MEDICARE PLATINO CONTRACT

APPENDIX C (1) (22)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)





MMM HEALTHCARE, LLC

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4003-017





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: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 12:01:24 PM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 11:19:34 AM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 02:57:12 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 08:11:08 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02360

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Completed
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 B17 Status Completed

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

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1





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

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

40300 - Guaynabo, PR

40310 - Gurabo, PR 40320 - Hatillo, PR

MMM HEALTHCARE, LLC



west -

Service Area(s):

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

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

40710 - Utuado, PR 40720 - Vega Alta, PR

40730 - Vega Baja, PR 40740 - Vieques, PR



Service Area(s):

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	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4003	
Plan ID:	017	
Segment ID:	0	
Contract Period:	2022	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Indicate CY2022 total projected member months for this plan:	872464	
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	Co.
Physician Website Address:	www.mmmpr.com	7-22
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	DAINISTRACION CON
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	Contrato Número
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	22 - 003
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471	POSDESA
SECTION A: SECTION A-4		

(787)620-2396

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Customer Service Contact Local Phone Number

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

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

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital

services that have tiered cost sharing are entered

in Section B of the PBP software)

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

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

No

No

No

No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

obtains care?

Is there an enrollee Coinsurance? No

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

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

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

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



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6/7/2021

period?

Do you charge cost sharing on the day of

discharge?

Ño

Is authorization required?

Yes No

Is a referral required for Inpatient Hospital-

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part

No

C?

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Is there a service-specific Maximum Enrollee

ZEL

Prior to SNF Admission (0-2):

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No



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SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

100

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

Yes



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amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

500.00

amount:

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

Yes : Worldwide Emergency Coverage

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

: Worldwide Urgent Coverage

Indicate Minimum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Yes

Urgent Coverage if admitted to hospital? Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes



Is a referral required for Home Health Services?

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

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

: 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 there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select enhanced benefit:

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

Yes
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No





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

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Yes

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes
Is a referral required for Mental Health
Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory
Is this benefit unlimited for Routine Foot Care? No

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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



M

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? 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: #71 PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required?

Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

: 7d: Physician Specialist Services Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

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

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

ADDITIONAL TELEHEALTH SERVICES Notes:

No

No

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS.

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





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Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

Is there an enrollee Copayment? No

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

Is authorization required?

Yes
Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes



Observation Services?

Is a referral required for Medicare-covered

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Ambulatory Surgical No

Center Services?

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

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

Is authorization required? Yes

Is a referral required for Outpatient Substance Yes

Abuse?

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

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Is a referral required for Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

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

One-way

Approved Health-related Location:

Approved Health-related Location:

Select Mode of Transportation for Plan

: Rideshare Services

: Bus/Subway

: Van

No

: Taxi



Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Yes Is authorization required?

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

Is there a service-specific Maximum Enrollee No





Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No





Out-of-Pocket Cost?

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?

Select type of benefit for OTC Items:

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

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Does this cover all of the OTC list which may

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

: The Nicotine Replacement Therapy (NRT)

being offered does not duplicate any Part D

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES

OTC or formulary drugs.

- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE

Yes

Yes

No

No

Yes

100.00

Mandatory

Every three months

5) INCONTINENCE SUPPLIES (ADULT





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about:blank



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)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

zero dollar cost sharing.

Is authorization required?

Is a referral required?

Yes No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes



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Supplemental Benefits as a benefit under Part C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory

Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

6

Indicate setting for Nutritional/Dietary Benefit:

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

Indicate number of visits offered in addition to

Medicare:

Both Sessions (Individual and Group)

Mandatory

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

: Nursing Hotline

Mandatory

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

12

Yes

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies Coverage amount (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage

100.00

amount for Home and Bathroom Safety Devices and Modifications:

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Home and Bathroom Safety Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage

100.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

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

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

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

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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

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





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

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

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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. THE FOLLOWING ITEMS WILL BE

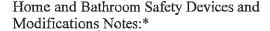
1) MEDICAL BATHMAT

- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER

COVERED:

5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.





SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

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THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

No

Education Services?

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

No

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Yes

Diabetes Self-Management Training?

Yes

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

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

: Part B to Part B? Does the benefit step from (select all that

apply):

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

Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Mandatory Select type of benefit for Restorative Services:

No, indicate number Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative 1

Services:

Other. Describe Select the Restorative Services periodicity:

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,

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics, 1

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?





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Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Plan-specified amount per period

5000.00

Every year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No No

No

Is there an enrollee Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes No

Is a referral required for Comprehensive Dental

Services?

Notes:

RESTORATIVE SERVICES:

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

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

off





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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?

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

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?
Is a referral required for Eye Exams?

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? No

No

No

No No

Yes

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Yes





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Select type of benefit for Eyeglasses (lenses and Mandatory frames): Is this benefit unlimited for Eyeglasses (lenses Yes and frames)? SECTION B: #17B EYEWEAR - BASE 3 Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Select the Maximum Plan Benefit Coverage Plan-specified amount per period type: Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 825.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: **SECTION B: #17B EYEWEAR - BASE 4** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #17B EYEWEAR - BASE 5** Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #17B EYEWEAR - BASE 6** Is authorization required? No Is a referral required for Eyewear? No **SECTION B: #18A HEARING EXAMS - BASE 1** Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: Contrato Número SECTION B: #18A HEARING EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there a service-specific Maximum Plan

Is there a service-specific Maximum Enrollee

Benefit Coverage amount?

Is there an enrollee Deductible?

Out-of-Pocket Cost?

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No

No

No

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

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

Yes

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all

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

Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears

Both ears combined

combined?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

3000.00

amount:

Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

No

No Is there an enrollee Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Yes Is authorization required? No

Is a referral required for Hearing Aids?

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

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

benefits?

No

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Select what type of benefit your SSBCI

Yes

: Additional Benefits

includes:

Are you offering a VBID Hospice Benefit?

Yes

Are you offering Part C benefits under the

Yes



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

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

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?

Yes

Type of Part C Reward or Incentive:

: Debit Card : Gift Card

20.00

Part C Reward or Incentive amount(s)

Frequency of Reward or Incentive Eligibility:

Other Description:

Other, Describe

AVAILABLE TO REDEEM INSTANTLY OR

ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT

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:

945

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

1

Type of Part C Reward or Incentive:

: Debit Card : Gift Card

Part C Reward or Incentive amount(s):

130.00

Frequency of Reward or Incentive Eligibility:

Other, Describe

Other Description:

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY OR CAN OPT TO ACCUMULATE EARNED FUNDS

M

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Eligibility Criteria:



FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY. ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and Incentives Available:

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C No

150.00

reductions in cost?

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C Yes

2

benefits?

How many packages do your Additional

Benefits contain? (1-15)

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

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Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

1569

Expected Number of Enrollees to be engaged

784

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Yes Is authorization required?

Is a referral required for Other Services? Yes

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

Notes:

THE INTENTION IS TO UTILIZE A

PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED



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FOR DETECTING TRENDS AND TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders

: Chronic heart failure

: Dementia

: Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD)

: Severe hematologic disorders

: HIV/AIDS

: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

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

Yes

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?

Specify the maximum benefit amount: 90.00





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

Notes:

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 / HOME APPLIANCES / CAR REPAIRS, TOWELS/LINENS AND CLOTHING)
- PEST CONTROL (CLEANING PRODUCTS / GARDENING AND HARDWARE ITEMS)
- SOCIAL NEEDS BENEFIT: ENTERTAINMENT (CONCERTS/THEATER/MOVIES, ETC)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE SERVICES/ITEMS

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.

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.





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

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

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Yes

Mandatory

ا ا عر

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

amount:

90.00

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 No

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

Care Manual?

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

Notes:

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?

Calact time of honofit for Food and Produce

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Yes

Mandatory

Yes

90.00

No

Other, Describe

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

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: MONTHLY ALLOWANCE.

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

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

Select type of benefit for Meals (beyond limited

basis):

Is the meal benefit unlimited?

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

Yes

Mandatory

Yes







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Indicate Maximum Plan Benefit Coverage

90.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

PACKAGE #2

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

Is there an enrollee Copayment?

Is authorization required?

No

Is a referral required for the Meals (beyond No

limited basis)?

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

Notes:

MONTHLY ALLOWANCE FOR PREPARED

FOOD.

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

Does the plan provide Pest Control as a

supplemental benefit under Part C?

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

90.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS, GARDENING / HARDWARE.

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

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Select type of benefit for Social Needs Benefit:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

90.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

MONTHLY ALLOWANCE. Notes:

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

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is a referral required for General Supports for

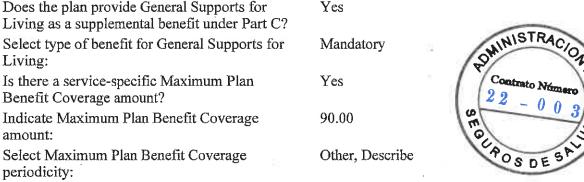
Living?

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

No

about:blank

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PACKAGE #2

Notes:

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, CAR REPAIRS, TOWELS / LINENS AND CLOTHING.

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

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

: Other 3 : Other 4

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

PET CARE

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

90.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES, ETC.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

PERSONAL CARE SERVICES

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

wit

Indicate Maximum Plan Benefit Coverage

90.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 2: PACKAGE #2**

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

Is a referral required for Other 2 Services?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #2**

Notes:



MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE SERVICES / ITEMS SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES, HAIR GROWTH AND ANTI-AGE / SPOT

CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #2**

Enter name of Service:

ROADSIDE ASSISTANCE

Select type of benefit for Other 3:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 2: PACKAGE #2**

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Is a referral required for Other 3 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #2**

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR FOR ROADSIDE ASSISTANCE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #2**

Enter name of Service:

IN-HOME MINOR REPAIRS

Select type of benefit for Other 4:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

200.00

periodicity:

Other, Describe

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 2: PACKAGE #2**

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No No

Is authorization required?

No

Is a referral required for Other 4 Services?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #2**

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8 INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR IN-HOME MINOR REPAIR SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 1: PACKAGE #2

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 2: PACKAGE #2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 4: PACKAGE #2**

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

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Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 5: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

90.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 6: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

90.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 12: PACKAGE #2**

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 14: PACKAGE #2**

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 15: PACKAGE #2**

Home and Bathroom Safety Devices and

Modifications Notes:*

MONTHLY ALLOWANCE.

THE FOLLOWING ITEMS WILL BE

COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

ITEM OUIANTITY LIMITS IN EACH CATEGORY MAY APPLY.



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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #2

5%

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19C VBID	HOSPICE-	RASE 1
- MIDA - 1 14 JIN IN: #+1 74 - V 13111		10/41/71/

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	5%

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

Indicate the Maximum Coinsurance percentage

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

Indicate the maximum per day amount 5

SECTION B: #19C VBID HOSPICE- BASE 2

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

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:

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

Is there an enrollee Coinsurance? Yes
Indicate the Minimum Coinsurance percentage 5%

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

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

Indicate the maximum per day amount

SECTION B: #19C VBID HOSPICE- BASE 3





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5%

5

Yes

3250.00

Yes

Yes

No

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

Are you offering hospice supplemental benefits? 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?

Is your In-Network Maximum Enrollee Out-of-Voluntary

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription Yes

drug (Part D) benefit?

Defined Standard Select the type of drug benefit:

Describe the components of your pharmacy : Standard Retail

network (select all that apply): : Out-of-Network : Standard Mail-Order

: Long-Term Care

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

423,154.

SECTION RX: MEDICARE RX GENERAL 2

No Does plan utilize floor pricing?

Does plan utilize ceiling pricing? No

Do you pay for over-the-counter medications

(OTCs) under the utilization management

program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply

No

*Standard Retail Cost Sharing - 3 month Supply Location/supply amount(s) that apply:



SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID

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 WISTRACIO
	Sharing 1-month supply: Enter number of days for Standard Retail Cost Sharing 3-month supply: Select all Out-of-Network Pharmacy Location/supply amount(s) that apply: Enter number of days for Out-of-Network Pharmacy 1-month supply: Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order Cost Sharing 3-month supply: Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply: Enter number of days for Long-Term Care Pharmacy 1-month supply: Are all of the drugs on your formulary available with an extended day supply? Are any of the drugs available at an extended day supply limited to a 1-month supply for the

No

wh

Model?

MMM HEALTHCARE, LLC

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4003-047





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: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 11:39:54 AM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 11:19:30 AM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 02:57:08 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 08:11:08 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02360

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Section B3 Status

Completed

Section B4 Status

Completed

Section B4 Status

Completed

Completed

Completed

Completed

Section B6 Status

Section B7 Status

Completed

Section B7 Status

Completed

Completed

Section B8 Status

Completed

Completed

Completed

Completed

Section B10 Status

Section B11 Status

Completed

Completed

Completed

Completed

Completed

Completed

Section B13 Status

Section B14 Status

Completed
Completed

Section B15 Status Completed
Section B16 Status Completed
Completed
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



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

MMM HEALTHCARE, LLC Medicare y Mucho Más www.mmmpr.com MMM Valor Platino (HMO D-SNP) Local CCP HMO Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



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

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

40710 - Utuado, PR

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR



Service Area(s):

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	047
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2022 total projected member months for this plan:	344190
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: SECTION A: SECTION A-4	(866)333-5471
·	(797)620 2306



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Customer Service Contact Local Phone Number

(787)620-2396

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for	No





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

No

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

Do any of your outpatient services have tiered

cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered

in Section B of the PBP software)

Section D of the PBP?

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

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

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Coinsurance? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

 PBP Data Report Page 6 of 35

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes

Is a referral required for Inpatient Psychiatric No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

Do you allow less than 3 day inpatient hospital Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

No

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

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

No

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No



about:blank 6/7/2021 SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Nο

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C? Select enhanced benefit:

: Worldwide Emergency Cover ANINISTRAC . Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

Yes



amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

No

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

Out-of-1 ocket cost:

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes





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Is a referral required for Home Health Services? No

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

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

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

No

No

Is there an enrollee Deductible?

No

Yes

Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Is a referral required for Occupational Therapy Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No

Indicate number of Routine Foot Care visits:

6

Select the Routine Foot Care periodicity:

Every year

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Podiatrist Services?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

Is there an enrollee Copayment?

No No

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



Yes Is authorization required? Yes Is a referral required for Other Health Care Professional Services? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Psychiatric Services? Yes SECTION B: #7I PT AND SP SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #7I PT AND SP SERVICES - BASE 2 Is authorization required? Yes Is a referral required for Physical Therapy and No

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

Do you offer an Additional Telehealth benefit

Speech-Language Pathology Services?

Yes

for Part B services?

Select the Medicare-covered benefits that may

: 7d: Physician Specialist Services

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

lee No

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

No

Telehealth Services?

Is a referral required for Additional Telehealth

No

Services? Notes:

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES

PROVIDED IN THE MULTI SPECIALTY

CLINICS.

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





No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

No Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

Is authorization required?

Is a referral required for Opioid Treatment No

Program Services?

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

Yes

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

No Is there an enrollee Deductible?

No Is there an enrollee Copayment?

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

Yes Is authorization required?

Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No

No Is there an enrollee Copayment?

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

Yes

Yes Is authorization required?

Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

No Is there an enrollee Deductible?

No Is there an enrollee Copayment?

Is authorization required for Medicare-covered Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes





	Observation Services?			
	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	E 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	E ABUSE - BASE 3		
	Is authorization required?	Yes		
1	Is a referral required for Outpatient Substance Abuse?	Yes		
I	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 SER	RVICES - BASE 2		
	Is there an enrollee Deductible?	No		
	Is there an enrollee Copayment?	·No		
	Is authorization required?	Yes		
	Is a referral required for Outpatient Blood	No		

SECTION B: #10A AMBULANCE SERVICES - BASE 1

No

No

Is there a service-specific Maximum Enrollee



Services?

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

Mandatory

related Location:

Select enhanced benefit:

Is this benefit unlimited for number of trips for

Yes

Plan Approved Health-related Location?

Select Type of Transportation for Plan

One-way

Approved Health-related Location:

: Taxi

Select Mode of Transportation for Plan

Rideshare Services

Approved Health-related Location:

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Yes

Indicate Minimum Coinsurance percentage for

20%

Medicare-covered Benefits:

Is there an enrollee Coinsurance?

Indicate Maximum Coinsurance percentage for

20%

Medicare-covered Benefits:

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

SECTION B: #11A DME - BASE 2

No

Are there preferred vendors/manufacturers for

No





Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Yes

Select which Prosthetics/Medical Supplies have

: Medicare-covered Prosthetic Devices

a Coinsurance (Select all that apply):

: 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

20%

Medicare-covered Medical Supplies:

20%

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

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

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

Is there an enrollee Copayment?

Do you limit Diabetic Supplies and Services to

No

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?





	- 11 C	: Number of Treatments	
	Select enhanced benefit:		
	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	
	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	
j	Select type of benefit for OTC Items:	Mandatory Yes RIMNISTRACION	
	Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes Contrato Número	1
	Indicate Maximum Plan Benefit Coverage amount:	100.00	1
	Select Maximum Plan Benefit Coverage periodicity:	Every three months No	-
	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	2	
	Is there an enrollee Coinsurance?	No	
	Is there an enrollee Deductible?	No	

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

No

No

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)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. 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 No

6/7/2021

MMCM should be entered in this section.

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

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

Is a referral required?

Yes No

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

Does the plan provide the Annual Physical

No

Yes

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Both Sessions (Individual and Group)

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory

Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

6

9

Indicate setting for Nutritional/Dietary Benefit:

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

Indicate number of visits offered in addition to

Medicare:

Mandatory

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

technologies and Nursing Hotline):

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

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

-

Mandatory

: Nursing Hotline

Mandatory

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

Select type of benefit for Alternative Therapies:

Mandatory



Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage

100.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Devices and Modifications:

Every three months

Devices and modifications

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

Indicate Maximum Plan Benefit Coverage

100.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A

EDUCATIONAL INTERVENTIONS BASED

HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE



April

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



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

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A OUIT 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 15

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 HIMO'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. THE FOLLOWING ITEMS WILL BE

COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT





Home and Bathroom Safety Devices and Modifications Notes:*

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

w/b



THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-covered

No

Preventive Services?

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

Is there an enrollee Coinsurance?

No

about:blank 6/7/2021

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

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

Nο

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 Yes

Does the plan offer step therapy? Does the benefit step from (select all that

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

Yes

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

1

Services:



Select the Restorative Services periodicity:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

1

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

amount:

1500.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

Notes:

RESTORATIVE SERVICES:

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

AUTHORIZATION.

PROSTHODONTIC SERVICES:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE





SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee

No

No

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.

REPAIR SERVICES, INCLUDING

SERVICES RELATED TO THE REPAIR OF

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

SECTION B: #17A	EYE	EXAMS -	BASE 2
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Is there an enrollee Coinsurance?

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 Yes supplemental benefit under Part C?

Select enhanced benefits:

: Contact lenses
: Eyeglasses (lenses and frames)

Yes

450.00

Every year

Plan-specified amount per period

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and Mandatory

Mandatory

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

frames):

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?
Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit Yes

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit Coverage amount:

Select the Combined Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

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

Is there an enrollee Coinsurance?

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)
1	Select type of benefit for Hearing Aids (all types):	Mandatory
ĺ	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	Contrato Número
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No 22 - 0 0 3
	Is there an enrollee Coinsurance?	No Post Sh

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

Yes Is authorization required? Is a referral required for Hearing Aids? No

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

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

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically Ill?

: Additional Benefits Select what type of benefit your SSBCI

includes:

Are you offering a VBID Hospice Benefit? Yes Are you offering Part C benefits under the Yes

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

Section Rx)

In addition to wellness and health care planning, what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

No

: I attest that Value-Based Insurance Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or more):

: Telephonic : In-Person : Web-Based

Yes

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

: Debit Card Type of Part C Reward or Incentive:

Part C Reward or Incentive amount(s)

Frequency of Reward or Incentive Eligibility:

Other Description:

: Gift Card 20.00

Other, Describe

AVAILABLE TO REDEEM INSTANTLY OR

ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT

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.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

220

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

Part C Reward or Incentive amount(s): Frequency of Reward or Incentive Eligibility:

Other Description:

Eligibility Criteria:

: Debit Card

: Gift Card

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO

RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT

ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE

EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR

LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN,



SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

150.00

Incentives Available:

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

476

Expected Number of Enrollees to be engaged

238

and receive Model benefits:

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

INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

(OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

6/7/2021

about:blank

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

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

Notes:



THE INTENTION IS TO UTILIZE A
PROFESSIONAL CONTINUOUS GLUCOSE
MONITORING (CGM) DEVICE INDICATED
FOR DETECTING TRENDS AND
TRACKING PATTERNS AND GLUCOSE
LEVEL EXCURSIONS ABOVE OR BELOW
THE DESIRED RANGE, FACILITATING
THERAPY ADJUSTMENTS IN PERSONS
(AGE 18 AND OLDER) WITH DIABETES.
THE SYSTEM IS INTENDED FOR USE BY

HEALTH CARE PROFESSIONALS.

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit apply? (Select all that apply):

- : Chronic alcohol and other drug dependence
- : Autoimmune disorders
- : Cancer
- : Cardiovascular disorders : Chronic heart failure
- : Dementia
- : Diabetes
- : End-stage liver disease
- End-stage renal disease (ESRD)
- : Severe hematologic disorders
- : HIV/AIDS
- : Chronic lung disorders
- : Chronic and disabling mental health conditions
- : Neurologic disorders
- : Stroke

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

Is there a prerequisite for any additional benefits No

about:blank 6/7/2021

OSDE

for this package?

Select all the Non-Medicare-covered additional

: 13i-O: Non-Primarily Health Related Benefits

benefits offered in this package:

for the Chronically Ill (Other)

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

Nο

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:

WE WILL OFFER ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIR SERVICES.

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

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #2**

Enter name of Service:

ROADSIDE ASSISTANCE

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED **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 Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #2**

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR FOR

ROADSIDE ASSISTANCE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #2**

Enter name of Service:

IN-HOME MINOR REPAIRS

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

6/7/2021 about:blank

	Indicate Maximum Plan Benefit Coverage amount:	200.00
	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 OTHE BENEFIT - BASE 2: PACKAGE #2	R 2 NON-PRIMARILY HEALTH RELATED
	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 Other 2 Services?	No
	SECTION B: VBID/UF/SSBCI 19B #13I OTHE	R 2 NON-PRIMARILY HEALTH RELATED
	BENEFIT - BASE 3: PACKAGE #2	
	Notes:	MEMBER WILL BE ELIGIBLE FOR UP TO 8 INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR INHOME MINOR REPAIR SERVICES.
	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%
1	Indicate the maximum per drug amount	5
,	Is there an enrollee Copayment?	No
Man.	Is there an enrollee Coinsurance?	Yes 5% SHIMISTRACION
	Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	Contrato Número
	Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5% 22 - 0 0 3 or
	Indicate the maximum per day amount SECTION B: #19C VBID HOSPICE- BASE 2	5 OUROS DE SP
	Is there an enrollee Coinsurance?	Yes

5%

5%



drugs and biologics:

drugs and biologics:

Indicate the Minimum Coinsurance percentage

for Medicare covered Benefits for prescription

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription

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
SECTION B: #19C VBID HOSPICE- BASE 3	•
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)
Is there an In-Network Maximum Enrollee Out- of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Non- Medicare-covered plan services?	Yes
SECTION D: REDUCTIONS IN COST SHARI	NG - GENERAL No
Do you offer Reductions in Cost Sharing?	No PAI
SECTION D: COMBINED BENEFITS - GENE	RAL Contrato Número
Do you offer Combined Supplemental Benefits with uniform cost sharing?	No 22 - 0 0 3
SECTION RX: MEDICARE RX GENERAL 1	100
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes Yes
Select the type of drug benefit:	Defined Standard
	Gr. 1 1 D -4-11

: Standard Retail : Out-of-Network

: Standard Mail-Order Long-Term Care



Describe the components of your pharmacy

network (select all that apply):

program?

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

No Does plan utilize floor pricing? No Does plan utilize ceiling pricing? Do you pay for over-the-counter medications (OTCs) under the utilization management.

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing 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

30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

90

Sharing 3-month supply:

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

Enter number of days for Out-of-Network

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

No

first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No



MMM HEALTHCARE, LLC

APPENDIX C-1
PLAN BENEFIT PACKAGE (PBP)
H4003-049





Page 1 of 35

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: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 11:41:10 AM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 02:51:18 PM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 02:57:06 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 08:11:08 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02360

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Section B7 Status

Completed

Section B7 Status

Section B8 Status

Completed
Section B9 Status

Completed
Section B10 Status

Completed
Section B11 Status

Completed
Section B12 Status

Completed
Section B13 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



about:blank 6/8/2021

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

Medicare y Mucho Más www.mmmpr.com MMM Grande Platino (HMO D-SNP) Local CCP HMO Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

MMM HEALTHCARE, LLC



of

Service Area(s):

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

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

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



.

Service Area(s):

	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4003	
Plan ID:	049	
Segment ID:	0	
Contract Period:	2022	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Indicate CY2022 total projected member months for this plan:	46939	
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	DAINISTRA
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	Contrato No
Customer Service Contact Local Phone Number	(787)620-2396	log l

(866)333-5471

SECTION A: SECTION A-4

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

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number (787)620-2396



for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-AC	CUTE - BASE 1

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

No

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

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Does this plan's Medicare-covered benefit cost No

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

Is there an enrollee Coinsurance?

No

SECTION B: #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

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





period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

No

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

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

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

No

obtains care?

No

Is there an enrollee Coinsurance?

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

No Is there an enrollee Deductible?

No Is there an enrollee Copayment?

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

What is your Inpatient Hospital Psychiatric benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

discharge?

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

No

C?

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

Yes

Indicate the Number of Hospital Days Required

Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

Is there an enrollee Coinsurance?

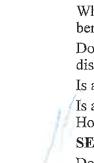
No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No





Contrato Número

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

Yes



amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

500.00

No

amount:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes
Is a referral required for Partial Hospitalization? Yes
SECTION B: #6 HOME HEALTH SERVICES - BASE 1

ble Hold B. Wo Holds Health blit Tollo

Is there a service-specific Maximum Enrollee N

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes

west -



Is a referral required for Home Health Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



29h

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

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

Is there an enrollee Copayment? No

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



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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

No

Yes

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Psychiatric Services? Yes
SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

Notes: ADDITIONAL TELEHEALTH SERVICES

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

: 7d: Physician Specialist Services

CLINICS.

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





Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Is authorization required?

Is a referral required for Opioid Treatment No

Program Services?

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

Nο

Yes

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Is authorization required? Yes

Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment? No

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

Yes

Is authorization required?

Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

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

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes





Observation Services?

Observation Services:	
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	E ARI



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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

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

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

 \mathbb{C} ?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible? No No

Is there an enrollee Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3 Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location Select enhanced benefit:

Yes

No

12

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

Every year

Select Plan Approved Health-related Location Trips periodicity:

Select Type of Transportation for Plan

Approved Health-related Location:

One-way

Select Mode of Transportation for Plan : Taxi

: Rideshare Services Approved Health-related Location:

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for

0%

Medicare-covered Benefits:

20% Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits:



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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

No

10%

10%

10%

Bed 5%, DME Power Wheelchair 20%, All

: Medicare-covered Medical Supplies

other DME 0%

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is there an enrollee Copayment?

Do you limit Diabetic Supplies and Services to No

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No





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SECTION B: #12	DIALYSIS	SERVICES -	BASE 2
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Yes Is authorization required? 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:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

Yes

Indicate Maximum Plan Benefit Coverage

amount:

50.00

Select Maximum Plan Benefit Coverage periodicity:

Every three months

Does your Maximum Plan Benefit Coverage

unused?

No

Is there a service-specific Maximum Enrollee

amount carry forward to the next period if it is

Out-of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

SECTION B: #13B OTC ITEMS - BASE 2

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

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

Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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

No

No

No

No



THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING

SPECIFICALLY MONITOR BLOOD





PRESSURE

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

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)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section. No

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Yes

Is authorization required? Is a referral required?

No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

NA D



: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

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

Both Sessions (Individual and Group)

Mandatory

Indicate number of visits offered in addition to

Medicare:

9

6

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

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

12

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices 50.00

and Modifications:

Select Maximum Plan Benefit Coverage

Every three months

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periodicity for Home and Bathroom Safety

Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage

50.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:

Every three months

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No No

Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

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

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

EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

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

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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR, OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A **OUIT 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 15

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

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Remote Access Technologies (Nursing Hotline) Notes:

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Home and Bathroom Safety Devices and Modifications Notes:*

NURSING HOTLINE, FACILITATE ACCES TO THE PLAN'S WEBSITE FOR IMPORTANT INFORMATION, FACILITATE ACCESS TO THE PLAN'S SOCIAL MEDIA IN WHICH PREVENTIVE AND EDUCATIONAL STRATEGIES ARE DISTRIBUTED, ETC. MEMBER CAN USE THE SMARTPHONE AS LONG AS THEY ARE ENROLLED IN THE PLAN. MEMBER WILL HAVE TO RETURN THE SMARTHPHONE TO THE PLAN IN CASE OF DISENROLLMENT OR CHANGE IN PLAN COVERAGE.

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

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT

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- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.



Is there a service-specific Maximum Enrollee

 $0 \ 0$

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No Yes

Is authorization required?

ът

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 No

Preventive Services?

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

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Is there an enrollee Coinsurance?

Νo

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Yes

Diabetes Self-Management Training?

Yes

Is authorization required for Medicare-covered Barium Enemas?

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost? -

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

1



Services:

Select the Restorative Services periodicity:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

1

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

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?

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

- 0 0

POSDE

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:	200.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	NSTRACIO
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No POMINISTRACION DE
Is there an enrollee Coinsurance?	No Contrato Número 2 - 0 0 3
SECTION B: #17B EYEWEAR - BASE 5	(p) 2 - 0 3 Q
Is there an enrollee Deductible?	N. (9)
Is there an enrollee Copayment?	No POSDE 3F
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



: Fitting/Evaluation for Hearing Aid Select enhanced benefits: Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? 1 Indicate number for Fitting/Evaluation for Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** No Is there a service-specific Maximum Plan Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #18A HEARING EXAMS - BASE 3 No Is there an enrollee Copayment? Yes Is authorization required? Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? Select enhanced benefits: : Hearing Aids (all types) Select type of benefit for Hearing Aids (all Mandatory types): Is this benefit unlimited for Hearing Aids (all Yes types)? SECTION B: #18B HEARING AIDS - BASE 2 Yes Is there a service-specific Maximum Plan Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined Amount apply per ear or for both ears combined? Select the Maximum Plan Benefit Coverage Plan-specified amount per period type: Indicate Maximum Plan Benefit Coverage 100.00 amount: Indicate Maximum Plan Benefit Coverage Every year periodicity: **SECTION B: #18B HEARING AIDS - BASE 3** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No

wh

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SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

Yes Is authorization required? No Is a referral required for Hearing Aids?

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

Does your plan include MA Uniformity No Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

: Additional Benefits Select what type of benefit your SSBCI

includes:

Yes 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)

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

: Medicare Advantage Rewards and Incentives

Programs

Yes

: Cash or Monetary Rebates

: I attest that Value-Based Insurance Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

: Telephonic WHP Mode of Engagement (choose one or

more):

: In-Person : Web-Based

Yes

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

WHP Services?

Type of Part C Reward or Incentive:

: Debit Card : Gift Card

20.00 Part C Reward or Incentive amount(s)

Other, Describe

Frequency of Reward or Incentive Eligibility:

Other Description:

AVAILABLE TO REDEEM INSTANTLY OR

ACCUMULATE FOR FUTURE

REDEMPTION, ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT

Does your organization offer provider

incentives for offering or engaging beneficiaries

No



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in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

23

1

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other Description:

Eligibility Criteria:



: Debit Card : Gift Card

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION

CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS

(ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO

RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY

(MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT

ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE

EXCLUDED: ESRD (RECEIVING

DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE,



HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

Incentives Available:

150.00

SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or Monetary Rebates:

: Debit Card/Check

Cash or Monetary Rebates amount per month:

145.00

Maximum Annual Cash or Monetary Rebates

1740.00

available:

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

81

Expected Number of Enrollees to be engaged

40

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

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Are you offering retroactive reimbursement?

Is there a maximum benefit amount? No

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

No

NEW AND INNOVATIVE TECHNOLOGIES Notes:

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

NEW AND INNOVATIVE TECHNOLOGIES Enter name of Service (Optional):

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Νo

No

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

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

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

Notes: THE INTENTION IS TO UTILIZE A

> PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY

HEALTH CARE PROFESSIONALS.

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit

apply? (Select all that apply):

- : Chronic alcohol and other drug dependence
- : Autoimmune disorders
- : Cancer
- : Cardiovascular disorders
- : Chronic heart failure
- : Dementia
- : Diabetes
- : End-stage liver disease
- : End-stage renal disease (ESRD)
- : Severe hematologic disorders
- : HIV/AIDS





: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

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

Is there a prerequisite for any additional benefits

Νo

for this package?

Select all the Non-Medicare-covered additional

: 13i-O: Non-Primarily Health Related Benefits

benefits offered in this package:

for the Chronically Ill (Other)

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

WE WILL OFFER ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIR SERVICES.

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

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically III includes:

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

ROADSIDE ASSISTANCE

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEADER BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No



SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8 INDIVIDUAL EVENTS A YEAR FOR

6/8/2021

ROADSIDE ASSISTANCE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

IN-HOME MINOR REPAIRS

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

200.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 2 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

5%

5%

5

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8 INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR INHOME MINOR REPAIR SERVICES.

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:

Yes

5%

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:

drugs and biologics:
Indicate the maximum per drug amount 5

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

Yes

Indicate the Minimum Coinsurance percentage

5%

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

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

Indicate the maximum per day amount

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
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-	Yes

of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Do you offer Reductions in Cost Sharing?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1



Does your plan offer a Medicare Prescription Yes drug (Part D) benefit? Select the type of drug benefit: Defined Standard : Standard Retail Describe the components of your pharmacy : Out-of-Network network (select all that apply): : Standard Mail-Order . Long-Term Care : Sponsor attests that it will comply with 42 Sponsor attests that it will comply with 42 CFR 423.154. CFR 423.154. SECTION RX: MEDICARE RX GENERAL 2 Does plan utilize floor pricing? No No Does plan utilize ceiling pricing? Do you pay for over-the-counter medications No (OTCs) under the utilization management program? SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply. Location/supply amount(s) that apply: : Standard Retail Cost Sharing - 3 month Supply Enter number of days for Standard Retail Cost 30 Sharing 1-month supply: Enter number of days for Standard Retail Cost 90 Sharing 3-month supply: Select all Out-of-Network Pharmacy : Out-of-Network Pharmacy = one month supply Location/supply amount(s) that apply: Enter number of days for Out-of-Network 30 Pharmacy 1-month supply: Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order 90

Cost Sharing 3-month supply:

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

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

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

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

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

: Standard Mail-Order - 3-month supply

: Long-Term Care Pharmacy - 1-month supply

No

31

No

No



MMM HEALTHCARE, LLC

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4004-048





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, SEGMENT 0

Module: PBP Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 11:43:49 AM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 07:04:00 PM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 07:13:18 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 08:11:08 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02360

PLAN STATUS

Section A Status Plan Ready for Upload

Completed Section B1 Status Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Completed Section B10 Status Section B11 Status Completed

Section B12 StatusCompletedSection B13 StatusCompletedSection B14 StatusCompletedSection B15 StatusCompleted

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

April



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MMM HEALTHCARE, LLC Organization Legal Name: Organization Marketing Name: PMC Medicare Choice Organization Web Site: www.mmmpr.com PMC Premier Platino (HMO D-SNP) Plan Name: Local CCP Organization Type: HMO Plan Type: Enrollee Type: Part A and Part B 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): Service Area(s): 40060 - Anasco, PR 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR Service Area(s): Service Area(s): 40090 - Barceloneta, PR 40100 - Barranquitas, PR Service Area(s): Service Area(s): 40110 - Bayamon, PR 40120 - Cabo Rojo, PR Service Area(s): 40130 - Caguas, PR Service Area(s): Service Area(s): 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR



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

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6/8/2021 about:blank

40300 - Guaynabo, PR

40310 - Gurabo, PR 40320 - Hatillo, PR

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Service Area(s):

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1	Service Area(s):

Service Area(s):

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

> 40700 - Trujillo Alto, PR 40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR



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	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	048
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2022 total projected member months for this plan:	103935
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



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(787)620-2396

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard hid for	No



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

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



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

No

No

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

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

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

No

Is there an enrollee Coinsurance? No

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

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

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

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

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period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

obtains care?

No

No

Is there an enrollee Coinsurance? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

No

Do you charge cost sharing on the day of discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

Yes Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Indicate the Number of Hospital Days Required

Zero

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

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

No

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No



SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

No

Yes

Mandatory

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

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage Yes





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amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit No

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes

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Is a referral required for Home Health Services? No

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

Ves

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

Yes
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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Is authorization required? Yes Is a referral required for Other Health Care Yes Professional Services? SECTION B: #7H PSYCHIATRIC SERVICES ~ BASE 1 Is there a service-specific Maximum Enrollee Νo Out-of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3 Yes Is authorization required? Is a referral required for Psychiatric Services? Yes SECTION B: #71 PT AND SP SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Νo Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2

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

Do you offer an Additional Telehealth benefit

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

for Part B services?

Is authorization required?

Yes

No

Yes No

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

: 7d: Physician Specialist Services

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

Telehealth Services?

No

Is a referral required for Additional Telehealth

Services?

No

Notes: ADDITIONAL TELEHEALTH SERVICES

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes





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Observation Services?	
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 SUBSTANC	E ABUSE - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B. #9C OUTPATIENT SUBSTANC	E ABUSE - BASE 2



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

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

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

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

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

Services as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Does the plan provide Outpatient Blood

No

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No



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No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

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:

Select enhanced benefit:

24

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

One-way

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

No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

Are there preferred vendors/manufacturers for

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

No



Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is there an enrollee Copayment?

No
Do you limit Diabetic Supplies and Services to
No

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00





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amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?

Is a referral required for Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Every year

No

No No

No

Yes

Yes

Yes

Mandatory

Yes

200.00

Every month

No

No

Yes

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

No No

No

No

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS



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THAT ALLEVIATE SYMPTOMS

- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE

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

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

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Select type of benefit for Meals:

Select the type of primarily health related meals benefit offered:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

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

Yes

Mandatory

: Immediately following surgery or inpatient hospitilization

No

No

No No

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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: #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 No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

Contrato Número

- 0 0

C?

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

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

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

Hotline)*

Yes

: 14c8: Home and Bathroom Safety Devices and

Modifications*

Mandatory

Mandatory

: 14c17: Alternative Therapies*

Select type of benefit for Health Education:

POSDE

Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Additional Sessions of

Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Remote Access Technologies (including Web/Phone-based No, indicate number

6

Both Sessions (Individual and Group)

Mandatory

9

Mandatory

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

: Nursing Hotline

offered (Select all that apply):

Select type of benefit for Home and Bathroom

Mandatory

Safety Devices and Modifications:

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Modifications

Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage

200.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Devices and Modifications:

Other, Describe

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

Indicate Maximum Plan Benefit Coverage

200.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

DAY

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OSDE

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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

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SERVICES TO HELP THEM ESTABLISH A OUIT 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 15

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.

Home and Bathroom Safety Devices and Modifications Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.



Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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?

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

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

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

Is there an enrollee Copayment? No

Is authorization required for Medicare-covered Yes

Glaucoma Screening?

Is authorization required for Medicare-covered Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Yes

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

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

Yes

Is a referral required for any Services?

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

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

SECTION R: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Yes

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

Prosthodontics, Other Oral/Maxillofacial

OPE



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No

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

1

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics.

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

1

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

ype

Indicate Maximum Plan Benefit Coverage

3000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes:

RESTORATIVE SERVICES:

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

D'AL



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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

THE MAXIMUM PLAN BENEFIT

AUTHORIZATION.

WHO





COVERAGE AMOUNT WILL APPLY FOR
ALL COMPREHENSIVE SERVICES.

SECTION B: #17A EYE EXAMS - BASE 1

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

Yes

No

No

: Contact lenses

Eyeglasses (lenses and frames)

Select type of benefit for Contact lenses: Mandatory

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

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

Yes

Yes

Mandatory

SECTION B: #17B EYEWEAR - BASE 3

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

Select the Maximum Plan Benefit Coverage

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17B EYEWEAR - BASE 5

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

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 6

Yes

Plan-specified amount per period

Yes

600.00

Every year

No

No

No

No



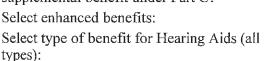




Is authorization required? No Is a referral required for Eyewear? No SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #18A HEARING EXAMS - BASE 3 Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C?







Is this benefit unlimited for Hearing Aids (all

Yes

Mandatory

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 Both ears combined

: Hearing Aids (all types)

combined?
Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

types)?

Indicate Maximum Plan Benefit Coverage

2500.00

amount:

Indicate Maximum Plan Benefit Coverage

Every year

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periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? Yes
Is a referral required for Hearing Aids? No

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

Does your plan include MA Uniformity No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically III?

Select what type of benefit your SSBCI : Additional Benefits

includes:

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the Yes

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

Section (XX)

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

: Medicare Advantage Rewards and Incentives

Programs

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?

Yes

Type of Part C Reward or Incentive: : Debit Card : Gift Card

Part C Reward or Incentive amount(s) 20.00

Frequency of Reward or Incentive Eligibility: Other, Describe

Other Description: AVAILABLE TO REDEEM INSTANTLY OR

web

about:blank

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ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

Expected Number of Beneficiaries to be Engaged Annually:

: Electronic Health Records/Electronic Medical Records

: Provider/Patient portals

923

No

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

Part C Reward or Incentive amount(s): Frequency of Reward or Incentive Eligibility:

Other Description:

: Debit Card

: Gift Card

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT

ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE

Eligibility Criteria:



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EXCLUDED: ESRD (RECEIVING

DIALYSIS), ALZHEIMER'S (SEVERE OR

LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

DMINISTRAC/C

Maximum Annual Part C Rewards and

Incentives Available:

150.00

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

both:

: Chronic Condition(s)

Which disease states does this benefit apply?

(Select all that apply):

: Diabetes

Expected Number of Enrollees to be Targeted: 152 Expected Number of Enrollees to be engaged 76

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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





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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: NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional): NEW AND INNOVATIVE TECHNOLOGIES

No

No

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

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

Notes: THE INTENTION IS TO UTILIZE A

PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY

HEALTH CARE PROFESSIONALS.

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit

To which chromic condition does mis bene

apply? (Select all that apply):

about:blank

- : Chronic alcohol and other drug dependence
- : Autoimmune disorders
- : Cancer
- : Cardiovascular disorders
- : Chronic heart failure
- : Dementia
- : Diabetes
- : End-stage liver disease
- : End-stage renal disease (ESRD)
- : Severe hematologic disorders
- : HIV/AIDS



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: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

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?

Ν̈́ο

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement? No
Is there a maximum benefit amount? Yes
Specify the maximum benefit amount: 50.00

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

Notes:

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 / HOME

APPLIANCES / CAR REPAIRS,

TOWELS/LINENS AND CLOTHING)

- PEST CONTROL (CLEANING

PRODUCTS / GARDENING AND

HARDWARE ITEMS)

- SOCIAL NEEDS BENEFIT:

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS

- ALTERNATIVE THERAPIES

(HOMEOPATHIC / NATURAL MEDICINE

ITEMS ONLY)

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- HOME AND BATHROOM SAFETY DEVICES

- PET CARE
- PERSONAL CARE SERVICES/ITEMS

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.

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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

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

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:
Does your Maximum Plan Benefit Coverage

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

No

No

Every month

Yes

Yes

apy (NRT) : 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?

Is there an enrollee Copayment?

No
Does this cover all of the OTC list which may

No

be found in Chapter 4 of the Medicare Managed

Care Manual?

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

who

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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: 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:

OMINISTRACIO

: Food and Produce

: Meals (beyond limited basis)

Pest Control

: Social Needs Benefit

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No



Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

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: MONTHLY ALLOWANCE

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

Mandatory

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

Select type of benefit for Meals (beyond limited

basis):

Is the meal benefit unlimited? No
Is there a service-specific Maximum Plan
Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for the Meals (beyond limited basis)?

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

Notes: 2 MEALS PER DAY, FOR 10 DAYS, UP TO 1

TIME PER YEAR, FOR 20 MEALS MAX PER

YEAR.

ALSO INCLUDES A MONTHLY

ALLOWANCE FOR THE PURCHASE OF PREPARED FOOD / ADDITIONAL MEALS.

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

wat

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

No 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:

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS, GARDENING / HARDWARE.

SDESP

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

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment? 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:

MONTHLY ALLOWANCE.

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

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Yes

Mandatory

Does the plan provide General Supports for

Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for
No

Living?

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

Notes: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, CAR REPAIRS, TOWELS /

S

SDES

LINENS AND CLOTHING.

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

Select what Other type of benefit your Non-Primarily Health Related Benefits for the : Other 2 Chronically Ill includes: : Other 3 : Other 4

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: PET CARE
Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?





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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED **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 Other 1 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

> UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES. SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES, ETC.

> > Contrato Número

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: PERSONAL CARE SERVICES

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Other, Describe Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED 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 Other 2 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

> UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE SERVICES / ITEMS SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES, HAIR

GROWTH AND ANTI-AGE / SPOT

CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED

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BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: ROADSIDE ASSISTANCE

Select type of benefit for Other 3: Mandatory

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 3 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR FOR ROADSIDE ASSISTANCE SERVICES.

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: IN-HOME MINOR REPAIRS

Select type of benefit for Other 4: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 4 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR INHOME MINOR REPAIR SERVICES.





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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Yes

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BI BASE 5: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

50.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Other, Describe

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

50.00

amount for Alternative Thérapies:

Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:

Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

No

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



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BASE 12: PACKAGE #2

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #2

Is authorization required? No
Is a referral required for Other Defined No
Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #2

Home and Bathroom Safety Devices and Modifications Notes:*

MONTHLY ALLOWANCE.

THE FOLLOWING ITEMS WILL BE COVERED:

1) MEDICAL BATHMAT 2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

4) REACHER 5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #2

Alternative Therapies Notes:* MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19C VBID HOSPICE- BASE 1

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

for Medicare covered Benefits for a respite care



April

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	day:		
	Indicate the maximum per day amount	5	
	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	
	SECTION B: #19C VBID HOSPICE- BASE 3	No ADMINISTA	
	Are you offering hospice supplemental benefits?	No RDI	
	SECTION C: V/T - GENERAL - US	Contrato No	
	Do you offer a US Visitor/Travel Program?	No ω	
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)	
	Is there an In-Network Plan Deductible?	No	
Is there an In-Network Plan Deductible? SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK) Is there on In Network Maximum Envelles Out.			
	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	
	AND AND ARROW IN CONTROL AND ARROWS AND ARRO	and the state of t	

about:blank 6/8/2021

No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Reductions in Cost Sharing?

benefits

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Do you offer Combined Supplemental Benefits No with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription Yes

drug (Part D) benefit?

Select the type of drug benefit:

Defined Standard

: Standard Retail

network (select all that apply):

: Out-of-Network

: Standard Mail-Order

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

Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

No
Do you pay for over-the-counter medications
(OTCs) under the utilization management

program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

CFR 423.154.

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost 90 Sharing 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy 1-month supply:

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

Enter number of days for Standard Mail-Order 90
Cost Sharing 3-month supply:

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

Enter number of days for Long-Term Care 31 Pharmacy 1-month supply:

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

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

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID

No

No



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MMM HEALTHCARE, LLC

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4004-061

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 061, SEGMENT 0

Module: PBP Requested By: mjnt

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 11:45:25 AM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 11:19:22 AM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 02:57:00 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 08:11:08 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02360

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

Section B11 Status

Section B12 Status

Section B13 Status

Completed

Completed

Completed

Completed

Completed

Section B13 Status

Completed

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

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

MMM HEALTHCARE, LLC PMC Medicare Choice www.mmmpr.com MMM Relax Platino (HMO D-SNP) Local CCP HMO Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR





Service Area(s):

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

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

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



Service Area(s):

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	061
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	**
Indicate CY2022 total projected member months for this plan:	288814
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	(787)620-2396



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(866)333-5471

(787)620-2396

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

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number

SECTION A: SECTION A-4

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	



Is your organization filing a standard bid for

Section B of the PBP?

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

SECTION A: SECTION A-6

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

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered

in Section B of the PBP software)

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

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

No

No

No

No

No

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

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

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

Is there an enrollee Coinsurance? No

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

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

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

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



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period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

Is authorization required?

No

discharge?

Yes

No

Is a referral required for Inpatient Psychiatric Hospital Services?

SECTION B: #2 SNF - BASE 1

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

No

C?

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

Zero

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

No

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

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No





SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

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

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage : Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

Yes

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amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

No

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes
Is a referral required for Partial Hospitalization? Yes
SECTION B: #6 HOME HEALTH SERVICES - BASE 1

SECTION D: #0 HOME BEALTH SERVICES - DASE

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes





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Is a referral required for Home Health Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care

Yes

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select enhanced benefit:

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

Yes
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Occupational Therapy Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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



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No

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Psychiatric Services? Yes SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may

: 7d: Physician Specialist Services

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

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

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

ADDITIONAL TELEHEALTH SERVICES Notes:

> COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS.

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





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Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? Yes

Is a referral required for Opioid Treatment No

Program Services?

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

Is there a service-specific Maximum Enrollee Nο

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? Nο

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

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

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

Is authorization required? Yes

Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? Yes

Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Is authorization required for Medicare-covered

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes





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Observation Services?		
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	No	

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

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

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

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

Mandatory

related Location:

Select enhanced benefit:

Is this benefit unlimited for number of trips for

Yes

Plan Approved Health-related Location?

Select Type of Transportation for Plan

One-way

Approved Health-related Location:

Select Mode of Transportation for Plan

: Taxi

Approved Health-related Location:

: Rideshare Services

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required? Yes Is a referral required for Transportation

Services?

No

No

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No





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Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Bed 0%, DME Power Wheelchair 10%, All

other DME 0%

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

a Coinsurance (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 0%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for 0%

Medicare-covered Medical Supplies:

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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



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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

Mandatory

Treatments:

Is this benefit unlimited for Number of

No

6

Treatments?

Indicate limit for Number of Treatments:

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

500.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Acupuncture?

Yes

SECTION B: #13B OTC ITEMS - BASE 1

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

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 60.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every three months

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

unused?

No

Yes

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

DES

OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2



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

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

No

No

No

No

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE

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

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

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.



Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C?

No

Mele





Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

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 No Is a referral required?

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

Does the plan provide the Annual Physical

No

Yes

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit: Select type of benefit for Additional Sessions of

Smoking and Tobacco Cessation Counseling: Indicate number of visits offered in addition to

Medicare:

Both Sessions (Individual and Group)

Mandatory

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

technologies and Nursing Hotline): Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

9

Mandatory

: Nursing Hotline

Mandatory





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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

12 Indicate number of visits offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

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

Supplemental Benefits?

Select which Other Defined Supplemental : 14c8: Home and Bathroom Safety Devices and

Modifications Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply): : 14c17: Alternative Therapies

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

60.00 Indicate Maximum Plan Benefit Coverage

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage Every three months

periodicity for Home and Bathroom Safety

Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage .60.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage Every three months

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance? No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

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

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

Is authorization required? No

Is a referral required for Other Defined Νo Supplemental Benefits?

Health Education Notes: THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION

TO PROVIDE HEALTH INFORMATION





April

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

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

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

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. THE FOLLOWING ITEMS WILL BE

COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT



Home and Bathroom Safety Devices and Modifications Notes:*

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- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.



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 No

Education Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

Is there an enrollee Copayment? No

Is authorization required for Medicare-covered Yes

Glaucoma Screening?

Is authorization required for Medicare-covered Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Yes

Barium Enemas?

Is authorization required for Medicare-covered Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

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

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance? No

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

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

Does the benefit step from (select all that : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion No

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Mandatory

Yes

No, indicate number

Services?

Indicate number of visits for Restorative 1



about:blank

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Services:

Select the Restorative Services periodicity:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

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

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

amount:

2500.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

No SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental

Services?

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,



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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

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.

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

REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER

CROWNS REQUIRE PRE AUTHORIZATION.

	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:	600.00
	Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
	SECTION B: #17B EYEWEAR - BASE 4	Co
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No (22
	Is there an enrollee Coinsurance?	No
	SECTION B: #17B EYEWEAR - BASE 5	No No
	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



about:blank

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Select enhanced benefits: : Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

1

No

No

Yes

Yes

Yes

Mandatory

Both ears combined

Plan-specified amount per period

Mandatory

No, indicate number

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all

types):

Is this benefit unlimited for Hearing Aids (all

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

periodicity:

Indicate Maximum Plan Benefit Coverage Every three years

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

600.00

No





about:blank

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

Is there an enrollee Deductible? No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? Is a referral required for Hearing Aids? No

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

Does your plan include MA Uniformity

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically III?

Select what type of benefit your SSBCI

includes:

Are you offering a VBID Hospice Benefit?

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

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Reduced Cost Sharing

: Additional Benefits

: Medicare Advantage Rewards and Incentives

Programs

No

Yes

No

Yes

Yes

Yes

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?

Yes

Type of Part C Reward or Incentive:

: Debit Card

: Gift Card

Part C Reward or Incentive amount(s)

20.00

Frequency of Reward or Incentive Eligibility:

Other, Describe

Other Description: AVAILABLE TO REDEEM INSTANTLY OR

ACCUMULATE FOR FUTURE

REDEMPTION, ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

No





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Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

201

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other Description:

Eligibility Criteria:

: Debit Card : Gift Card

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION

WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING

HEALTH CARE STAGES WILL BE **EXCLUDED: ESRD (RECEIVING**

DIALYSIS), ALZHEIMER'S (SEVERE OR

LATE STAGE), ACTIVE CANCER (RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN,



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> SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

150.00

Incentives Available:

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

Does your VBID/MA Uniformity

Yes

1

Flexibility/SSBCI benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

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

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

Is this package applicable to VBID, MA

SSBCI

Uniformity Flexibility or SSBCI?

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

CONDITIONS: SSBCI: PACKAGE #1

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders

: Chronic heart failure

: Dementia

: Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD)

: Severe hematologic disorders

: HIV/AIDS

Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

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

Is there a prerequisite for reduction of cost

No

sharing for this package?

Select the benefits that apply to reduced cost

: Medicare-covered benefits

sharing:

Select the Medicare-covered benefits that will

: 11a: Durable Medical Equipment (DME)

receive reduced cost sharing:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Do you offer reduced Coinsurance?

Yes





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Select the types of benefits that apply to the

coinsurance cost sharing:

: Medicare-covered benefits

Select the Medicare-covered benefits that will

: 11a: Durable Medical Equipment (DME)

receive reduced coinsurance:

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

Indicate Minimum Coinsurance Percentage for

0%

Durable Medical Equipment (DME)

Indicate Maximum Coinsurance Percentage for

0%

Durable Medical Equipment (DME)

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

Do you offer a reduced deductible amount?

No

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

Do you offer reduced Copayment?

No

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

Are you offering retroactive reimbursement?

No

Is there a maximum aggregate amount of

Yes

reduced cost sharing?

Specify the maximum aggregate amount of

75.00

reduced cost sharing:

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

#1

Notes:



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.

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:



Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

486

Expected Number of Enrollees to be engaged

243

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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 #1

Notes:

THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE

MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES.

THE SYSTEM IS INTENDED FOR USE BY



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HEALTH CARE PROFESSIONALS.

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders : Chronic heart failure

: Dementia

Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD)

: Severe hematologic disorders

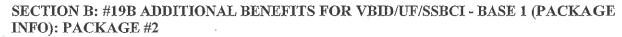
: HIV/AIDS

: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke



Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

Yes

Specify the maximum benefit amount:

75.00

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

Notes:

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

APU

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PACKAGES IN CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / CAR REPAIRS, TOWELS/LINENS AND CLOTHING)
- PEST CONTROL (CLEANING PRODUCTS / GARDENING AND
- HARDWARE ITEMS)
- SOCIAL NEEDS BENEFIT: ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES
- (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE SERVICES/ITEMS

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.

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.



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

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

Mandatory

Yes

75.00

Every month

No

of





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unused?

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?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Does this cover all of the OTC list which may
be found in Chapter 4 of the Medicare Managed

Care Manual?

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

Notes:

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 TESTI NG 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

Ab.



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:

Is there a service-specific Maximum Plan

Yes

Mandatory

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

75.00

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: MONTHLY ALLOWANCE.

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

Does the plan provide Meals (beyond limited

basis) as a supplemental benefit under Part C?

Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

Is the meal benefit unlimited? Yes Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

75.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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



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

limited basis)?

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

MONTHLY ALLOWANCE FOR PREPARED Notes:

FOOD.

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

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

75.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

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

Notes: MONTHLY ALLOWANCE.

> UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS, GARDENING / HARDWARE.

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

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit: Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

75.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Notes:

MONTHLY ALLOWANCE.

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

Mandatory

Living:

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

75.00

Indicate Maximum Plan Benefit Coverage amount:

75.00

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for

Living?

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

Notes: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, CAR REPAIRS, TOWELS /

LINENS AND CLOTHING.

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

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

Other 3

Other 4

wit

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

PET CARE

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

75.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED **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 Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES, ETC.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #2**

Enter name of Service:

PERSONAL CARE SERVICES

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

75.00

Indicate Maximum Plan Benefit Coverage

Select Maximum Plan Benefit Coverage

Other, Describe

amount:

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED 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 Other 2 Services? No

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE SERVICES / ITEMS SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES, HAIR

GROWTH AND ANTI-AGE / SPOT

CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

ROADSIDE ASSISTANCE

Select type of benefit for Other 3:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No

Is a referral required for Other 3 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 8 INDIVIDUAL EVENTS A YEAR FOR ROADSIDE ASSISTANCE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:

IN-HOME MINOR REPAIRS

Select type of benefit for Other 4:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

200.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

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

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Is there an enrollee Copayment?

Is authorization required?

No
Is a referral required for Other 4 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR INHOME MINOR REPAIR SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Home and Bathroom

Mandatory

Safety Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit

Modifications

Coverage amount (Select all that apply):

: 14c17: Alternative Therapies

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

BASE 5: PACKAGE #2

Indicate Maximum Plan Benefit Coverage 75.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BINE BASE 6: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

75.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #2

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #2

Home and Bathroom Safety Devices and

Modifications Notes:*

MONTHLY ALLOWANCE.

THE FOLLOWING ITEMS WILL BE

COVERED:

1) MEDICAL BATHMAT

2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

4) REACHER

5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #2

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY

APPLY:

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? Yes

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

drugs and biologics:

Indicate the Maximum Coinsurance percentage 5%

for Medicare covered Benefits for prescription



	drugs and biologics:	
	Indicate the maximum per drug amount	5
	Is there an enrollee Copayment?	No
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care	H
	day:	
	Indicate the Maximum Coinsurance percentage	5%
	for Medicare covered Benefits for a respite care day:	
	Indicate the maximum per day amount	5
	SECTION B: #19C VBID HOSPICE- BASE 2	3
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	5%
	for Medicare covered Benefits for prescription	370
	drugs and biologics:	
	Indicate the Maximum Coinsurance percentage	5%
	for Medicare covered Benefits for prescription	
	drugs and biologics:	
	Indicate the maximum per drug amount	5
)	Is there an enrollee Copayment?	No ADMINISTRAC
	Is there an enrollee Coinsurance?	Yes
	Indicate the Minimum Coinsurance percentage	Yes 5% Contacto Natura Contact
	for Medicare covered Benefits for a respite care	
	day: Indicate the Maximum Coinsurance percentage	5% DESALUC
1	for Medicare covered Benefits for a respite care	370
	day:	DESK
	Indicate the maximum per day amount	5
	SECTION B: #19C VBID HOSPICE- BASE 3	
	Are you offering hospice supplemental benefits?	No
	SECTION C: V/T - GENERAL - US	
	Do you offer a US Visitor/Travel Program?	No
	SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)
	Is there an In-Network Plan Deductible?	No
	SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)
	Is there an In-Network Maximum Enrollee Out-	Yes
	of-Pocket Cost?	
	Is your In-Network Maximum Enrollee Out-of-	Voluntary
	Pocket (MOOP) Cost at the Voluntary or	
	Mandatory Level?	2252.00
	Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
		: In-Network Medicare-covered benefits
	Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
		. A. A. T. O. T. C. T. T. C.



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Yes

Yes

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

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 : Standard Retail network (select all that apply): : 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

Do you pay for over-the-counter medications No

(OTCs) under the utilization management

program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply

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

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

: Out-of-Network Pharmacy - one month supply

30

Pharmacy 1-month supply:

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 31

NISTRAC SDESP



Pha	rmac	ÿ	1	-month s	supply:	
4		-	_	_		

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

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

No

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D	
Rewards and Incentives under the VBID	
Model?	

No

wit



MMM HEALTHCARE, LLC

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H4004-062





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 062, SEGMENT 0

PBP Module: Requested By: mint

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 11:46:25 AM SA Western Standard

Time

06/07/2021 11:19:20 AM SA Western Standard MA BPT Timestamp:

Time

06/07/2021 02:57:00 PM SA Western Standard PD BPT Timestamp;

Time

06/07/2021 08:11:08 PM SA Western Standard Last Upload File Creation Timestamp:

Time

06/07/2021 #02360 Upload Status:

PLAN STATUS

Section A Status Plan Ready for Upload

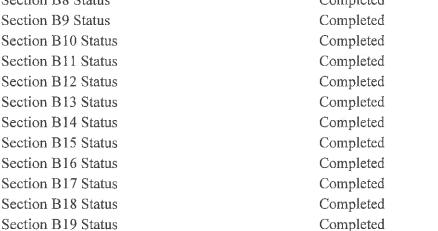
Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed

Section B12 Status Section B13 Status Section B14 Status Section B15 Status Section B16 Status

Section C Status

Completed Section D Status Completed Section Mrx Status Completed

SECTION A: SECTION A-1





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

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

MMM HEALTHCARE, LLC



Service Area(s):

Service Area(s):

Service Area(s):

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40310 - Gurabo, PR

40320 - Hatillo, PR

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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 40400 - Lares, PR Service Area(s): Service Area(s): 40410 - Las Marias, PR 40420 - Las Piedras, PR Service Area(s): Service Area(s): 40430 - Loiza, PR Service Area(s): 40440 - Luguillo, PR Service Area(s): 40450 - Manati, PR Service Area(s): 40460 - Maricao, PR 40470 - Maunabo, PR Service Area(s): Service Area(s): 40480 - Mayaguez, PR Service Area(s): 40490 - Moca, PR Service Area(s): 40500 - Morovis, PR 40510 - Naguabo, PR Service Area(s): 40520 - Naranjito, PR Service Area(s): Service Area(s): 40530 - Orocovis, PR Service Area(s): 40540 - Patillas, PR 40550 - Penuelas, PR Service Area(s): Service Area(s): 40560 - Ponce, PR 40570 - Quebradillas, PR Service Area(s): Service Area(s): 40580 - Rincon, PR 40590 - Rio Grande, PR Service Area(s): 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 40680 - Toa Alta, PR Service Area(s): 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 40740 - Vieques, PR Service Area(s):

Continto Número

22 - 003

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Service Area(s):

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	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	062
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2022 total projected member months for this plan:	13583
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	
	(=0=) (00 0 000 0

Customer Service Contact Local Phone Number



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(787)620-2396

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(877)522-0655
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered	No





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

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

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

No

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

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

No

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

No

Is there an enrollee Coinsurance?

No

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

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

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

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

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period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required?

Is a referral required for Inpatient Hospital-

Yes No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

No

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

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

Is there an enrollee Coinsurance?

Do you charge cost sharing on the day of discharge?

No

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

C?

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

Yes

Indicate the Number of Hospital Days Required

Is there a service-specific Maximum Enrollee

Zero

Prior to SNF Admission (0-2):

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

No

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No



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SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

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

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

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

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

No

Yes

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage Yes





amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

500.00

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1 No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes







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Is a referral required for Home Health Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No

Is authorization required?

Yes

Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



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

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

Is authorization required?

Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Is authorization required? Yes
Is a referral required for Mental Health
Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No Benefit Coverage amount?

To these a convict one of the Marinesser Fra

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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





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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance? Nο 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: #71 PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

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

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

ADDITIONAL TELEHEALTH SERVICES Notes:

> COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

: 7d: Physician Specialist Services

CLINICS.

No

Yes

No

No

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





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No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost? .

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes





Observation Services?	
Is a referral required for Medicare-covered 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 SUBSTANC	E ABUSE - BASE 1



SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

No

No

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? Nο Is there an enrollee Copayment? No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required? Yes Is a referral required for Outpatient Substance Yes Abuse?



Does the plan provide Outpatient Blood Services as a supplemental benefit under Part Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Outpatient Blood No Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No



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SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services No

as a supplemental benefit under Part C?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for 20%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Benefits:

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Is authorization required? Yes

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Select which Prosthetics/Medical Supplies have : Medicare-covered Prosthetic Devices

a Coinsurance (Select all that apply): : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for 20%

Medicare-covered Prosthetic Devices:

.

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for 20%

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Medical Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required? Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No





Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment? No
Do you limit Diabetic Supplies and Services to No

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a No supplemental benefit under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) No Items as a supplemental benefit under Part C?

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal
Benefit as a supplemental benefit under Part C?
Note: Only primarily health-related meals
offered in accordance with Chapter 4 of the
MMCM should be entered in this section.

SECTION B: #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

No

Exam as a supplemental benefit under Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

04



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: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No. indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

6

9

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Both Sessions (Individual and Group)

Mandatory

Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Mandatory

: Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

12

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

Is there an enrollee Copayment? SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?

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Is a referral required for Other Defined Supplemental Benefits?
Health Education Notes:

No

THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR



Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



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 15

Remote Access Technologies (Nursing Hotline) Notes:

240 // THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY

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No

TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC

CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL

COVER NATUROPATH VISITS.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Kidney Disease

No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment? No
Is authorization required for Medicare-covered Yes
Glaucoma Screening?

Is authorization required for Medicare-covered Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Yes

Barium Enemas?

Is authorization required for Medicare-covered Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment? No





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No

Yes

Is there an enrollee Deductible?

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative No, indicate number

Services?

Indicate number of visits for Restorative 1

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Mandatory Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, No, indicate number

Other Oral/Maxillofacial Surgery, Other Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Nο

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





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(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 No supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? Yes
Is a referral required for Eye Exams? No

No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear? No





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SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a No

supplemental benefit under Part C?

SECTION B: #18A HEARING EXAMS - BASE 2

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No
Is authorization required? Yes

Is authorization required? Yes
Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a No

supplemental benefit under Part C?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically III?

Select what type of benefit your SSBCI : Reduced Cost Sharing

includes: : Additional Benefits

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the Yes

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

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?

Type of Part C Reward or Incentive:

Yes

: Debit Card



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: Gift Card

Part C Reward or Incentive amount(s)

20.00

Frequency of Reward or Incentive Eligibility:

Other, Describe

Other Description:

AVAILABLE TO REDEEM INSTANTLY OR

ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

: Electronic Health Records/Electronic Medical

Records

No

that advance care plans and/or advance directives are connected from your program to

Program Connectedness: Please check the way

: Provider/Patient portals

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

15

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

: Debit Card : Gift Card

Part C Reward or Incentive amount(s):

130.00

Frequency of Reward or Incentive Eligibility:

Other, Describe

Other Description:

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

Eligibility Criteria:

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES

AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE

PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO

RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE

MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.



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> ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

Incentives Available:

150.00

Yes

1

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA

SSBCI

Uniformity Flexibility or SSBCI?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - CHRONIC **CONDITIONS: SSBCI: PACKAGE #1**

To which chronic condition does this benefit

apply? (Select all that apply)

: Autoimmune disorders

: Cancer

: Cardiovascular disorders : Chronic heart failure

: Dementia

: Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD) : Severe hematologic disorders

: HIV/AIDS

: Chronic lung disorders

: Chronic and disabling mental health conditions

: Chronic alcohol and other drug dependence

: Neurologic disorders

: Stroke

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

: Medicare-covered benefits

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sharing:

Select the Medicare-covered benefits that will

: 11a: Durable Medical Equipment (DME) 11b1: Prosthetic Devices

receive reduced cost sharing:

: 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

No

deductible?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?

Yes

Select the types of benefits that apply to the

: Medicare-covered benefits

coinsurance cost sharing:

: 11a: Durable Medical Equipment (DME)

Select the Medicare-covered benefits that will receive reduced coinsurance:

: 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

0% Durable Medical Equipment (DME)

Indicate Maximum Coinsurance Percentage for 0%

Durable Medical Equipment (DME)

Indicate Minimum Coinsurance Percentage for 0%

Prosthetic Devices

Indicate Maximum Coinsurance Percentage for 0%

Prosthetic Devices

Indicate Minimum Coinsurance Percentage for 0%

Medical Supplies

Indicate Maximum Coinsurance Percentage for 0%

Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?

· No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment? No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum aggregate amount of

Yes

reduced cost sharing?

225.00

Specify the maximum aggregate amount of reduced cost sharing:

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

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Notes:



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.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

packages do your Additionar

Benefits contain? (1-15)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA

VBID

2

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

: Chronic Condition(s)

Which disease states does this benefit apply?

(Select all that apply):

: Diabetes

Expected Number of Enrollees to be Targeted:

Expected Number of Enrollees to be engaged

and receive Model benefits:

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?

ts No

23

11

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 #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1
Notes:
NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #1

Enter name of Service (Optional): NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1: Mandatory



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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: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

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0.0

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #1

Notes:

THE INTENTION IS TO UTILIZE A
PROFESSIONAL CONTINUOUS GLUCOSE
MONITORING (CGM) DEVICE INDICATED
FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY

HEALTH CARE PROFESSIONALS.



Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders : Chronic heart failure

: Dementia : Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD) : Severe hematologic disorders

: HIV/AIDS

: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

No

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?

eft

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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

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

Yes

Specify the maximum benefit amount: 225.00

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:

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 / HOME

APPLIANCES / CAR REPAIRS,

TOWELS/LINENS AND CLOTHING)

- PEST CONTROL (CLEANING PRODUCTS / GARDENING AND

HARDWARE ITEMS)

- SOCIAL NEEDS BENEFIT:

ENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

- OTC ITEMS

- ALTERNATIVE THERAPIES

(HOMEOPATHIC / NATURAL MEDICINE

ITEMS ONLY)

- HOME AND BATHROOM SAFETY

DEVICES

- PET CARE

- PERSONAL CARE SERVICES/ITEMS

THESE ARE COMBINED BENEFITS WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED





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> SERVICES INCLUDED WITHIN SSBCI PACKAGES IN CATEGORIES 19A AND 19B.

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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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?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Does your Maximum Plan Benefit Coverage

amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

Care Manual?

Every month

No

Yes

No

Yes

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may No be found in Chapter 4 of the Medicare Managed

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #2

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)

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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; 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:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

Yes

Indicate Maximum Plan Benefit Coverage

225.00

Select Maximum Plan Benefit Coverage

periodicity:

amount:

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Other, Describe

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



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Yes

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #2

Does the plan provide Meals (beyond limited

basis) as a supplemental benefit under Part C?

Select type of benefit for Meals (beyond limited Mandatory

basis):

Is the meal benefit unlimited?

Yes

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for the Meals (beyond)

No

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE FOR PREPARED

FOOD.

Yes

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?

Select type of benefit for Pest Control: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No



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Is there an enrollee Copayment?

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: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS, GARDENING / HARDWARE.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #2

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

225.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No



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SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Social Needs Benefit?

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

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

Mandatory

Living:

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

225.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

710

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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?

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?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, CAR REPAIRS, TOWELS /

LINENS AND CLOTHING.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #2

Select what Other type of benefit your Non-Primarily Health Related Benefits for the : Other 2 Chronically III includes: : Other 3 : Other 4

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: PET CARE
Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.





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UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES, ETC.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: PERSONAL CARE SERVICES

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 2 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE SERVICES / ITEMS SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES, HAIR

GROWTH AND ANTI-AGE / SPOT

CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: ROADSIDE ASSISTANCE

Select type of benefit for Other 3: Mandatory

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No



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Is authorization required? No Is a referral required for Other 3 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR FOR ROADSIDE ASSISTANCE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service: IN-HOME MINOR REPAIRS

Select type of benefit for Other 4: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 4 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 4 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes: MEMBER WILL BE ELIGIBLE FOR UP TO 8

INDIVIDUAL EVENTS A YEAR, WITH A MAXIMUM OF \$200 PER EVENT, FOR INHOME MINOR REPAIR SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #2

Select type of benefit for Alternative Therapies: Mandatory





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Is this benefit unlimited for Alternative

Therapies?

Yes

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 4: PACKAGE #2**

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c8: Home and Bathroom Safety Devices and

Benefits have a Maximum Plan Benefit Modifications

: 14c17: Alternative Therapies Coverage amount (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEME EFITS -

BASE 5: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

amount for Home and Bathroom Safety Devices

and Modifications:

Other, Describe

225.00

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BASE 6: PACKAGE #2

Indicate Maximum Plan Benefit Coverage

amount for Alternative Therapies:

225.00

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 7: PACKAGE #2

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 10: PACKAGE #2

Is there an enrollee Coinsurance? No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 12: PACKAGE #2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 14: PACKAGE #2

Is authorization required? No Is a referral required for Other Defined No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 15: PACKAGE #2

Home and Bathroom Safety Devices and MONTHLY ALLOWANCE.

Modifications Notes:*

THE FOLLOWING ITEMS WILL BE



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COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #2

Yes

Alternative Therapies Notes:*

Is there an enrollee Coinsurance?

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19C VBID HOSPICE-BASE 1

is there an emonee comstrainee:	I Co
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
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

Indicate the maximum per drug amount

Is there an enrollee Copayment?

drugs and biologics:



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5%

5

No

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	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% 5 ROMINISTRACION	
	Indicate the maximum per day amount SECTION B: #19C VBID HOSPICE-BASE 3	Contrato Número	
	Are you offering hospice supplemental benefits? SECTION C: V/T - GENERAL - US	No O 3	
	Do you offer a US Visitor/Travel Program? SECTION D: PLAN DEDUCTIBLE (IN-NETW	No VORK)	
	Is there an In-Network Plan Deductible?	No	
	SECTION D: MAX ENROLLEE COST LIMIT		
	Is there an In-Network Maximum Enrollee Out-	Yes	
	of-Pocket Cost?		
)	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	
1	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: REDUCTIONS IN COST SHARING - GENERAL			
	Do you offer Reductions in Cost Sharing?	No	
	SECTION D: COMBINED BENEFITS - GENE	RAL	
	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	: Sponsor attests that it will comply with 42	

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CFR 423.154.

423.154.

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SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

No
Do you pay for over-the-counter medications
(OTCs) under the utilization management

program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply Location/supply amount(s) that apply: : Standard Retail Cost Sharing - 3 month Supply

30

30

90

31

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost 90

Sharing 3-month supply:

Select all Out-of-Network Pharmacy : Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply:
Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing : 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:

Select the Long-Term Care Pharmacy one : Long-Term Care Pharmacy - 1-month supply month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available No

with an extended day supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the

first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID

Model?

No

No



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