MEDICARE PLATINO 2021

APPENDIX C (1) (21)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFIT

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	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	MMM HEALTHCARE, LLC

Organization Marketing Name:	Medicare y Mucho Más
Organization Web Site:	www.mmmpr.com
Plan Name:	MMM Diamante Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	

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	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	

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Service Area(s):	40760 - Yabucoa, PR 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

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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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-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 period?	Per Admission or Per Stay

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

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	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 discharge?	No
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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	No

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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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 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: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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Is there an enrollee Copayment?	No

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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

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

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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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

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

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

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

Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
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

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 Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	100.00
Select Maximum Plan Benefit Coverage	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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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: #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?	No
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?	Yes
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
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 Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline

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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 Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	No
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 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.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR

STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline)
Notes:

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

	TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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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 Cost?	No
Is there an enrollee Coinsurance?	No

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

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

Is Authorization Required?	Yes
Does the plan offer step therapy?	No

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	5000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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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 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 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 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?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

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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
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

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	Mandatory

types):	
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

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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 Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	593

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

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

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

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

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 Supplemental Benefits as a benefit under Part C?	Yes
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 technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Web/Phone-based technologies

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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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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

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 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

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)

- 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.

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?	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:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	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 be found in Chapter 4 of the Medicare Managed Care Manual?	No

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

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

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

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.

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 basis):	Mandatory
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:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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 the Meals (beyond limited basis)?	No

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 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 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

	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 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 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?	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)

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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 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

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 Living?	No

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 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?	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-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or	Voluntary

Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee 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 COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

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:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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 Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : 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
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:	: Standard Mail-Order - 3-month supply
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 1-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 first fill?	No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

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

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	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	MMM HEALTHCARE, LLC

Organization Marketing Name:	Medicare y Mucho Más
Organization Web Site:	www.mmmpr.com
Plan Name:	MMM Valor Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	

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	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	

Service Area(s):	40760 - Yabucoa, PR 40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	047
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:	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
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

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-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 period?	Per Admission or Per Stay

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

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	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 discharge?	No
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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	No

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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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 Out-of-Pocket Cost?	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?	Yes
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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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Is there an enrollee Copayment?	No

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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 Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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

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

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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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway

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SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	20%
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 Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	20%

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

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

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

Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

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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 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 periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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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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):	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?	No
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?	Yes
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
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 Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined	No

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?	No
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 Supplemental Benefits?	No
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 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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	INTERVENTIONS.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

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

Remote Access Technologies (Nursing Hotline) Notes:	THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE

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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 Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered	Yes

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EKG following Welcome Visit?	
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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

Is a referral required for any Services?	No

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

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
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?	No

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 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 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?	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?	Yes
Select enhanced benefits:	: Contact lenses

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	: Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	450.00
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
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	
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	
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:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every two years
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?	No
Are you offering a VBID Hospice Benefit?	Yes

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 WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	91

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 Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

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

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

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 Supplemental Benefits as a benefit under Part C?	Yes
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 technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Web/Phone-based technologies

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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:	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

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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

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: 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 COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

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:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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 Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : 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
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

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 1-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 first fill?	No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

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

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, 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 08:27:32 PM SA Western Standard Time
MA BPT Timestamp:	05/29/2020 03:22:18 PM SA Western Standard Time
PD BPT Timestamp:	05/29/2020 02:15:14 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
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	MMM HEALTHCARE, LLC

Organization Marketing Name:	PMC Medicare Choice
Organization Web Site:	www.mmmpr.com
Plan Name:	PMC Premier Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	

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	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	

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Service Area(s):	40760 - Yabucoa, PR 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 for Prospective Part D Medicare Beneficiaries:	(787)620-2396

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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-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 period?	Per Admission or Per Stay

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

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 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: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

Is there an enrollee Copayment?	No

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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 Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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

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

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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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan	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 Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

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

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

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

Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

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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

Benefit Coverage amount?	
Indicate Maximum Plan Benefit Coverage amount:	150.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
How many days does your Meal Benefit last?	10
What is the maximum number of meals the benefit provides?	20
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: #13C MEAL BENEFIT - 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 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
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?	No
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.

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

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	Yes
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
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

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline

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

Select type of benefit for In-Home Support Services:	Mandatory

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 Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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

Is a referral required for any Services?	No

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

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
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 Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
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:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	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 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.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	450.00
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
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	

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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 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
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	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:	2500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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?	Yes
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 WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals

Expected Number of Beneficiaries to be Engaged Annually:	101

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

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

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

Which disease states does this benefit apply? (Select all that apply):	: Diabetes : Chronic Obstructive Pulmonary Disease (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 package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level deductible?	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

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 Supplemental Benefits as a benefit under Part C?	Yes
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 technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Web/Phone-based technologies

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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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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

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 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

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

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

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?	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:	20.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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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 be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - 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.

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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	20.00
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

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 basis):	Mandatory
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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 the Meals (beyond limited basis)?	No

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

	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 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 Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	20.00
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 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:	$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 supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	20.00
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 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?	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)

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

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
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:	20.00
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

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 Living?	No

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

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

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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

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: 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 COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

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:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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

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SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

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 1-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 first fill?	No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

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

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	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

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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 Grande Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	

	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	

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Service Area(s):	40760 - Yabucoa, PR 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 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

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-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 period?	Per Admission or Per Stay

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

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	No

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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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 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: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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Is there an enrollee Copayment?	No

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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 Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	20%
Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	DME Supplies 0%, Wheelchair 5%, DME Hosp Bed 5%, DME Power Wheelchair 20%, All other DME 0%

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%

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

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

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

Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

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?	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.

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

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Is authorization required?	Yes
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
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 Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based 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 Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED

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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.

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

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

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

Remote Access 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 Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered	Yes

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Digital Rectal Exams?	
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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

Is a referral required for any Services?	No

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

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1

Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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%
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 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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SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a

supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

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 FLEXIBILITY/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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the Chronically Ill?	
Select what type of benefit your SSBCI includes:	: Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	: I attest that

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 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 Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	3

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? (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?	Yes
Which prerequisites are required for this package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level deductible?	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

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 Supplemental Benefits as a benefit under Part C?	Yes
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

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 Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13i: Non-Primarily Health Related Benefits for the Chronically 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 Ill includes:	: Meals (beyond limited basis)

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 basis):	Mandatory
How many days do your Meals (beyond limited basis) last?	10
What is the maximum number of meals the benefit provides?	20
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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 the Meals (beyond limited basis)?	No

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

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

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

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

POPULATION: VBID: PACKAGE #3

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Other CMS-Approved Disease State
Expected Number of Enrollees to be Targeted:	2397
Expected Number of Enrollees to be engaged and receive Model benefits:	2397

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 benefits offered in this package:	: 13d: Other 1

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 deductible?	No

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 Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	130.00
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 #13D OTHER 1 - BASE 2: PACKAGE #3

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?	Yes

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

Notes:	THE CASH OR MONETARY REBATE WILL

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	BE IMPLEMENTED IN THE FORM OF A 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.

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?	No
Is there an enrollee Coinsurance?	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
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-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: 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 COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

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	Yes

drug (Part D) benefit?	
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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

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SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : 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
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:	: Standard Mail-Order - 3-month supply
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 1-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 first fill?	No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

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

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 050, 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 08:25:03 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
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	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

Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	

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Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	050
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:	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 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
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	(877)522-0655

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Prospective Medicare Beneficiaries:	
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-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 period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No

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?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 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: #7B CHIROPRACTIC SERVICES - BASE 1

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

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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes
Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

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?	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 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: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee	No

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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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	4
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van

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SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	20%
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 Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	20%

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

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Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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: #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?	No
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?	Yes
Is a referral required?	No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part	Yes

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 Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based 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 Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	No
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 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.

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

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

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

Remote Access 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 Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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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 Cost?	No
Is there an enrollee Coinsurance?	No

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage	1000.00

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:	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

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.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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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?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	200.00
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
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

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

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

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?	Yes
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 WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
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
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

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

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	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 : Non-Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies
Select the Non-Medicare-covered benefits that will receive reduced cost sharing:	: 16b3: Restorative Services : 16b7: Prosthodontics, Other Oral/Maxillofacial 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 deductible?	No

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 coinsurance cost sharing:	: Medicare-covered benefits : Non-Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced coinsurance:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies
Select the Non-Medicare-covered benefits that will receive reduced coinsurance:	: 16b3: Restorative Services : 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 Durable Medical Equipment (DME)	0%
Indicate Maximum Coinsurance Percentage for Durable Medical Equipment (DME)	0%
Indicate Minimum Coinsurance Percentage for Prosthetic Devices	0%
Indicate Maximum Coinsurance Percentage for Prosthetic Devices	0%
Indicate Minimum Coinsurance Percentage for Medical Supplies	0%
Indicate Maximum Coinsurance Percentage for Medical Supplies	0%

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 7 (REDUCED COINSURANCE): PACKAGE #1

Indicate Minimum Coinsurance Percentage for Restorative Services	0%
Indicate Maximum Coinsurance Percentage for Restorative Services	0%
Indicate Minimum Coinsurance Percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	0%

Indicate Maximum Coinsurance Percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	0%

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 reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	145.00

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.

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

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

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

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

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

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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
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 deductible?	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

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 Supplemental Benefits as a benefit under Part C?	Yes
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 technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Web/Phone-based technologies

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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

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 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

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

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?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	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 be found in Chapter 4 of the Medicare Managed Care Manual?	No

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

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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
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

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.

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 basis):	Mandatory
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:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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 the Meals (beyond limited basis)?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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. 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 Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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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?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
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 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?	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)

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

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
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:	145.00
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

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 Living?	No

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?	Yes
Indicate the Minimum Coinsurance percentage	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-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: 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 COVERAGE

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:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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 Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : 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
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:	: Standard Mail-Order - 3-month supply

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 1-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 first fill?	No

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

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

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
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	MMM HEALTHCARE, LLC

Organization Marketing Name:	PMC Medicare Choice
Organization Web Site:	www.mmmpr.com
Plan Name:	MMM Relax Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	

	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	

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Service Area(s):	40760 - Yabucoa, PR 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 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

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-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 period?	Per Admission or Per Stay

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

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

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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
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 benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	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 Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
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 Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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?	No
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 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: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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Is there an enrollee Copayment?	No

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

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

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

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

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 Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Speech-Language Pathology Services?	No

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

Do you offer an Additional Telehealth benefit for Part B services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
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 Program Services?	No

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

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

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 Procedures/Test/Lab Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

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

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

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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 Abuse?	Yes

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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 Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway

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SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	20%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	DME Supplies 0%, Wheelchair 5%, DME Hosp Bed 5%, DME Power Wheelchair 20%, All other DME 0%

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%

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

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

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

Is authorization required?	Yes

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	60.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes

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

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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: #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?	No
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?	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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
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 Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access 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 Supplemental Benefits?	No

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?	No

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 Supplemental Benefits?	No
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 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.

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

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

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

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

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes
Is authorization required for Other Medicare-covered Preventive Services?	Yes

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

Is a referral required for any Services?	No

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

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items	No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
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 Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
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:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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 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 (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?	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?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	450.00
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

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	
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	
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:	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?	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:	: Reduced Cost Sharing : Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
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 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

directives are connected from your program to access points of care.	: Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	362

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

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

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	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
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?	Yes
Select the types of benefits that apply to the coinsurance cost sharing:	: Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced coinsurance:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

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

Indicate Minimum Coinsurance Percentage for Durable Medical Equipment (DME)	0%
Indicate Maximum Coinsurance Percentage for Durable Medical Equipment (DME)	0%
Indicate Minimum Coinsurance Percentage for Prosthetic Devices	0%
Indicate Maximum Coinsurance Percentage for Prosthetic Devices	0%

Indicate Minimum Coinsurance Percentage for Medical Supplies	0%
Indicate Maximum Coinsurance Percentage for Medical Supplies	0%

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 reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	30.00

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.

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

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

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

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

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

Which disease states does this benefit apply? (Select all that apply):	: Diabetes : Chronic Obstructive Pulmonary Disease (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 package?	: Participation in a Care Management Program
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level deductible?	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

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 Supplemental Benefits as a benefit under Part C?	Yes
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 technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Web/Phone-based technologies

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

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 Supplemental Benefits?	Yes

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 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

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.

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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?	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:	30.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	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 be found in Chapter 4 of the Medicare Managed Care Manual?	No

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

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

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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

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.

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 basis):	Mandatory
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:	30.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - 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 the Meals (beyond limited basis)?	No

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

	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 Benefit Coverage amount?	Yes
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 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.

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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 Benefit Coverage amount?	Yes
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 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?	No

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)

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

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
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:	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 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 Living?	No

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?	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	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-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: 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 COVERAGE	
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:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: 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
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
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

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SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

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 1-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 first fill?	No

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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