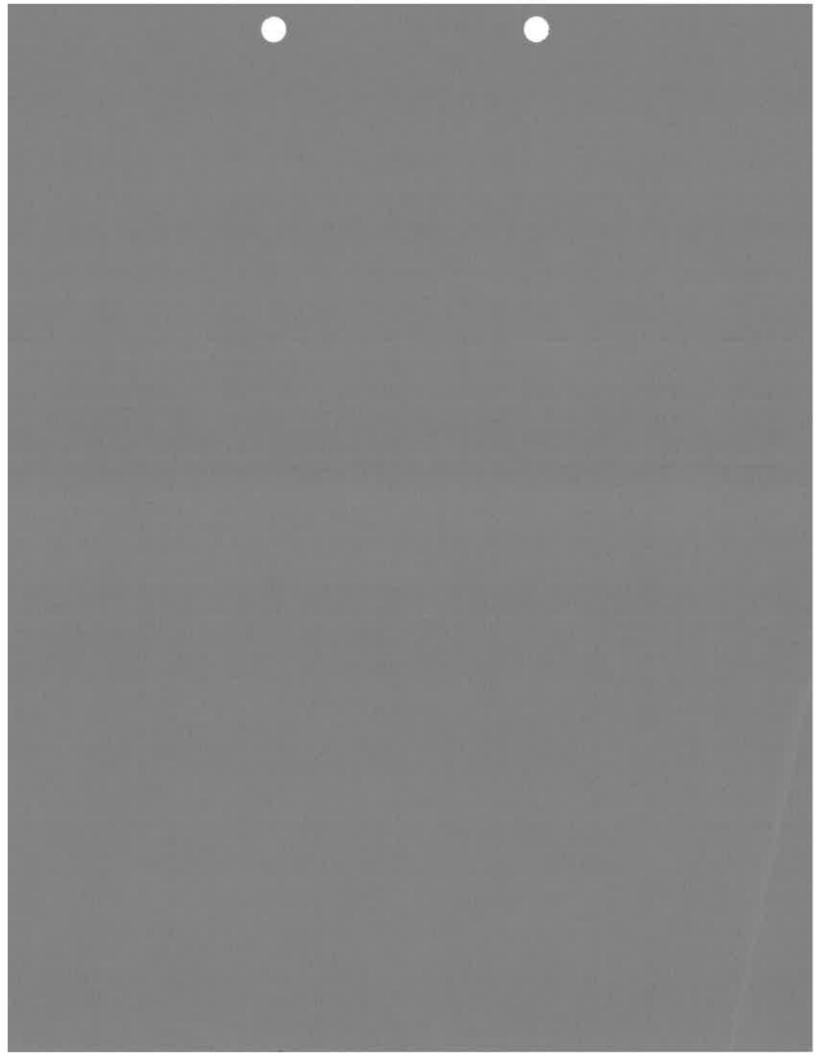
MEDICARE PLATINO 2021

APPENDIX C (1) (21)
MEDICARE ADVANTAGE
PRODUCT PLAN BENEFIT



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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: 05/31/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/31/2020 08:26:24 PM SA Western Standard

Time

MA BPT Timestamp: 05/29/2020 01:39:54 PM SA Western Standard

Time

PD BPT Timestamp: 05/29/2020 10:52:32 AM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/29/2020 08:19:47 PM SA Western Standard

Time

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
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: MMM HEALTHCARE, LLC

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

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 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR

40320 - Hatillo, PR

40330 - Hormigueros, PR

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Service Area(s):

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40340 - Humacao, PR

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

Service Area(s):

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



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40740 - Vieques, PR

40750 - Villalba, PR

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	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	017
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No.
SECTION A: SECTION A-2	110
Indicate CY2021 total projected member months for this plan:	801365
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)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
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)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396



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4-	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
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:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
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	No



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

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)

Section D of the PBP?

No

No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee Νo 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? No

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

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

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

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

period?



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Do you charge cost sharing on the day of No discharge? Is authorization required? Yes Is a referral required for Inpatient Hospital-No

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

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Is there an enrollee Coinsurance?

No

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 authorization required? Is a referral required for Inpatient Psychiatric No

SECTION B: #2 SNF - BASE 1

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

C?

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?

Hospital Services?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost No 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



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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?

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/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - 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?

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:

Mandatory

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Yes

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

No







Coverage?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

No

No

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 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?

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 Yes

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 Every year

Select Routine Care periodicity:

No

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

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? 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 Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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Is there an enrollee Copayment?

No

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

Is authorization required?

No Yes

Is a referral required for Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee

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

Benefit Coverage amount?

No

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?

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

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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 PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes No

Is a referral required for Outpatient Diagnostic

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Qutpatient 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? Yes 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?

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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 Yes

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

Plan Approved Health-related Location?

One-way

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

Select Mode of Transportation for Plan : Taxi

: Rideshare Services Approved Health-related Location:

: Bus/Subway

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Yes

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SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? 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? 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)?

No

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No Is there an enrollee Copayment? 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 those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1



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	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 - BASE 2		
í	s authorization required?	Yes
1	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	
	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?	Yes
	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 amount:	100.00

Select Maximum Plan Benefit Coverage



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Every three months

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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:

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) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 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 MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

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6) IN HOME TESTING AND MONITORING

7) FIBER SUPPLEMENTS

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- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
- 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional): Select type of benefit for Other 3:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13F OTHER 3 - BASE 2

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

Is a referral required for Other Services?

SECTION B: #13F OTHER 3 - BASE 3

Notes:

No

COVID-19 PUBLIC HEALTH EMERGENCY

Mandatory

No

No

No

No No

Yes

No



SHOULD THE PUBLIC HEALTH
EMERGENCY EXTEND IN TO 2021, MMM
INTENDS ON OFFERING BENEFITS THAT
WILL ADDRESS THE HEALTH NEEDS OF
OUR MEMBERSHIP UNDER THE
PREVAILING CIRCUMSTANCES. THOSE
BENEFITS MAY INCLUDE COST-SHARING
REDUCTIONS, ADDITIONAL
SUPPLEMENTAL BENEFITS, OR
CHANGES IN MEDICAL MANAGEMENT
DESIGNED TO IMPROVE THE QUALITY
AND OUTCOME OF MMMs HEALTHCARE
DELIVERY.

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

Medicare-covered Zero Dollar Preventive : I attest that there is no coinsurance,

Services Attestation 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 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): : 14c1: Health Education

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

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Hotline)*

9

Select type of benefit for Health Education: Mandatory

Select type of benefit for Additional Sessions of Mandatory 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

Mandatory

technologies and Nursing Hotline):

Select the type of Remote Access Technologies : Nursing Hotline

offered (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?

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?

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Is a referral required for Other Defined Supplemental Benefits?
Health Education Notes:



Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

No

THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. 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 MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

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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:

Arc



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

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> TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC

HELP AND OTHERS CLINICAL AREAS.

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

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

No Is there an enrollee Copayment? 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?

Is authorization required for Medicare-covered Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is authorization required for Other Medicare-

Is there a Maximum Enrollee Out-of-Pocket

covered Preventive Services?

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

Yes

Yes

No

Is a referral required for any Services? No

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

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

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No

No

Yes

Mandatory

1

Yes

5000.00

No

Plan-specified amount per period

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 mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

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: Mandatory

Is this benefit unlimited for Restorative No, indicate number

Services?

Indicate number of visits for Restorative 1

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Every year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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No

AUTHORIZATION.

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





RESTORATIVE SERVICES:
CORE BUILDUP AND PIN RETENTION PER
TOOTH, PER SURFACE, ONCE EVERY 24
MONTHS. POST AND CORE AND SINGLE
CROWNS COVERED. REPLACEMENT
CROWNS COVERED EVERY 5 YEARS PER
TOOTH. SINGLE CROWNS REQUIRE PRE

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 (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES. **FIXED DENTURES:**

RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS:

SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT

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SUPPORTED PORCELAIN CROWN
(CERAMIC) COVERED.
CROWNS ON IMPLANTS ARE COVERED 1
PER TOOTH EVERY 5 YEARS WITH
APPROPRIATE JUSTIFICATION.
IMPLANT SERVICES WILL ONLY BE
COVERED WHEN PERFOMED BY A
CERTIFIED PROVIDER.
ALL OTHER PROSTHODONTIC SERVICES
ARE NOT COVERED.
REMOVABLE PROSTHODONTICS, FIXED
DENTURES, IMPLANTS AND RETAINER
CROWNS REQUIRE PRE
AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a No supplemental benefit under Part C?

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

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?

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

Select type of benefit for Contact lenses:

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)?

SECTION B: #17B EYEWEAR - BASE 3

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

Select the Maximum Plan Benefit Coverage type:

Yes

Yes

Yes

Plan-specified amount per period



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	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 Out-of-Pocket Cost?	No
1	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
-	SECTION B: #18A HEARING EXAMS - BASE	1
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 Benefit Coverage amount?	No
	Is there an enrollee Deductible?	No No
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No No Contrato Múrmero
	Is there an enrollee Coinsurance?	No 21 - 0 0 2
	SECTION B: #18A HEARING EXAMS - BASE	3
	Is there an enrollee Copayment?	No 3
	Is authorization required?	Yes POSDE 9
	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	Mandatory

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types):

Is this benefit unlimited for Hearing Aids (all

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

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

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Yes

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

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:

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

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

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic In-Person





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No

No

: Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

593

: Provider/Patient portals

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

mity No

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

PACKAGE #1

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

2

Which disease states does this benefit apply?

(Select all that apply):

: Diabetes

: 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

for this package?

Which prerequisites are required for this

Yes

: Participation in a Care Management Program



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package?

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 IN ALL

> PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN THE INTERDISCIPLINARY 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

Select enhanced benefit (Select all that apply): : 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

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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

Supplemental Benefits?

No Benefit Coverage amount for Other Defined

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, AMONG OTHERS.

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

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

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

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?

Yes

Specify the maximum benefit amount:

65.00

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

Notes:

\$65 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY

19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)



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- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B.

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

Does the plan provide Over-The-Counter (OTC) Yes

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:

periodicity:

Select Maximum Plan Benefit Coverage

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:

No

No

Mandatory

Every month

Yes

65.00

Yes

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

Contrato Número

OTC or formulary drugs.

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

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may No

be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

Notes: \$65 MONTHLY ALLOWANCE IN THE

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY



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19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

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) INCONTINENCE SUPPLIES (ADULT **DIAPERS & UNDER PADS)**
- 6) 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 MAY REQUIRE MEDICAL **EVALUATION AND/OR** PREAUTHORIZATION.

- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED
- ANTIBACTERIAL/ANTIMICROBIAL SOAP) ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY





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

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

: Food and Produce

: Meals (beyond limited basis)

Pest Control

: Social Needs Benefit

: General Supports for Living

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?

Yes

Select type of benefit for Food and Produce:

Mandatory

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Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

amount:

65.00

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? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

\$65 MONTHLY ALLOWANCE IN THE Notes:

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGE IN CATEGORY

19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

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? Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

How many days do your Meals (beyond limited

basis) last?

365

What is the maximum number of meals the

999

benefit provides?

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for the Meals (beyond No limited basis)?

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

Notes:

\$65 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

MEALS (BEYOND LIMITED BASIS) ARE UNLIMITED.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes:

\$65 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED



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WITHIN SSBCI PACKAGE IN CATEGORY 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

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 SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Social Needs Benefit?

Contrato Número

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes:

\$65 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY

19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS/THEATER/MOVIES, ETC)

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for

Yes



Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Living:

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

amount:

65.00

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 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for General Supports for No Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:

\$65 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES & HOUSING.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? Yes Indicate the Minimum Coinsurance percentage 5% for Medicare covered Benefits for prescription drugs and biologics: Indicate the Maximum Coinsurance percentage 5% for Medicare covered Benefits for prescription drugs and biologics: Indicate the maximum per drug amount 5



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	Is there an enrollee Copayment?	No
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care	
	day:	
	Indicate the Maximum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care	
	day:	_
1	Indicate the maximum per day amount	5
	Is there an enrollee Copayment?	No
	SECTION B: #19C VBID HOSPICE- BASE 2	
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	5%
	for Medicare covered Benefits for prescription	
	drugs and biologics:	5%
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription	370
	drugs and biologics:	
	Indicate the maximum per drug amount	5
	Is there an enrollee Copayment?	No
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care	
	day:	
	Indicate the Maximum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care	
	day:	_
	Indicate the maximum per day amount	5
	Is there an enrollee Copayment?	No
	SECTION B: #19C VBID HOSPICE- BASE 3	
	Mandatory supplemental benefits for enrollees	No
	that elect hospice?	0.00
	Enter the Maximum plan benefit amount:	0.00
	Are hospice supplemental benefits contingent	No
	upon receiving services from an in-network provider?	
	SECTION C: V/T - GENERAL - US	
	Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWO)		
	Is there an In-Network Plan Deductible?	No.
	SECTION D: MAX ENROLLEE COST LIMIT	
	Is there an In-Network Maximum Enrollee Out-	Yes
	of-Pocket Cost?	1 03
	Is your In-Network Maximum Enrollee Out-of-	Voluntary
	Pocket (MOOP) Cost at the Voluntary or	
	•	



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

Medicare-covered plan services?

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

Medicare-covered plan services?

Yes

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

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 pharmacy

network (select all that apply):

Defined Standard

: Standard Retail

: Out-of-Network : Standard Mail-Order

: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42

CFR 423,154.

SECTION RX: MEDICARE RX GENERAL 2

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?

No

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

design)?

Yes

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

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SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

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

30

90

30

90

31

No

No

: Standard Mail-Order - 3-month supply

: Long-Term Care Pharmacy - 1-month supply

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

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

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

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

first fill?

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

programs through the model?

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: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/31/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/31/2020 08:25:35 PM SA Western Standard

Time

MA BPT Timestamp: 05/29/2020 02:56:56 PM SA Western Standard

Time

PD BPT Timestamp: 05/29/2020 02:05:42 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/29/2020 08:19:47 PM SA Western Standard

Time

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Completed
Completed
Section B7 Status

Completed

Section B8 StatusCompletedSection B9 StatusCompletedSection B10 StatusCompleted

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 B19 Status Completed
Section C Status Completed
Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1

Organization Legal Name: MMM HEALTHCARE, LLC

M



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Organization Marketing Name: Organization Web Site: Plan Name: Organization Type: Plan Type: Eprollee Type: Service Area(s): Service Area(s):

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

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 - 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



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40300 - Guaynabo, PR

40330 - Hormigueros, PR

40310 - Gurabo, PR 40320 - Hatillo, PR

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

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 40750 - Villalba, PR



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		40760 - Yabucoa, PR	
	Service Area(s):	40770 - Yauco, PR	
	Contract Number:	H4003	
	Plan ID:	047	
	Segment ID:	0	
1	Contract Period:	2021	
/	Plan Geographic Name:	Puerto Rico	
	Is this an Employer-Only plan?	No	
	SECTION A: SECTION A-2		
	Indicate CY2021 total projected member months for this plan:	214861	
	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)333-5471	
	Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396	
	Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471	
	Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	NISTRACIO
	Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	Contrato Número
	Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	21-002
	Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471	OF DE SAL
	SECTION A: SECTION A-4		O Dist

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(787)620-2396

Customer Service Contact Local Phone Number

for Prospective Part D Medicare Beneficiaries:

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Section D of the PBP?

	Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
	Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
	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:	(877)522-0655
	Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
	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	
1	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	No

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

No

Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part C?

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)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

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?

Contrato Número
21 - 0 0 2

OR OS DE SA

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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?

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 No Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital Yes

Zero

Does this plan's Medicare-covered benefit cost No sharing vary by the Skilled Nursing Facility in

SECTION B: #2 SNF - BASE 10



stay prior to SNF admission? 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** 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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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

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?

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 a referral required for Cardiac and Pulmonary Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - 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?

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

Is there an enrollee Copayment?

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 M

Coverage:

Mandatory

Yes

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Coverage.

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

No

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No

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
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?

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?

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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

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?

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?

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



M

Is there an enrollee Copayment?

No

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

Is authorization required?

No Yes

Is a referral required for Physician Specialist

Services?

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

h there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? Nο 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

Is there a service-specific Maximum Plan

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

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 Nο

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?

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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? Is there an enrollee Copayment? No Nο

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes Yes

Is a referral required for Psychiatric Services?

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

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 PROGRAM SERVICES - BASE 2

Is authorization required?

Yes

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

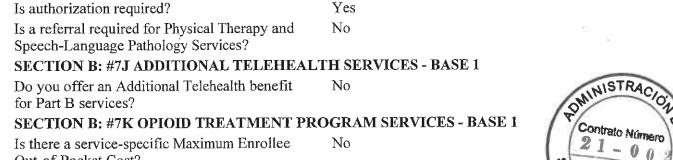
SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No





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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?

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?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

No Does the plan provide Outpatient Blood

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

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

Select enhanced benefit: Plan Approved Health-related Location

Yes

Yes

One-way

Mandatory Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

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

Select Mode of Transportation for Plan : Taxi

: Rideshare Services Approved Health-related Location:

: Bus/Subway



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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

As 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
Indicate Minimum Coinsurance percentage for 20%

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 No

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

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

20%

20%

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Thereare within an Consulation percentage for

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? 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

you limit Diabetic Supplies and Services to No

Mose from specified manufacturers?

Is authorization required? Yes

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

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 Yes

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?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?



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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Acupuncture?	Yes
SECTION R. #13R 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: 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? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may No be found in Chapter 4 of the Medicare Managed

Care Manual? SECTION B: #13B OTC ITEMS - BASE 3

Notes:



Yes

Mandatory

Yes

100.00

Every three months

No

No

Yes

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

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) INCONTINENCE SUPPLIES (ADULT

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DIAPERS & UNDER PADS)

6) 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 MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
- 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):
Select type of benefit for Other 3:
Is there a service-specific Maximum Plan
Benefit Coverage amount?
Is there a service-specific Maximum Enrollee

COVID-19 PUBLIC HEALTH EMERGENCY

Mandatory

No

No

SECTION B: #13F OTHER 3 - BASE 2

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Is a referral required for Other Services?

No



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SECTION B: #13F OTHER 3 - BASE 3

Notes: SHOULD THE PUBLIC HEALTH

> EMERGENCY EXTEND IN TO 2021, MMM INTENDS ON OFFERING BENEFITS THAT WILL ADDRESS THE HEALTH NEEDS OF

OUR MEMBERSHIP UNDER THE

PREVAILING CIRCUMSTANCES. THOSE BENEFITS MAY INCLUDE COST-SHARING

REDUCTIONS, ADDITIONAL SUPPLEMENTAL BENEFITS, OR

CHANGES IN MEDICAL MANAGEMENT DESIGNED TO IMPROVE THE QUALITY AND OUTCOME OF MMMs HEALTHCARE

DELIVERY.

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.

No

Yes

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?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)* Mandatory

Mandatory

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:

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

Select the type of Remote Access Technologies

offered (Select all that apply):

Mandatory

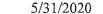
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

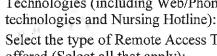
Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

No

9





: Nursing Hotline



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:

J.



THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH, 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 MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE **EDUCATORS PROVIDE INFORMATION TO** IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL **ACTIVITY AWARENESS AND ONLINE** ACCESS TO EDUCATIONAL LITERATURE

AS PART OF THE EDUCATIONAL

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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

J. A.

INTERVENTIONS.

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 OUIT 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

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> 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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

No Is there an enrollee Copayment? Is authorization required for Medicare-covered Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

Is authorization required for Medicare-covered

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

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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

K 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 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

Yes

1

1

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:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

No, indicate number

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Other, Describe

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

about:blank 5/31/2020



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SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

amount:

1500.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

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:

> CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

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 (SUCH AS: VALPLAST)

COVERED EVERY 5 YEARS. RELINE OR

REBASE ARE NOT COVERED IN

FLEXIBLE BASE DENTURES AND/OR

FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES:

RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER



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CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE. IMPLANTS: SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

Contrato Número

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? 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

Yes

No

AUTHORIZATION.

Yes

: Contact lenses

Eyeglasses (lenses and frames) Mandatory Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes 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 450.00 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 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?

1

No

Every year

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

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

Is there an enrollee Deductible? No





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Is there a service-specific Maximum Enrollee
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

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:

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Indicate Maximum Plan Benefit Coverage Every two 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?

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?

Are you offering a VBID Hospice Benefit? Yes

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

No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

Annual Wellness Visit

: Medicare Health Risk Assessment

: Care Management Program

In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

. Web-Based

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

No

WHP Services?

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

No

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

Expected Number of Beneficiaries to be

Engaged Annually:

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

No

91

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?

: Diabetes

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

Other 1 Description:

Cardiovascular Disorders



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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 Yes

for this package?

Which prerequisites are required for this

package?

: Participation in a Care Management Program

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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 IN ALL

> PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN

THE INTERDISCIPLINARY 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): : 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

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

No

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 -

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No

BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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, AMONG OTHERS.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? Yes
Indicate the Minimum Coinsurance percentage
for Medicare covered Benefits for prescription

drugs and biologics:

Indicate the Maximum Coinsurance percentage 5% for Medicare covered Benefits for prescription

drugs and biologics:

Indicate the maximum per drug amount 5

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

Indicate the Minimum Coinsurance percentage 5%

for Medicare covered Benefits for a respite care day:

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:

Indicate the maximum per day amount 5
Is there an enrollee Copayment? No

SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance? Yes



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5%

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	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%	
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%	
	Indicate the maximum per drug amount	5	
	Is there an enrollee Copayment?	No	
,	Is there an enrollee Coinsurance?	Yes	
/	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%	
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%	
	Indicate the maximum per day amount	5	
_	Is there an enrollee Copayment?	No	
	SECTION B: #19C VBID HOSPICE- BASE 3		
	Mandatory supplemental benefits for enrollees that elect hospice?	No	
	Enter the Maximum plan benefit amount:	0.00	
	Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	No	
	SECTION C: V/T - GENERAL - US		
	Do you offer a US Visitor/Travel Program?	No	NISTRAC
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)	MINISTRACION
	Is there an In-Network Plan Deductible?	No	Contrato Número
	SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)	21 - 002
	Is there an In-Network Maximum Enrollee Out- of-Pocket Cost?	Yes	0
	Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary	POS DE ST
	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 be : In-Network Non-Medicare-cover	
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes	
	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 COVERA	.GE	

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Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

Yes

drug (Part D) benefit?

Defined Standard

Describe the components of your pharmacy

: Standard Retail : Out-of-Network

: Long-Term Care

network (select all that apply):

Select the type of drug benefit:

: Standard Mail-Order

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42

CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

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?

No

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?

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

: Standard Retail Cost Sharing - 1 month Supply

: Out-of-Network Pharmacy - one month supply

Contrato Número

Location/supply amount(s) that apply:

: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

30

Enter number of days for Standard Retail Cost

90

Sharing 3-month supply:

Select all Out-of-Network Pharmacy

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

Pharmacy 1-month supply:

30

Select all Standard Mail-Order Cost Sharing

: Standard Mail-Order - 3-month supply





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Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

90

Select the Long-Term Care Pharmacy one

month Location/supply amount(s) that apply:

: Long-Term Care Pharmacy - 1-month supply

Enter number of days for Long-Term Care

Pharmacy I-month supply:

31

Are all of the drugs on your formulary available

with an extended day supply?

No

Are any of the drugs available at an extended day supply limited to a 1-month supply for the No

first fill?

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

No

programs through the model?







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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, SEGMENT 0

Module: PBP mint Requested By:

PLAN SYSTEM INFORMATION

Last entry Date: 05/31/2020 PDP Software Version: 2021.01

05/31/2020 08:27:32 PM SA Western Standard Plan Ready for Upload Timestamp:

Time

MA BPT Timestamp: 05/29/2020 03:22:18 PM SA Western Standard

Time

05/29/2020 02:15:14 PM SA Western Standard PD BPT Timestamp:

Time

05/29/2020 08:19:47 PM SA Western Standard Last Upload File Creation Timestamp:

Time

PLAN STATUS

Section A Status Plan Ready for Upload

Completed Section B1 Status Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Section B8 Status Completed Section B9 Status Completed Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status

Completed Completed Completed Completed

Completed Completed

SECTION A: SECTION A-1

Section B18 Status

Section B19 Status Section C Status

Section D Status

Section Mrx Status

Organization Legal Name: MMM HEALTHCARE, LLC



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Organization Marketing Name: Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

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

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

40330 - Hormigueros, PR

MINISTRACION Contrato Número - 0 CROSOE

	Service Area(s):
	Service Area(s):
	Service Area(s):
./	Service Area(s):
1//	Service Area(s):
///	Service Area(s):
//	Service Area(s):
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	Service Area(s):

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 40750 - Villalba, PR

		40760 - Yabucoa, PR
	Service Area(s):	40770 - Yauco, PR
	Contract Number:	H4004
	Plan ID:	048
	Segment ID:	0
	Contract Period:	2021
	Plan Geographic Name:	Puerto Rico
	Is this an Employer-Only plan?	No
	SECTION A: SECTION A-2	
	Indicate CY2021 total projected member months for this plan:	113575
	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.mmmpr.com
	Formulary Website Address:	www.mmmpr.com
	Physician Website Address:	www.mmmpr.com
	Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
•,	Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
	Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
	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)333-5471
	Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
	Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
	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:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
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:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
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-AC	CUTE - BASE 1

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 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

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee

obtains care?

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 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 Inpatient Psychiatric No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Is there an enrollee Coinsurance?

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

No

No

C?

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Yes

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Zero

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No

SECTION B: #2 SNF - BASE 10



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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

No

Yes

Is authorization required? Yes Is a referral required for Cardiac and Pulmonary Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Mandatory

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage No

amount for Worldwide Emergency/Urgent





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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?

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

Yes

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:

Every year

Select Routine Care periodicity: Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

No

6

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 R: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

No No

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

Yes Is authorization required? Is a referral required for Occupational Therapy Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No



Is there an enrollee Copayment?

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?

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? 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?

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

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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 PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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



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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?

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?

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?

Is there an enrollee Copayment?

Is authorization required? Yes

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?

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SECTION B: #90	COUTPATIENT	SUBSTANCE	ABUSE - BASE 2
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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
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?

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 Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

No

Select type of benefit for Plan Approved Health- Mandatory

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved 24

Health-related Location:

Select Plan Approved Health-related Location Every year

Trips periodicity:

Select Type of Transportation for Plan One-way



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Approved Health-related Location:

Select Mode of Transportation for Plan : Taxi

Approved Health-related Location: : Rideshare Services

: 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?

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?

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?

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

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

Is there an enrollee Copayment? No

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Do you limit Diabetic Supplies and Services to	No
those from specified manufacturers?	NO
Is authorization required?	Yes
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	
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?	Yes
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	Yes



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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:

150.00

Every month

No

No

Yes

No

No

No

No

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

OTC or formulary drugs.

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) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) 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 MAY REQUIRE MEDICAL



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EVALUATION AND/OR PREAUTHORIZATION.

7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT

10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)

11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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.

Select type of benefit for Meals: Mandatory

How many days does your Meal Benefit last? 10 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: #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 10 DAYS UP TO 1 TIME PER YEAR FOR 20 MEALS MAX PER

YEAR

Yes

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional): COVID-19 PUBLIC HEALTH EMERGENCY

Select type of benefit for Other 3: Mandatory

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Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13F OTHER 3 - 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 Other Services? **SECTION B: #13F OTHER 3 - BASE 3**

Notes:

EMERGENCY EXTEND IN TO 2021, MMM INTENDS ON OFFERING BENEFITS THAT WILL ADDRESS THE HEALTH NEEDS OF

OUR MEMBERSHIP UNDER THE

SHOULD THE PUBLIC HEALTH

PREVAILING CIRCUMSTANCES. THOSE BENEFITS MAY INCLUDE COST-SHARING

REDUCTIONS, ADDITIONAL SUPPLEMENTAL BENEFITS, OR

CHANGES IN MEDICAL MANAGEMENT DESIGNED TO IMPROVE THE QUALITY AND OUTCOME OF MMMs HEALTHCARE

DELIVERY.



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

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Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

No

Yes

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

: 14c21: In-Home Support Services*

Select type of benefit for Health Education: Mandatory







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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

Mandatory

9

: Nursing Hotline

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

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED

ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND

PROVIDES NUTRITIONAL EDUCATION

TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A

HEALTHIER LIFESTYLE AND DEVELOP

SELF CARE CAPABILITIES TO IMPROVE

THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH

EDUCATIONAL NEEDS, PLAN

EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL



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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:





STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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.

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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.



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In-Home Support Services Notes:*

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)

Y COPD (STAGE 3&4)

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

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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?

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 Yes

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

No

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment?

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



ARC

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Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

: Restorative Services Select enhanced benefits:

Surgery, Other Services

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative

Services:

Select the Restorative Services periodicity: Other, Describe SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics.

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

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 No

Services?

RESTORATIVE SERVICES: Notes:

CORE BUILDUP AND PIN RETENTION PER

Yes

: Prosthodontics, Other Oral/Maxillofacial

Mandatory

No, indicate number

1

Mandatory

No, indicate number

1

Other, Describe

Plan-specified amount per period

2500.00

Yes

Every year

No





about:blank

TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS, POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.

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 (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES. FIXED DENTURES: RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE. IMPLANTS:

SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER







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No

No

CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE 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? No Is there an enrollee Copayment? No Is there an enrollee Deductible? No

SECTION B: #17A EYE EXAMS - BASE 3

Yes Is authorization required? 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

Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes

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

Is this benefit unlimited for Eyeglasses (lenses 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

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?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Eyeglasses (lenses and frames)

Mandatory

Yes

Yes

Plan-specified amount per period

Yes

450.00

Every year

No

No



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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 **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 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage.amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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) Contrato Número 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?

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Both ears combined

Plan-specified amount per period

Does the Maximum Plan Benefit Coverage

Select the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

type:

Indicate Maximum Plan Benefit Coverage

amount:

2500.00

Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? 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 Flexibility with reductions in cost or additional

benefits?

Yes

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Yes

Select what type of benefit your SSBCI

includes:

: Additional Benefits

Are you offering a VBID Hospice Benefit?

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

Section Rx)

Yes No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

: Annual Wellness Visit

Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

Telephonic : In-Person

: Web-Based

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

WHP Services?

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

No

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

: Provider/Patient portals



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Expected Number of Beneficiaries to be

101

Engaged Annually:

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

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?

: 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

for this package?

Yes

Which prerequisites are required for this

: Participation in a Care Management Program

package?

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





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

SERVICE COVERED IN ALL Notes:

> PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN THE INTERDISCIPLINARY 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?

DAINISTRACIO Select enhanced benefit (Select all that apply): : 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

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Hotline)*

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

Mandatory

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 BENEFIT

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

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LICENSED PROVIDER SUCH AS:

ENDOCRINOLOGIST, PULMONOLOGIST,

CARDIOLOGIST, 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

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

: 13i: Non-Primarily Health Related Benefits for benefits offered in this package:

the Chronically Ill

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

Are any benefits exempt from the plan-level

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? Yes Specify the maximum benefit amount: 20.00



Notes:

\$20 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B, SUCH AS:

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B.



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Yes

Yes

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

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 20.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

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

Is there a service-specific Maximum Enrollee

unused?

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

No

Yes

No

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

OTC or formulary drugs.

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

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may No

be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

\$20 MONTHLY ALLOWANCE IN THE Notes:

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGE IN CATEGORY 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

THE FOLLOWING CATEGORIES ARE

COVERED:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS

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THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT

DIAPERS & UNDER PADS)

6) 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 MAY REQUIRE MEDICAL

EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT

10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)

11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY



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 III

includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

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?

Yes

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

20.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

perrouterty.

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

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Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:

\$20 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGE IN CATEGORY

19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

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?

Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

How many days do your Meals (beyond limited

365

basis) last?

What is the maximum number of meals the

999

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?

Is there an enrollee Copayment?

No
Is authorization required?

No
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

\$20 MONTHLY ALLOWANCE IN THE

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> FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR THE PURCHASE OF ADDITIONAL MEALS AND ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B. THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM

> > -0.0

BENEFIT AMOUNT.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

20.00

Indicate Maximum Plan Benefit Coverage

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? Νo Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes:

\$20 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGE IN CATEGORY

19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a

Yes

supplemental benefit under Part C?

Select type of benefit for Social Needs Benefit:

Mandatory

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Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

20,00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Social Needs Benefit?

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes: \$20 MONTHLY ALLOWANCE IN THE

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY

19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE

COVERING ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Yes

Living as a supplemental benefit under Part C?

Mandatory

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

20.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2:





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PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for	No
Living?	

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:

\$20 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGE IN CATEGORY 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES & HOUSING.

SECTION B: #19C VBID HOSPICE- BASE 1

5201101127127	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

SECTION B: #19C VBID HOSPICE- BASE 2



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No

Yes

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	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologies:	5%
	Indicate the maximum per drug amount	5
	Is there an enrollee Copayment?	No
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
	Indicate the maximum per day amount	5
	Is there an enrollee Copayment?	No
	SECTION B: #19C VBID HOSPICE- BASE 3	
	Mandatory supplemental benefits for enrollees that elect hospice?	No
3	Enter the Maximum plan benefit amount:	0.00
7	Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	No
	SECTION C: V/T - GENERAL - US	
	Do you offer a US Visitor/Travel Program?	No
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	VORK)
	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:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes Yes Yes Contrate Neighbor
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Non- Medicare-covered plan services?	Yes Contrato Afrimero 2 1 - 0 0 2
	SECTION D: MAX PLAN BENEFIT COVERA	

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

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

Yes

Select the type of drug benefit:

Defined Standard

Describe the components of your pharmacy

: Standard Retail : Out-of-Network

network (select all that apply):

: Standard Mail-Order

: Sponsor attests that it will comply with 42

: Long-Term Care

Sponsor attests that it will comply with 42 CFR

CFR 423.154.

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 Yes

prescription drugs?

Will your plan be limiting on-formulary No

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?

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

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

90

Sharing 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

: Standard Mail-Order - 3-month supply

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Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

Select the Long-Term Care Pharmacy one : Long-Term Care Pharmacy - 1-month supply month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

Are all of the drugs on your formulary available No 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

90

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

No

programs through the model?





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 049, SEGMENT 0

Module: PBP Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/31/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/31/2020 08:25:24 PM SA Western Standard

Time

MA BPT Timestamp: 05/29/2020 06:08:52 PM SA Western Standard

Time

PD BPT Timestamp: 05/29/2020 05:49:24 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/29/2020 08:19:47 PM SA Western Standard

Time

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

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

Completed
Section B7 Status

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 A: SECTION A-1

Section Mrx Status

Organization Legal Name: MMM HEALTHCARE, LLC





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Completed

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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):

Medicare y Mucho Más www.mmmpr.com MMM Grande 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

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40300 - Guaynabo, PR

40330 - Hormigueros, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

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

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

40750 - Villalba, PR

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	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	049
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2021 total projected member months for this plan:	28766
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)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
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)333-5471
Customer Service Contact Local Phone Number	(787)620-2396

for Current Part D Medicare Beneficiaries:

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Phone Number for

Customer Service Contact Local Phone Number

for Prospective Part D Medicare Beneficiaries:

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(866)333-5471

(787)620-2396

Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
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:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
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	No

[]

SECTION A: SECTION A-6

Section C of the PBP?

Is your organization filing a standard bid for No Section D of the PBP?

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)

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

Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part C?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

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

Does this plan's Medicare-covered benefit cost
sharing vary by hospital(s) in which an enrollee
obtains care?

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?



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No

Do you charge cost sharing on the day of 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

No

No

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? 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?

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
C?

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

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

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

SECTION B: #2 SNF - BASE 2

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

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10





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Zero

No

No

No

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?

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

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

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? N٥ 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/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

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

No 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 Mandatory

Coverage:

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

No

No

Yes



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No

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 Is there an enrollee Copayment? Yes

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

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 Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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



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No

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

Yes

No

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

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

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes

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 Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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



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Is there an enrollee Copayment?

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?

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? 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?

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

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Is a referral required for Other Health Care

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Yes

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?

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 PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Opioid Treatment No

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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



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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?

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

Is there an enrollee Deductible?

No

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

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is a referral required for Medicare-covered

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?

Contrato Número

SECTION B:	#9C OU	TPATIENT	SUBSTANCE	ABUSE -	BASE 2
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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 Yes
Abuse?

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

Does the plan provide Outpatient Blood No Services as a supplemental benefit under Part

U!

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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 Yes

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

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Benefits:

Is there an enrollee Deductible?







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No

10%

10%

10%

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required? Yes

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

is there an enronce Comsurance?

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 10%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Medicare-covered Prostnetic Devices:

Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

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 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

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

Contrato Número

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OR POS DE SP



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?	No
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	No
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: #13F OTHER 3 - BASE 1	
Enter name of Service (Optional):	COVID-19 PUBLIC HEALTH EMERGENCY
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

Notes:

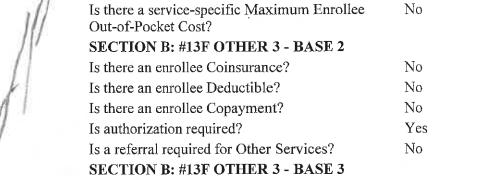
SHOULD THE PUBLIC HEALTH EMERGENCY EXTEND IN TO 2021, MMM INTENDS ON OFFERING BENEFITS THAT WILL ADDRESS THE HEALTH NEEDS OF OUR MEMBERSHIP UNDER THE PREVAILING CIRCUMSTANCES. THOSE BENEFITS MAY INCLUDE COST-SHARING REDUCTIONS, ADDITIONAL SUPPLEMENTAL BENEFITS, OR CHANGES IN MEDICAL MANAGEMENT DESIGNED TO IMPROVE THE QUALITY AND OUTCOME OF MMMs HEALTHCARE DELIVERY.

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.







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Yes

No

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): : 14c1: Health Education

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: 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

Mandatory

Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

9

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

: 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?

No

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?

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

Is there an enrollee Deductible?

No

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 HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED



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man a bazz,

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. 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 MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION. AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

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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 Technology (Web/Phone-based technologies) Notes:*

MEMBER WILL RECEIVE ONE SMARTPHONE WITH VOICE AND DATA PLAN FOR HEALTH-RELATED PURPOSES SUCH AS: TO FACILITATE ENGAGEMENT WITH HEALTHCARE PROVIDERS, USE THE PLAN'S MOBILE APP TO ACCESS ONLINE SERVICES LIKE OTC ORDERS, FACILITATE ACCESS TO THE PLAN'S NURSING HOTLINE, FACILITATE ACCESS TO THE PLANS WEBSITE FOR IMPORTANT INFORMATION, FACILITATE ACCESS TO THE PLAN'S SOCIAL MEDIA IN WHICH PREVENTIVE AND **EDUCATIONAL STRATEGIES ARE** DISTRIBUTED, ETC. MEMBER CAN USE THE SMARTPHONE AS LONG AS THEY ARE ENROLLED IN THE PLAN. MEMBER WILL HAVE TO RETURN THE SMARTHPHONE TO THE PLAN IN CASE OF DISENROLLMENT OR CHANGE IN PLAN COVERAGE.

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

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

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Yes

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Yes





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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

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

Is there a Maximum Enrollee Out-of-Pocket

Nο

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment? 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

Yes

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

Mandatory

No, indicate number

Services?

Indicate number of visits for Restorative

Services:

Select the Restorative Services periodicity: Other, Describe

Select type of benefit for Prosthodontics, Other

Is this benefit unlimited for Prosthodontics,

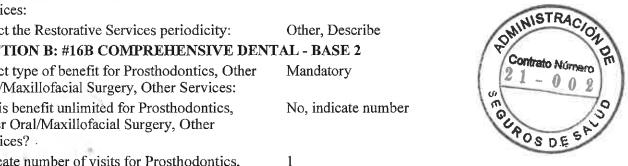
Other Oral/Maxillofacial Surgery, Other

Services?

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

Services:

1 SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2 Mandatory Oral/Maxillofacial Surgery, Other Services: No, indicate number







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Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

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):

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

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%

No

Is there an enrollee Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

No Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Yes Is authorization required?

Is a referral required for Comprehensive Dental

Services?

No

RESTORATIVE SERVICES: Notes:

> CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

PROSTHODONTIC SERVICES:

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SECTION B: #17A EYE EXAMS - BASE 1 Does the plan provide Eve Exams as a

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 (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES. FIXED DENTURES: RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE. IMPLANTS: SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE

AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

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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
SECTION B: #18A HEARING EXAMS - BASE	1
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	No
SECTION B: #18A HEARING EXAMS - BASE	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 supplemental benefit under Part C?	No
SECTION B: #19 VBID/MA UNIFORMITY FL	EXIBILITY/SSBCI
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for	Yes



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Yes

Yes

the Chronically III?

Select what type of benefit your SSBCI

includes:

: Additional Benefits

Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the

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

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

Value-Based Insurance Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic In-Person

: I attest that

: Web-Based

No

No

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

Expected Number of Beneficiaries to be

Engaged Annually:

2397

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

No

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

Does your VBID/MA Uniformity

Yes

3

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility



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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?

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

for this package?

Yes

Which prerequisites are required for this

package?

: Participation in a Care Management Program

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

SERVICE COVERED IN ALL Notes:

> PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN

THE INTERDISCIPLINARY 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

Select enhanced benefit (Select all that apply):

: 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

Hotline)*

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

Mandatory

: 14c: Other Defined Supplemental Benefits Select all the Non-Medicare-covered additional benefits offered in this package: SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1 Contrato Númer Are any benefits exempt from the plan-level No deductible?

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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?

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

BASE 11: PACKAGE #1

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

No

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

BASE 13: PACKAGE #1

Is authorization required? Is a referral required for Other Defined Yes

Supplemental Benefits?

Yes

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEF BASÉ 14: PACKAGE #1

Remote Access Technology (Web/Phone-based

technologies) Notes:*

REAL TIME INTERACTIVE AUDIO AND

Contrato Número

VIDEO TECHNOLOGIES CONSULTATION SERVICE PROVIDED BY STATE

LICENSED PROVIDER SUCH AS:

ENDOCRINOLOGIST, PULMONOLOGIST,

CARDIOLOGIST, 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

: 13i: Non-Primarily Health Related Benefits for

benefits offered in this package:

the Chronically Ill

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

(OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level No

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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: HOME DELIVERED MEALS BENEFIT

(BEYOND A 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 Health Related Benefits for the Chronically III

: 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?

Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

How many days do your Meals (beyond limited

10

basis) last?

20

What is the maximum number of meals the benefit provides?

20

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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?

No
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

Contrato Número

POS DE

YEAR

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #3

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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





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POPULATION: VBID: PACKAGE #3

Targeting Methodology - Please choose one or : Chronic Condition(s)

both:

Which disease states does this benefit apply?

(Select all that apply):

: Other CMS-Approved Disease State

Expected Number of Enrollees to be Targeted:

Expected Number of Enrollees to be engaged

23972397

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement? No
Is there a maximum benefit amount? Yes
Specify the maximum benefit amount: 130.00

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes: CASH OR MONETARY REBATES

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

Enter name of Service (Optional): CASH OR MONETARY REBATES

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 130.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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 Other Services?

Yes

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

Notes: THE CASH OR MONETARY REBATE WILL

who are



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DEBIT CARD FROM WHICH THE ENROLLEE CAN WITHDRAW CASH FROM ATMS. ENROLLEES WILL BE PROVIDED WITH A DEBIT CARD WHICH WILL INCLUDE THEIR FULL NAME AND INFORMATION ON HOW TO ACTIVATE THE CARD. THE MEMBER WILL RECEIVE AN ALLOWANCE DEPOSITED INTO THEIR DEBIT CARD ONCE A MONTH AND WILL ALSO RECEIVE AN EOB TO BE ABLE TO MONITOR ALL TRANSACTIONS. THE ENROLLEE CAN RECEIVE AN ALLOWANCE OF UP TO \$130 PER MONTH, FOR A TOTAL OF UP TO \$1,560 EVERY

YEAR.

BE IMPLEMENTED IN THE FORM OF A

NH.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
Is there an enrollee Copayment?	No
SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5

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



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No

Yes

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	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%			
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%			
	Indicate the maximum per day amount	5			
7	Is there an enrollee Copayment?	No			
	SECTION B: #19C VBID HOSPICE- BASE 3				
	Mandatory supplemental benefits for enrollees that elect hospice?	No			
	Enter the Maximum plan benefit amount:	0.00			
	Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	No			
	SECTION C: V/T - GENERAL - US				
	Do you offer a US Visitor/Travel Program?	No			
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)			
	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:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits			
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes			
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Non- Medicare-covered plan services?	Yes GE No Contrato Número			
	SECTION D: MAX PLAN BENEFIT COVERA	GE			
	Is there a Maximum Plan Benefit Coverage Amount?	No Contrato Número 2 1 - 0 0 2			
	SECTION D: REDUCTIONS IN COST SHARI	NG - GENERAL			
	Do you offer Reductions in Cost Sharing?	No G			
	SECTION D: COMBINED BENEFITS - GENE	No RAL GUROS DE SP			

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No

Yes

Do you offer Combined Supplemental Benefits with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1Does your plan offer a Medicare Prescription

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drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Defined Standard

Standard Retail : Out-of-Network

: Standard Mail-Order

Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42

Contrato Número

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?

Yes

Yes

No

No

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

Yes

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

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

30

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

: Out-of-Network Pharmacy - one month supply

: Long-Term Care Pharmacy - 1-month supply

: Standard Mail-Order - 3-month supply

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

30

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

90

Select the Long-Term Care Pharmacy one

month Location/supply amount(s) that apply:

31

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

No





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

No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

No

programs through the model?



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 050, SEGMENT 0

Module:

Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/31/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/31/2020 08:25:03 PM SA Western Standard

Time

Completed

PBP

PLAN STATUS

Section B12 Status

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B6 Status

Completed

Section B7 Status

Section B8 Status

Completed

Completed

Completed

Section B9 Status

Completed

Section B10 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 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: MMM HEALTHCARE, LLC

Organization Marketing Name: Medicare y Mucho Más

Organization Web Site: www.mmmpr.com

Plan Name: MMM Conectado Platino (HMO D-SNP)

Organization Type: Local CCP Plan Type: HMO

Enrollee Type: Part A and Part B





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

Service Area(s):

40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR

40330 - Hormigueros, PR

40340 - Humacao, PR

40370 - Juana Diaz, PR

40350 - Isabela, PR

40360 - Jayuya, PR

40380 - Juncos, PR

40390 - Lajas, PR



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Service Area(s):
Service Area(s):
Contract Number:
Plan ID:
Segment ID:

40400 - Lares, PR
40410 - Las Marias, PR
40420 - Las Piedras, PR
40430 - Loiza, PR
40440 - Luquillo, PR
40450 - Manati, PR
40460 - Maricao, PR
40470 - Maunabo, PR
40480 - Mayaguez, PR
40490 - Moca, PR
40500 - Morovis, PR
40510 - Naguabo, PR
40520 - Naranjito, PR
40530 - Orocovis, PR
40540 - Patillas, PR
40550 - Penuelas, PR
40560 - Ponce, PR
40570 - Quebradillas, PR
40580 - Rincon, PR
40590 - Rio Grande, PR
40610 - Sabana Grande, PR
40620 - Salinas, PR
40630 - San German, PR
40640 - San Juan, PR
40650 - San Lorenzo, PR
40660 - San Sebastian, PR
40670 - Santa Isabel, PR
40680 - Toa Alta, PR
40690 - Toa Baja, PR
40700 - Trujillo Alto, PR
40710 - Utuado, PR
40720 - Vega Alta, PR
40730 - Vega Baja, PR
40740 - Vieques, PR
40750 - Villalba, PR
40760 - Yabucoa, PR
40770 - Yauco, PR
H4003
050
0
2021



Contract Period:

Plan Geographic Name:

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		Puerto Rico
	Is this an Employer-Only plan? SECTION A: SECTION A-2	No
	Indicate CY2021 total projected member months for this plan:	170429
	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 prollees in your D-SNP?	No
U	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)333-5471
	Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
	Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
	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)333-5471
	Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
	Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	.(866)333-5471
	SECTION A: SECTION A-4	JISTRAC
	Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396 Contrato Núm
	Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
	Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
	Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
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(877)522-0655

Customer Service Contact Local TTY/TDD for

Prospective Medicare Beneficiaries:

Customer Service Contact TTY/TDD for (877)522-0655

Current Part D Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (877)522-0655

Current Part D Medicare Beneficiaries:

Customer Service Contact TTY/TDD for (877)522-0655

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (877)522-0655

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-5

Is your organization filing a standard bid for No

Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for No Section D of the PBP?

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)

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

Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?

Is there an enrollee Coinsurance?

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

No

No

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?

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





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No

Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

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

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

Services as a supplemental benefit under Part

C?

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?

Is there an enrollee Coinsurance?

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
Is a referral required for SNF Services? No

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

No

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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

Yes Is authorization required? Is a referral required for Cardiac and Pulmonary Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - 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

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Coverage:

Coverage:

amount for Worldwide Emergency/Urgent

Coverage?

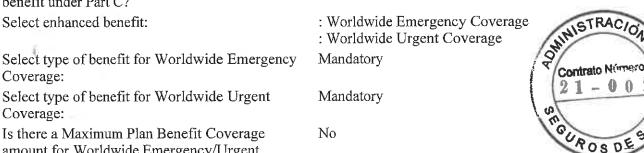
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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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

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

No

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: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?



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No

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

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 No Is there an enrollee Copayment? 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 Yes

Is a referral required for Occupational Therapy

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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



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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Nο

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

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? 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



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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?

Is a referral required for Psychiatric Services?

Yes

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?

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 PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

1



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Yes

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No 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?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered
Outpatient Hospital Services?

Is authorization required for Medicare-covered

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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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

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes 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?

Plan Approved Health-related Location Select enhanced benefit:

No

Yes

No

4

Mandatory

Every year

One-way

Select type of benefit for Plan Approved Health-

related Location:

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

Approved Health-related Location:

Select Mode of Transportation for Plan

: Taxi

: Rideshare Services Approved Health-related Location: : Bus/Subway

Van





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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

No

20%

No

20%

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?

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

Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 20%

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

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

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

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Prosthetic Devices:

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

W Delic



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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
those from specified manufacturers?

Is authorization required? Yes

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 No supplemental benefit under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Every three months

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:

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

OTC or formulary drugs.

No

No

Yes

SECTION B: #13B OTC ITEMS - BASE 2



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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:

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) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) 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 MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
- 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY





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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: #13F OTHER 3 - BASE 1

Enter name of Service (Optional): COVID-19 PUBLIC HEALTH EMERGENCY

Select type of benefit for Other 3: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #13F OTHER 3 - 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 Other Services?

No

SECTION B: #13F OTHER 3 - BASE 3

Notes: SHOULD THE PUBLIC HEALTH

EMERGENCY EXTEND IN TO 2021, MMM INTENDS ON OFFERING BENEFITS THAT WILL ADDRESS THE HEALTH NEEDS OF

OUR MEMBERSHIP UNDER THE

PREVAILING CIRCUMSTANCES. THOSE BENEFITS MAY INCLUDE COST-SHARING

REDUCTIONS, ADDITIONAL SUPPLEMENTAL BENEFITS, OR

CHANGES IN MEDICAL MANAGEMENT DESIGNED TO IMPROVE THE QUALITY AND OUTCOME OF MMMs HEALTHCARE

DELIVERY.

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

NISTRACION

Contrato Número

1 - 0.0

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?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

No

MENTAL BENEFITS - BASE 1
Yes

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C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*
Mandatory

Mandatory

9

No

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

Mandatory

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): : Nursing Hotline

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined

Complemental Descriptor

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?

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 HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE

THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH



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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



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 MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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,

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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 Technology (Web/Phone-based technologies) Notes:*



Hu

Remote Access Technologies (Nursing Hotline) Notes:



MEMBER WILL RECEIVE ONE SMARTPHONE WITH VOICE AND DATA PLAN FOR HEALTH-RELATED PURPOSES SUCH AS: TO FACILITATE ENGAGEMENT WITH HEALTHCARE PROVIDERS, USE THE PLAN'S MOBILE APP TO ACCESS ONLINE SERVICES LIKE OTC ORDERS, FACILITATE ACCESS TO THE PLAN'S NURSING HOTLINE, FACILITATE ACCESS TO THE PLANS WEBSITE FOR IMPORTANT INFORMATION, FACILITATE ACCESS TO THE PLAN'S SOCIAL MEDIA IN WHICH PREVENTIVE AND EDUCATIONAL STRATEGIES ARE DISTRIBUTED, ETC. MEMBER CAN USE THE SMARTPHONE AS LONG AS THEY ARE ENROLLED IN THE PLAN. MEMBER WILL HAVE TO RETURN THE SMARTHPHONE TO THE PLAN IN CASE OF DISENROLLMENT OR CHANGE IN PLAN COVERAGE.

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.

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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?

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?
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

Yes

Digital Rectal Exams?

d Y

Is authorization required for Medicare-covered EKG following Welcome Visit?

Yes

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

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No

No

Yes

1

1

Yes

Mandatory

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

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

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?

: Restorative Services Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

No, indicate number

Other, Describe

No, indicate number

Mandatory

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative

Select the Restorative Services periodicity:

Services:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

Plan-specified amount per period

1000.00

Other, Describe





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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):

: Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Indicate Minimum Coinsurance percentage for

Restorative Services:

20%

Indicate Maximum Coinsurance percentage for

Restorative Services:

20%

Indicate Minimum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

20%

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services:

20%

Is there an enrollee Deductible?

No

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:

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

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 (SUCH AS: VALPLAST)

COVERED EVERY 5 YEARS. RELINE OR



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FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES. FIXED DENTURES: RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE. IMPLANTS: SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

REBASE ARE NOT COVERED IN

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a No supplemental benefit under Part C?

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

SECTION B: #17A EYE EXAMS - BASE 2

SECTION B: #17A EYE EXAMS - BASE 3

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



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, No

No

No

No

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Yes

Yes

Yes

No

200.00

Every year

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits: : Contact lenses

Eyeglasses (lenses and frames)

Plan-specified amount per period

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and Mandatory

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 3

s there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

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?

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

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Yes

: Fitting/Evaluation for Hearing Aid

Mandatory

No, indicate number



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	Select Fitting/Evaluation for Hearing Aid periodicity:	Every year		
	SECTION B: #18A HEARING EXAMS - BASE	2		
	Is there a service-specific Maximum Plan Benefit Coverage amount?	No		
	Is there an enrollee Deductible?	No		
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No		
	Is there an enrollee Coinsurance?	No		
	SECTION B: #18A HEARING EXAMS - 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 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	1 1		
	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:	100.00		
	Indicate Maximum Plan Benefit Coverage periodicity:	Every year		
	SECTION B: #18B HEARING AIDS - BASE 3			
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No		
	Is there an enrollee Coinsurance?	No		
SECTION B: #18B HEARING AIDS - BASE 4				
	Is there an enrollee Copayment?	No		
	Is there an enrollee Deductible?	No		

SECTION B: #18B HEARING AIDS - BASE 5

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

Is a referral required for Hearing Aids?

Is authorization required?

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Yes

No

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Yes

Yes

Does your plan include MA Uniformity

Flexibility with reductions in cost or additional

henefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Select what type of benefit your SSBCI

: Reduced Cost Sharing : Additional Benefits

Yes

includes:

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

No

Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

> : Medicare Health Risk Assessment : Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic In-Person : Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

No

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

STRAC/O

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Records

: Provider/Patient portals

Expected Number of Beneficiaries to be

Engaged Annually:

126

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

Yes

1

How many packages does your 19a Reduction

in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA

SSBCI

Uniformity Flexibility or SSBCI?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost

No

sharing for this package?

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Select the benefits that apply to reduced cost : Medicare-covered benefits sharing: : Non-Medicare-covered benefits Select the Medicare-covered benefits that will : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices receive reduced cost sharing: : 11b2: Medical Supplies Select the Non-Medicare-covered benefits that : 16b3: Restorative Services : 16b7: Prosthodontics, Other Oral/Maxillofacial will receive reduced cost sharing: Surgery, Other Services SECTION B: #19A REDUCED COST SHARING 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: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1 Do you offer reduced Coinsurance? Yes Select the types of benefits that apply to the : Medicare-covered benefits coinsurance cost sharing: : Non-Medicare-covered benefits Select the Medicare-covered benefits that will : 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices receive reduced coinsurance: : 11b2: Medical Supplies Select the Non-Medicare-covered benefits that : 16b3: Restorative Services will receive reduced coinsurance: : 16b7: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 5 (REDUCED **COINSURANCE): PACKAGE #1** Indicate Minimum Coinsurance Percentage for 0% Durable Medical Equipment (DME) Indicate Maximum Coinsurance Percentage for 0% Durable Medical Equipment (DME) Indicate Minimum Coinsurance Percentage for 0% Prosthetic Devices Contrato Número Indicate Maximum Coinsurance Percentage for 0% Prosthetic Devices Indicate Minimum Coinsurance Percentage for 0% Medical Supplies Indicate Maximum Coinsurance Percentage for 0% Medical Supplies SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 7 (REDUCED COINSURANCE): PACKAGE #1

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0%

0%

0%

Indicate Minimum Coinsurance Percentage for

Indicate Maximum Coinsurance Percentage for

Indicate Minimum Coinsurance Percentage for Prosthodontics, Other Oral/Maxillofacial

Restorative Services

Restorative Services

Surgery, Other Services

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Indicate Maximum Coinsurance Percentage for

0%

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED

DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED

COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18

(RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum aggregate amount of

Yes

reduced cost sharing?

Specify the maximum aggregate amount of

145.00

reduced cost sharing:

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

\$145 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN

CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

- TO COVER

COPAYMENTS/COINSURANCE FOR PRIMARILY HEALTH RELATED

SERVICES

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

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



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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

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(COPD)

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

. Outer

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

: Participation in a Care Management Program

package?

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 IN ALL

PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN

THE INTERDISCIPLINARY 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):

: 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing

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?

No

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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, 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



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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?

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

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

Are any benefits exempt from the plan-level

deductible?

No

No

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? Yes
Specify the maximum benefit amount: 145.00

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

Notes:

\$145 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN

CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

- TO COVER

COPAYMENTS/COINSURANCE FOR PRIMARILY HEALTH RELATED

SERVICES

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

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

Does the plan provide Over-The-Counter (OTC) Yes







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Items as a supplemental benefit under Part C?

Mandatory Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

145.00

Yes

Select Maximum Plan Benefit Coverage

periodicity:

Every month

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

unused?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Nicotine Replacement Therapy (NRT)

Attestation:

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

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

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may No be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

Notes:

\$145 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.



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) INCONTINENCE SUPPLIES (ADULT

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DIAPERS & UNDER PADS)

6) 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 MAY REQUIRE MEDICAL

EVALUATION AND/OR PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY

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

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

includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

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?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

Yes

Yes

145.00

Other, Describe

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

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



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No Is authorization required? Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

\$145 MONTHLY ALLOWANCE IN THE Notes:

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

Other, Describe

Yes

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 Mandatory

basis):

How many days do your Meals (beyond limited 365

basis) last?

What is the maximum number of meals the 999

benefit provides?

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for the Meals (beyond No

limited basis)?

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

PACKAGE #2

\$145 MONTHLY ALLOWANCE IN THE Notes:

> FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY



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> HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

MEALS (BEYOND A LIMITED BASIS) ARE UNLIMITED.

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SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

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

Yes

Select type of benefit for Pest Control:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Other, Describe

Mandatory



145.00

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes: \$145 MONTHLY ALLOWANCE IN THE

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Select type of benefit for Social Needs Benefit:

Mandatory

Yes











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Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

145.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Social Needs Benefit?

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes:

\$145 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE

COVERING ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for

Yes

Living as a supplemental benefit under Part C? Select type of benefit for General Supports for

Mandatory

Living:

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

145.00

periodicity:

Other, Describe

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2:



PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for	No
Living?	

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:

\$145 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES & HOUSING.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
Is there an enrollee Copayment?	No
SECTION B: #19C VBID HOSPICE- BASE 2	

Is there an enrollee Coinsurance?

Indicate the Minimum Coinsurance percentage



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Yes

5%



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	for Medicare covered Benefits for prescription drugs and biologics:		
Ž	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%	
1	Indicate the maximum per drug amount	5	
	Is there an enrollee Copayment?	No	
	Is there an enrollee Coinsurance?	Yes	
	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%	
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%	
	Indicate the maximum per day amount	5	
_	Is there an enrollee Copayment?	No	
	SECTION B: #19C VBID HOSPICE- BASE 3		
	Mandatory supplemental benefits for enrollees that elect hospice?	No	
	Enter the Maximum plan benefit amount:	0.00	
	Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	No	
	SECTION C: V/T - GENERAL - US		
	Do you offer a US Visitor/Travel Program?	No	
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)	
	Is there an In-Network Plan Deductible?	No	OTPAG
	SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)	MINISTRACION
	Is there an In-Network Maximum Enrollee Out- of-Pocket Cost?	Ϋ́es	Contrato Número
	Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary	21-002
	Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00	CUPOS DE SP
	Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-cove : In-Network Non-Medicare	
	Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes	
	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 COVERA	.GE	
	Is there a Maximum Plan Benefit Coverage	No	

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Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

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 pharmacy network (select all that apply):

Defined Standard

: Standard Retail Out-of-Network : Standard Mail-Order

: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42

CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

No

Does plan utilize ceiling pricing?

No Yes

Are there quantity limits on certain prescription

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

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

: Standard Retail Cost Sharing - 1 month Supply

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Location/supply amount(s) that apply:

: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

90

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

30

30

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

Enter number of days for Out-of-Network

: Out-of-Network Pharmacy - one month supply

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

: Standard Mail-Order - 3-month supply

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

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

: Long-Term Care Pharmacy - 1-month supply

Enter number of days for Long-Term Care Pharmacy 1-month supply:

31

90

Are all of the drugs on your formulary available

No

with an extended day supply?

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

No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives

No

programs through the model?



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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: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 05/31/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/31/2020 08:29:41 PM SA Western Standard

Time

MA BPT Timestamp: 05/29/2020 03:26:30 PM SA Western Standard

Time

PD BPT Timestamp: 05/29/2020 02:18:54 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/29/2020 08:19:47 PM SA Western Standard

Time

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 Completed Section B5 Status Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Completed Section B9 Status Section B10 Status Completed Section B11 Status Completed Completed

Section B12 Status Completed Section B13 Status Section B14 Status Completed Section B15 Status Completed Completed Section B16 Status 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: MMM HEALTHCARE, LLC

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PMC Medicare Choice

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):

Service Area(s):

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 40330 - Hormigueros, PR



W.

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

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

40710 - Utuado, PR

40720 - Vega Alta, PR 40730 - Vega Baja, PR

40740 - Vieques, PR

40750 - Villalba, PR

40700 - Trujillo Alto, PR



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	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	061
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2021 total projected member months for this plan:	230201
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.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
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)333-5471

Customer Service Contact Local Phone Number

Customer Service Contact Local Phone Number

for Prospective 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

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(787)620-2396

(866)333-5471

(787)620-2396

Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
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:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
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
CECTION A. CECTION A.C.	

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?

No

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

No

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

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

No

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

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

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

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit under Part C? No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Is there an enrollee Coinsurance? No

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

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

SECTION B: #2 SNF - BASE 1

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

Do you allow less than 3 day inpatient hospital 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?

Hospital Services?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost No 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

No Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10







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No

Yes

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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?

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

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/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - 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?

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 amount for Worldwide Emergency/Urgent

No



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

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?

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

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?



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No

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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

Yes

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

Therapies benefit, or both?

No

Therapies beliefit, of both.

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes 750.00

Indicate Maximum Plan Benefit Coverage

amount:

Every year

Select Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No

Is authorization required?

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?

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 Yes

Is a referral required for Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee

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

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

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? 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 Copayment?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

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

Is authorization required? Yes



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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2 Yes Is authorization required? 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 PROGRAM SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2



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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

Nο

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?

Is authorization required for Medicare-covered

Observation Services?

Yes

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?

Is authorization required?

No Yes

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

Out-of-Pocket Cost?

No



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

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

as a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

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

Select Mode of Transportation for Plan

: Taxi

Approved Health-related Location: : Rideshare Services

Bus/Subway

Mandatory

One-way

Yes





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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?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for 0%

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)?

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?

Is there an enrollee Coinsurance? Yes

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

No

No

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

10%

10% 10%

10%



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

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

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 No Is there an enrollee Deductible?

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

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

those from specified manufacturers?

Is authorization required? Yes

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 No Is there an enrollee Copayment?

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

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 60.00

amount:

Select Maximum Plan Benefit Coverage Every three months

periodicity:

Does your Maximum Plan Benefit Coverage No

amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy Yes

(NRT) as a Part C OTC benefit?



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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

Votes:

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) INCONTINENCE SUPPLIES (ADULT **DIAPERS & UNDER PADS)**
- 6) 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 MAY REOUIRE MEDICAL **EVALUATION AND/OR** PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)



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11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

COVID-19 PUBLIC HEALTH EMERGENCY

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: #13F OTHER 3 - BASE 1

Is there a service-specific Maximum Plan

Enter name of Service (Optional):

Select type of benefit for Other 3:

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Mandatory

SECTION B: #13F OTHER 3 - BASE 2

No 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 Other Services?

No

SECTION B: #13F OTHER 3 - BASE 3

Notes:

SHOULD THE PUBLIC HEALTH

EMERGENCY EXTEND IN TO 2021, MMM INTENDS ON OFFERING BENEFITS THAT WILL ADDRESS THE HEALTH NEEDS OF

OUR MEMBERSHIP UNDER THE

PREVAILING CIRCUMSTANCES. THOSE BENEFITS MAY INCLUDE COST-SHARING

REDUCTIONS, ADDITIONAL SUPPLEMENTAL BENEFITS, OR

CHANGES IN MEDICAL MANAGEMENT DESIGNED TO IMPROVE THE QUALITY AND OUTCOME OF MMMs HEALTHCARE

DELIVERY.

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

Yes

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

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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):

: 14c1: Health Education

14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: 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

Mandatory

Smoking and Tobacco Cessation Counseling:

9

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):

Select the type of Remote Access Technologies

: 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

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 HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION

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DEA)

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. 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 MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE **EDUCATORS PROVIDE INFORMATION TO** IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

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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

No

H

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Yes

Yes

Yes

Yes

Yes

Is there an enrollee Copayment? No
Is authorization required for Medicare-covered Yes
Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is authorization required for Other Medicare-

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?

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

Is there an enrollee Copayment?

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

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No



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No

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Yes

Mandatory

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: Mandatory

Is this benefit unlimited for Restorative No, indicate number

Services?

Indicate number of visits for Restorative 1

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics, 1

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

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

type:

Indicate Maximum Plan Benefit Coverage 2000.00

amount:

Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

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 No

Services?







Notes:



RESTORATIVE SERVICES: CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT

CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.

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 (SUCHA AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR

FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES:

RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC-PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS:

SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE.

ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED

PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED.

CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

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> REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE 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? Yes Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a

supplemental benefit under Part C?

Select enhanced benefits:

Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes 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

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Mandatory

Yes

Yes

Plan-specified amount per period

Yes

450.00

Every year

No

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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
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	2.2
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - 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 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

Is there a service-specific Maximum Plan

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

Benefit Coverage amount?

SECTION B: #18B HEARING AIDS - BASE 2

types)?

combined?

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Yes

Yes

Both ears combined

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

amount:

250.00

Indicate Maximum Plan Benefit Coverage

periodicity:

Every three years

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

-

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

SECTION B: #18B HEARING AIDS - BASE 4

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

No

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

Flexibility with reductions in cost or additional

benefits?

Yes

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Yes

Select what type of benefit your SSBCI

includes:

: Reduced Cost Sharing : Additional Benefits

Are you offering a VBID Hospice Benefit?

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

Section Rx)

Yes No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

: Annual Wellness Visit

: Medicare Health Risk Assessment

Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

: Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

No

Program Connectedness: Please check the way

that advance care plans and/or advance

: Electronic Health Records/Electronic Medical

Records

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directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be 362

Engaged Annually:

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA

SSBCI

Uniformity Flexibility or SSBCI?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost

sharing for this package?

No

Select the benefits that apply to reduced cost

sharing:

: Medicare-covered benefits

: Provider/Patient portals

Select the Medicare-covered benefits that will

receive reduced cost sharing:

: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices

: 11b2: Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

deductible?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?

Select the types of benefits that apply to the

coinsurance cost sharing:

Yes

: Medicare-covered benefits

Select the Medicare-covered benefits that will : 11a: Durable Medical Equipment (DME)

: 11b1: Prosthetic Devices receive reduced coinsurance:

: 11b2: Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 5 (REDUCED COINSURANCE): PACKAGE #1

0% Indicate Minimum Coinsurance Percentage for

Durable Medical Equipment (DME)

Indicate Maximum Coinsurance Percentage for

0%

Durable Medical Equipment (DME)

Indicate Minimum Coinsurance Percentage for

0%

Prosthetic Devices

Indicate Maximum Coinsurance Percentage for

0%

Prosthetic Devices



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Indicate Minimum Coinsurance Percentage for

Medical Supplies

Indicate Maximum Coinsurance Percentage for

Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED **DEDUCTIBLE): PACKAGE #1**

Do you offer a reduced deductible amount?

No

0%

0%

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED **COPAYMENT): PACKAGE #1**

Do you offer reduced Copayment?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum aggregate amount of

Yes

reduced cost sharing?

30.00

Specify the maximum aggregate amount of reduced cost sharing:

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN

CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

- TO COVER

COPAYMENTS/COINSURANCE FOR PRIMARILY HEALTH RELATED

SERVICES

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.





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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

2

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

PACKAGE #1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility

PACKAGE #1

Which disease states does this benefit apply? (Select all that apply): : Chronic Obstructive Pulmonary Disease

(COPD)

: Diabetes

: Congestive Heart Failure (CHF)

: Coronary Artery Disease

: Other 1

No

No

Yes

Cardiovascular Disorders Other 1 Description:

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

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?

package?

Select all the Non-Medicare-covered additional

Which prerequisites are required for this

benefits offered in this package:

: Participation in a Care Management Program

: 14c: Other Defined Supplemental Benefit

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

deductible?

Are any benefits exempt from the plan-level No

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

SERVICE COVERED IN ALL

PARTICIPATING INTERDISCIPLINARY CLINICS FOR MEMBERS ENROLLED IN

THE INTERDISCIPLINARY CLINIC

PROGRAM

Notes:

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

 \mathbb{C} ?

Select enhanced benefit (Select all that apply):

: 14c7: Remote Access Technologies (including

Web/Phone-based technologies and Nursing DMINISTR40

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 BEN

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

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 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, AMONG OTHERS.

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

PACKAGE #2

Is this package applicable to VBID or MA

SSBCI





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Uniformity Flexibility or 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:

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

: 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? Yes
Specify the maximum benefit amount: 30.00

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

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN

CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES & HOUSING)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

- TO COVER

COPAYMENTS/COINSURANCE FOR PRIMARILY HEALTH RELATED

SERVICES

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

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

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Yes

Yes

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 30.00

amount:

Select Maximum Plan Benefit Coverage Every month

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?

No

Yes

No

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

: The Nicotine Replacement Therapy (NRT)

being offered does not duplicate any Part D OTC or formulary drugs.

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

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





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5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

6) 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 MAY REQUIRE MEDICAL

EVALUATION AND/OR PREAUTHORIZATION.

7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) ITEM QUANTITY LIMITS IN EACH

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CATEGORY MAY APPLY

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 III

includes:

: Food and Produce

: Meals (beyond limited basis)

Pest Control

: Social Needs Benefit

: General Supports for Living

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?

Yes

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Mandatory

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

30.00

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

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Is authorization required? No Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

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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?

Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

How many days do your Meals (beyond limited

basis) last?

365

What is the maximum number of meals the

benefit provides?

999

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

amount:

amount:

30.00

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 MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for the Meals (beyond)

No

limited basis)?

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

Notes: \$30 MONTHLY ALLOWANCE IN THE

FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY



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HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

MEALS (BEYOND A LIMITED BASIS) ARE

UNLIMITED.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #2

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Indicate Maximum Plan Benefit Coverage

Yes

Benefit Coverage amount?

30.00

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #2

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN

CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a

Yes

supplemental benefit under Part C?

Select type of benefit for Social Needs Benefit: Mandatory

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Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

30.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Social Needs Benefit? Nο

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY

HEALTH RELATED SERVICES INCLUDED

WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT

AMOUNT.

UNDER THIS CATEGORY WE WILL BE

COVERING ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for

Yes

Living as a supplemental benefit under Part C?

Mandatory

Select type of benefit for General Supports for Living:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

30.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2:

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PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for	No
Living?	

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:

\$30 MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES & HOUSING.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? Indicate the Minimum Coinsurance percentage	Yes 5%
for Medicare covered Benefits for prescription drugs and biologics:	
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
Is there an enrollee Copayment?	No
SECTION B: #19C VBID HOSPICE- BASE 2	

Is there an enrollee Coinsurance?

Indicate the Minimum Coinsurance percentage



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Yes

5%

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for Medicare covered Benefits for prescription drugs and biologics:	
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
Is there an enrollee Copayment?	No
SECTION B: #19C VBID HOSPICE- BASE 3	
Mandatory supplemental benefits for enrollees that elect hospice?	No
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETV	VORK)
Is there an In-Network Plan Deductible?	VORK) No ROMINISTRACIO
SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK) Contra
Is there an In-Network Maximum Enrollee Out- of-Pocket Cost?	Yes (IN-NETWORK)
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary OF DE SALUO
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 Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
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 COVERA	AGE
Is there a Maximum Plan Benefit Coverage	No

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Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

No

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Defined Standard : Standard Retail

: Out-of-Network

: Standard Mail-Order : Long-Term Care

Sponsor attests that it will comply with 42 CFR

423,154.

: Sponsor attests that it will comply with 42

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CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

No Does plan utilize floor pricing?

Does plan utilize ceiling pricing? No

Are there quantity limits on certain prescription

drugs?

Yes

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

program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

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

Pharmacy 1-month supply:

: Out-of-Network Pharmacy - one month supply

Enter number of days for Out-of-Network

30

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

: Standard Mail-Order - 3-month supply

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Enter number of days for Standard Mail-Order

90 Cost Sharing 3-month supply:

Select the Long-Term Care Pharmacy one : Long-Term Care Pharmacy - 1-month supply month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care 31

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

Pharmacy 1-month supply:

Are any of the drugs available at an extended No day supply limited to a 1-month supply for the first fill?

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives No programs through the model?



