supply:

Select the Long Term Care Pharmacy one

month Location/supply amount(s) that apply:

Enter number of days for Long Term Care

Pharmacy one month supply:

: Long Term Care Pharmacy - one month supply

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order - three month supply

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Are all of the drugs on your formulary available

with an extended day supply?

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

No No





Wrap-Around Coverage Table 2020 ¹Coordination of Medicaid with Medicare Puerto Rico Health Insurance Administration (PRHIA) Medicare Platino Program





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<u>INPATIENT HOSPITAL SERVICES</u> Co-Payment Code 100-\$0.00 / 110-\$4.00 /120- \$5.00 /130- \$8.00

Medicare Part A. <u>Covers Hospitalization care</u>. Covers hospital services, including semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care.

Costs in Original Medicare: Part B Medicare is responsible for the costs of that inpatient stay.

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

<u>INPATIENT HOSPITAL FOR MENTAL HEALTH DISEASES</u> Co-Payment Code 100-\$0.00 / 110-\$4.00 / 120-\$5.00 / 130-\$8.00

Medicare Part A Covers Hospital inpatient Mental Health. Covers your room, meals, and nursing care. Medicare limited 190 days lifetime limit in psychiatric hospital. Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

INPATIENT SUBSTANCE USE DISORDER

Co-Payment Code 100-\$0.00 / 110-\$4.00 / 120- \$5.00 / 130- \$8.00

Medicare Part A. <u>Covers Inpatient Substances Abuse.</u>
Covers medically necessary inpatient substance abuse treatment services can be covered in Medicare certified

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-







hospital. Services provided in facilities that are not Medicare certified are not covered by Medicare.

private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

ÇO<u>VERAÇE ORIGI</u>NAL

TPTE ASTITONKÖD (BYÖR AST. SÖT ASTITET TPILATIN

OUTPATIENT SUBSTANCE USE DISORDER

Co-Payment Code 100-\$0.00 / 110-\$1.00 /120- \$1.50 /130- \$2.00

Medicare Part B Covers Partial Hospitalization.

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act).

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization.

According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

<u>OUTPATIENT MENTAL HEALTHCARE</u> <u>& PROFESSIONAL SERVICES</u>

Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00

Medicare Part B <u>Cover Mental Health Services and Visits</u>. Covers with these types of health professionals (deductibles and coinsurance may apply): Psychiatrist or other doctor, Clinical psychologist, Clinical social worker, Clinical nurse specialist, Nurse practitioner and Physician assistant, One <u>depression screening</u> per year. The

All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.



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screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use.

- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services.
- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "selfadministered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.
- Partial hospitalization.
- A one-time <u>"Welcome to Medicare"</u> preventive <u>visit</u>. This visit includes a review of your potential risk factors for depression.
- A <u>yearly "Wellness" visit</u>. This is a good time to talk to your doctor or other health care provider about changes in your mental health so they can evaluate your changes year to year.

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LABORATORY AND HIGH TECH LABORATORIES Co-Payment Code 100-\$0.00 / 110-50¢ /120-\$1.00 /130-\$1.50

Medicare Part B <u>Covers Clinical Diagnostic Laboratory</u> <u>Services.</u> Covers that are ordered by your doctor or practitioner. Laboratory tests include certain blood tests,

Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare





urinalysis, tests on tissue specimens, and some screening tests. They must be provided by a laboratory that meets Medicare requirements.

or the MAO supplementary benefits but included in the State Plan.

Medicare doesn't cover most Health Certificates

Medicare doesn't cover most EPSDT

EPSDT requirements non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

EPSDT Checkups must include all of the following:

A comprehensive health and developmental history; Developmental assessment, including mental, emotional, and Behavioral Health development; Measurements (including head circumference for infants); An assessment of nutritional status; A comprehensive unclothed physical exam; Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices (ACIP) (the vaccines themselves are provided and paid for by the Health Department for the Medicaid and CHIP Eligible. Certain laboratory tests; Anticipatory guidance and health education; Vision screening; Tuberculosis; Hearing screening; and Dental and oral health assessment. (Reference must be made to the corresponding CMS EPSDT guidelines and ASES policy).

COVERAGE ORIGINAL MEDICARE

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FAMILY PLANNING

Co-Payment Code

100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Medicare doesn't cover Family Planning

Family Planning services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be

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provide confidentially, voluntarily and including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations:

- Contra-indication with drugs that the Enrollee is already taking, and no other methods covered/available that can be used by the Enrollee.
- History of adverse reaction by the Enrollee to the contraceptive methods covered.
- History of adverse reaction by the Enrollee to the contraceptive medications that are covered.

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TOBACCO CESSATION Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120-\$0.00 / 130-\$0.00

Medicare Part B (Medical Insurance) covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.

Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.



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MATERNITY SERVICES Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Maternity Services

Medicare Part A and B Covers Prenatal and Maternity Care. Covers medically necessary services and Inpatient services

Abortions are only covered when the life of the mother would be in danger if the fetus is carried to term.

Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Abortions when the pregnancy is a result of rape or incest as certified by a physician.

COVERAGE ORIGINAL MEDICARE

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MEDICAL AND SURGICAL Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120-\$1.50 / 130-\$2.00

Medicare Part B <u>Covers Ambulatory Surgery</u>. Covers the facility and professional service fees related to approve surgical procedures provided in an ambulatory surgical center.

Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form included as Appendix (O) (20) of the Contract.

VISION SERVICES Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120-\$1.50 / 130-\$2.00

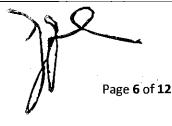
Medicare Part B - Medicare does not normally cover routine vision services, such as eyeglasses and eye exams. Covers Glaucoma Tests every 12 months under certain circumstances. For people with diabetes: It covers eye exam to check for diabetes retinopathy.

Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be pre authorized except intraocular lenses. Repair or replacement of eyeglasses









within 24 months when this is medically necessary and approved by the pre-authorization will be covered.

DENTAL SERVICES PREVENTIVE & RESTORATIVE

Co-Payment Code

Preventive (Child)100-\$0.00 / 110-\$0.00 / 120-\$0.00 / 130-\$0.00

Preventive (Adult)100-\$0.00 / 110-\$1.00 / 120-\$1.50 / 130-\$2.00

Restorative 100-\$0.00 / 110-\$1.00 / 120-\$1.50 / 130-\$2.00

Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

The following are the benefits included in the GHP;

- All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement
- Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21);
- Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy;
- Preventive dental services for Adults;
- Restorative dental services for Adults;
- One (1) comprehensive oral exam per year;
- One (1) periodical exam every six months;
- One (1) defined problem-limited oral exam;
- One (1) full series of intra oral radiographies, including bite, every three (3) years.
- One (1) initial periapical intra-oral radiography;
- Up to five (5) additional periapical/intra-oral radiographies per year;
- One (1) single film-bite radiography per year;
- One (1) two-film bite radiography per year;
- One (1) panoramic radiography every three (3) years;
- One (1) adult cleanse every six (6) months;
- One (1) child cleanse every six (6) months;

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Medicare doesn't cover most dental care, Part A can pay for inpatient hospital care to have emergency or

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complicated dental procedures, even though the dental care isn't covered

- One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old;
- Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies;
- Amalgam restoration;
- Resin restorations;
- Root Canal;
- Palliative treatment; and
- Oral Surgery

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HEARING EXAMS Co-Payment Code 100-\$0.00 / 110-\$1.00 /120-\$1.50 /130-\$2.00

Medicare Part B Covers Diagnostic Hearing and balance exams if the physician or other health care provider orders these tests to see if you need medical treatment. Medicare covers audio logic diagnostic testing provided by an Hearing related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

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audiologist when a physician or non-physician practitioner (nurse practitioner, clinical nurse specialist, or physician's assistant) orders the evaluation for the purpose of informing the physician's diagnostic medical evaluation or determining appropriate medical or surgical treatment of a hearing deficit or related medical problem

Medicare doesn't cover, hearing aids, or exams for fitting hearing aids.

Hearing aids for beneficiaries over 20 years old are excluded from coverage. Refer to ESPDT for hearing cover services.

COVERAGE ORIGINAL MEDICARE

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PREVENTIVE SERVICES Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120-\$0.00 / 130-\$0.00

Immunizations

Medicare Part B <u>Covers Normally covers one</u> <u>Immunizations</u> shot per: Influenza (Flu); Hepatitis B; and Pneumococcal shots. Also cover tetanus and rabies shots when expose or at risk episode.

Vaccines coverage according to the Medicare Benefit Package.

Immunization services non-covered by;

- 1- Medicare Part B.
- 2- MAO Part D drug formulary.
- 3- MAO supplementary plan benefits.
- 4- Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.

PHYSICAL, OCCUPATIONAL, SPEECH THERAPY Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00

Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services.

Medicare law no longer limits how much Medicare pays for your medically necessary outpatient therapy services in one calendar year. However, your therapist will need to add information to your therapy claims and your medical Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.



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record if your therapy services reach these amounts in 2018:

\$2,010 for physical therapy (PT) and speech-language pathology (SLP) services combined

\$2,010 for occupational therapy (OT) services
Once your therapy services reach these amounts, your
therapist will need to add a special code to your therapy
claim. By adding this code, your therapist confirms that:

Your therapy services are reasonable and necessary
Your medical record includes information to explain
why the services are medically necessary
A Medicare contractor may also review your medical
records to be sure your therapy services were medically
necessary. This review may happen if your therapy
services reach these amounts in 2018:

\$3,000 for PT and SLP services combined
\$3,000 for OT services
Your therapist or therapy provider must give you a
written notice before providing services that aren't
medically necessary. This includes therapy services that
are generally covered but aren't medically reasonable and
necessary for you at the time. This notice is called an
"Advance Beneficiary Notice of Non coverage"
(ABN). The ABN lets you choose whether or not you
want the therapy services. If you choose to get the
medically unnecessary services, you agree to pay for
them.







COVERAGE ORIGINAL MEDICARE

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PRESCRIPTION DRUGS

Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120-\$0.00 / 130-\$0.00 | Preferred (Children 0-21)
Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120-\$2.00 / 130-\$3.00 | Preferred (Adult) ****

Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00 Non-Preferred (Children 0-21)

Co-Payment Code 100-\$0.00 / 110-\$3.00 / 120- \$4.00 / 130- \$6.00 Non-Preferred (Adult) ****

Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120-\$0.00 / 130-\$0.00 Outpatient Substance Abuse

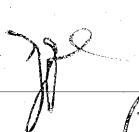
Drugs and biologicals are covered only if all of the following are met: they meet the definition of drugs or biologicals; they are not the type that are usually self-administered; they meet all of the general requirements for coverage of items as incident to a physician's services; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; they are not excluded as immunizations; and they have not been determined by the FDA to be less than effective.

Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan

The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings:

- All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution.
- Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap-Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category.
- Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs



Formularies should have the same therapeutic classes as GHP Formulary.

¹Medicare Platino cannot establish copayments higher than the ones specified in the Wrap Around table.

Platino wrap services are subject to the maximum co-payments in the table with exemptions and zero co-payments for Medicaid/CHIP beneficiaries and certain services as follows:

Medicaid/CHIP Beneficiaries

- Children from 0 to less than 21 years of age;
- Pregnant woman (during pregnancy and the 60-day post-partum period);
- American Indians and Alaskan Natives (AI/AN)
- Institutionalized Individuals; and
- Individuals receiving hospice care.

Services

- Emergency services, including ambulatory, hospital and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a);
- Family planning services and supplies;
- Preventative services provided to children less than 18 years of age
- Pregnancy related services and counseling and drugs for cessation of tobacco use;
- Provider-preventable services as defined in 42 CFR 447.26(b); and
- Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.

Notes: 1. Wrap around table is subject to change in 01/01/2020.

2. N/A= Medicare fulfill or exceeds PSG benefit

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